2014

“TAKE CARE” Project

WP2 - State of arts, needs and constraints in the sector

Final Report

This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

Project Number: 2013-1-FR1-LEO05-48501

Table of Contents

1. Introduction ……3
2. Methodology ……..5
3. Soft skills of caregivers - best practices and main evidence based advantages deriving from managing health care facilities in a Safe, Sustainability and HRM oriented ways - the results of previous studies …….....7
4. Health and safety legislation ……24
5. Analysis of system conditions (systemic factors) ……33
   - 5.1. Types of caregivers and their formal qualifications ……33
   - 5.2. Statistical forecasts ……...53
   - 5.3. Conclusions ……..66
6. Soft skills of caregivers - results of studies conducted in each partner country - comparison of results ……...68
7. Possible incentives that could motivate health institutions to invest in soft skills training - international comparison ……105
8. Main problems faced by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practices implementation - international comparison ……107
9. Conclusion ……..109
10. Literature ……112

Project Number: 2013-1-FR1-LEO05-48501

1. Introduction

In the last decades, European research on inclusion and participation has made remarkable steps forward. A crucial role in this respect has been played by an increasing number of national as well as international studies aimed at understanding how social interactions change over the life course, in some cases also including a cohort and/or longitudinal perspective (e.g. SHARE).

More than 4% of inhabitants of EU countries are aged 80+. In 2014 the corresponding percentage will be 5.2%. It is true that a sick or elderly patient just wants one wish to be fulfilled. He or she wants a warm and kind environment within the hospital, in which care givers and doctors spend enough time with the needs and problems of the patient. Let us now just mention that perception and reality is not alike. In fact the quality in patient care increased rapidly over the last years. According to a survey that has been conducted by RN4Cast in 2004 about International Care, the patient care giver relation counts 10:1.[1]

Within institutions, problems are more likely to occur where care standards are low, staff are poorly trained or overworked, interactions between staff and residents are difficult, the physical environment is deficient, management needs to be improved to face all these difficulties. In that situation one of the important elements are the soft skills of staff, especially caregivers.

Soft skills in the health care industry are increasingly being recognized as valuable skills that are necessary for nursing professionals to possess. The Institute of Medicine stresses that nurses need to function as a critical member of the health care team and need to be able to delegate skills in order to work at their highest level of practice. They want and need experience with professional communication and leaderships skills during they education to have a better understanding of their roles and responsibilities once they become licensed to practice[2],[3]. The IOM supports soft skills education and anticipates that nurses will be a part of the interdisciplinary teams that will be making changes in health care system.

In addition, employers desire to hire caregivers who not only demonstrate competency but also possess personal characteristics and abilities that support the provision of safe, sustainability, quality care. Caregivers that can provide evidence of possessing soft skills are

[1] http://www.minoritynurse.com/article/soft-skills-nursing. Date of access: Jan 2, 2014.
[2] *The Future of Nursing: Leading Change*, Advancing Health, IOM October 5, 2010.
[3] *Soft skills research: Aligning Nurse's Touch witch Best Practices,* Assessment Technologies Institute Inc. 2012.

at the greater advantage than those who can't provide such evidence with respect to employability[4],[5].

While the importance to effective communication in caregivers (nursing) is well agreed upon, concern over nurses' communication skills in the field continues to exist[6]. Deficits in communications can lead to mistrust between the caregivers and client, potential errors in client care instructions, and ineffective and inefficient interactions between health care team members. Moreover, leadership and management that help caregivers make task-oriented decisions related to priority- setting, delegation of task, and patient safety are essential to a successful nursing career. Leadership skills are also important to the healthcare industry as caregivers (nurses) in leadership roles are "pivotal part in retaining, motivating and developing caregiver managers and caregiver staff"[7].

The research consistency demonstrates that caregivers with more years of experience tend to display more professionalism[8],[9], so educating caregivers in the realm of soft skills may be highly beneficial.

Effective soft skills education programs ideally possess the following characteristics:

1. Skills-based on a comprehensive theoretical framework and connected to measurable outcomes
2. Both, education and practice of defined skills is provided
3. A multi-method assessment system that supports and evaluates attainment of skills is incorporated.

[4] Bowles N., Mackintosch C., Torn A., *Nurse's communication skills: An evaluation of the impact of solution-focused communication training*, Journal of Advanced Nursing, 36(3) 2001.
[5] Corning S.P., *Profiling and developing nursing leaders*, Journal of Nursing Administration, 32(7/8) 2002.
[6] Klachovich M., *Interpersonal communication. An essential skills for nursing students* (2009). Retrieved: http://www.phoenix.edu/profiles/faculty/marilyn-klakovich/articles/interpersonal-communication-an-essential-skill-for-nursing-students.html.
[7] Corning S.P., *Profiling and developing nursing leaders*, Journal of Nursing Administration, 32(7/8) 2002.
[8] Wynd C.A., *Current factors contributing to professionalism in nursing*, Journal of Professional Nursing, 19(5) 2003
[9] *Soft skills research: Aligning Nurse's Touch witch Best Practices,* Assessment Technologies Institute Inc. 2012

2. Methodology

This research analyses the current state of the caregivers sector with regard to occupational health and safety, education and qualifications, legal and organisational circumstances and the soft skills of caregivers in seven countries: Italy, France, Austria, Germany, Spain, Greece and Poland.

The aim of the activity is to test in what soft skills caregivers should be equipped and provide and a compendium illustrating the main competencies needed by Health Institutions.

This part of the project proceeded in two stages:

1. Desk research - analyzing the current state based on the secondary data
2. Questionnaire research - analyzing the needs of medical institutions in the field of the new solutions in terms of soft skills

The outputs of the first step - a desk research - gave information about:

- International best practices and main evidence based advantages deriving from managing health care facilities in a Safe, Sustainability and HRM oriented way,
- Health and safety legislation on different national levels.

The questionnaire research, conducted in partner countries will result in identification of:

- Main tasks/competencies needed by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practice implementation,
- Main problems faced by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practices implementation,
- Particular barriers among health institutions e.g. to the adoption of a flexible strategy for upgrading skills and competencies in the European Health Sector
- Possible incentives that could motivate health institutions, e.g. to invest in training

The survey includes:

- Methodology for conducting the survey
- Survey tools: questionnaire (in the language of each partner country)
- Answers analysis by project partners
- Final Report

Working activities for the desk research:

1. Best practices and main evidence based advantages deriving from managing health care facilities in a Safe, Sustainability and HRM oriented ways
2. Soft skills of caregivers - the results of previous studies in the partner countries
3. Health and safety legislation on different national levels in partner countries
4. Analysis of system conditions (systemic factors):
   - Who acts as caregivers in the health care system? In what institutions are they employed?
   - What formal qualifications are required from caregivers?
   - Analysis of the number of registered and employed caregivers in years 2010-2012 and forecast the number of registered and employed caregivers for the nest years,
   - Education caregivers, competence, qualifications
   - Age structure of caregivers
5. Legal conditions

The survey was a **testing survey**, with the objective to test:

— Main tasks/competencies needed by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practices implementation,

— Main tasks/competencies/soft skills needed by caregivers in the opinion of health managers

— Main problems faced by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practices implementation,

— Particular barriers among health institutions e.g. to the adoption of a flexible strategy for upgrading skills and competencies in the European Health Sector

— Possible incentives that could motivate health institutions, e.g. to invest in training

This survey is a cross-sectional survey. This means that it will take information concerning the above mentioned themes at a single point in time.

The survey run at the same time in seven countries, partners of Take Care Project: France, Italy, Poland, Spain, Germany, Greece and Austria with a minimum of 20 respondents from among health care managers and a minimum 20 respondents froam among caregivers in each country.

3. Soft skills of caregivers - best practices and main evidence based advantages deriving from managing health care facilities in a Safe, Sustainability and HRM oriented ways - the results of previous studies

The Bolognese Declaration accepted by the majority of European countries initiated the reform of the education system in Europe. The main aim of the reform in the field of nursing was to improve the quality of nurse education. Poland participated in many programs concerning staff education. One of the most important research project was *"Tunning Educational Structure in Europe 2001-2003"*. The Tunning project can be treated as a response of Polish universities to the Bolognese Declaration. It was supposed to contribute to the development of the homogeneous European Area of Higher Education through delivering a variety of tools to educational institutions and provide an opportunity to gain comparable professional nursing qualifications. The Tunning project resulted in defining professional competence of nurses [10].

Competences were broken into five major groups (four from the soft skills scope):

1. Competences associated with professional values and the role

1a. Acting as a responsible and independent employee in compliance with the professional, ethical, organizational and legal requirements, and responding to problems and moral-ethical dilemmas in the everyday practice.

1b. Providing care in the holistic, tolerant and protective way with respect to age, sex, views, culture, religion, nationality, lifestyle, beliefs and wishes of every person.

1c. Being able to work in diverse situations while promoting health, a sense of well-being and providing health care in order to satisfy people in different health conditions, healthy or dying, of ill health, in adversity, illness or disability.

1d. Having awareness of different roles, duties and tasks of the nurse and the ability of adapting the role depending on expectations of a patient and communities.

1e. Being responsible for one's own professional development and education in order to improve the quality of performed tasks.

1f. Having abilities suitable for needs and expectations of a patient, communities.

[10] Experts from 14 countries participated in the Tunning Project: Frederik De Decker (Belgium), Niger-Margrethe Jensen (Denmark), Marja Kaunanen (Finland), Ingrid Kollak (Germany), Sandor Hollos (Hungary), Clare Walsh (Island), Grace A. Jaccarini (Malta), Marten M. Kaaijk (The Netherlands), Bjorg Dale (Norway), Irena Wrońska (Poland), Peter Galajda (Slovakia), Koncha German Bes (Spain), Irina Y. Bulakh (The Ukraine), Mary Gobbi (Great Britain).

2. Cognitive competences

2a. The problem solving and the decision making.

2b. Critical analysis and interpretation of data and sources of information.

3. Interpersonal competences

3a. Ability to communicate effectively

3b. Enabling patients to express anxieties and worries and due answering.

3c. Ability to adopt a point of view of a patient and to respect his rights and dignity

3d. Applying the wide range of means of intercommunication to support a patient: a) giving advice; b) recognizing and dealing with difficult behaviours c) identifying anxieties, stress and breakdowns; d) granting emotional support, when it is necessary.

4. Managerial and organizational competences associated with team work

4a. Awareness that the soundness of charge is being reached as a result of professional operations of all members of the health-social care.

4b. Ability to cooperate in the frames of the health-social care team, to manage and coordinate team work.

4c. Ability to evaluate the threat/risk and the ability to actively support a sense of well-being and safety of all persons on-the-job (including oneself).

4d. Ability to apply appropriate methods for the evaluation and search of the care according to binding standards qualities.

General practical skills were divided in the three category:

1. Instrumental abilities (cognitive, professional, methodological and linguistic)
2. Interpersonal and system abilities (ability to understand and to change).
3. Ability to analyse and synthetise, to learn and solve problems.

Similarly to the WHO 2000 Strategy, the Tunning Project established the goal of the training of caregivers as competence development.

Requirements / guidelines for soft skills of caregivers in different countries are varied. Below are a collection of the most important guidelines of the project's partners.

According to the **French** experience "the professional attitudes and behaviours on the one hand, and care, on the other hand, are like two sides of the same coin, the quality and humanism care."[11] In nursing, ethical values and communication are among the most obvious and essential representations are also among the primordial dimensions to assess. In addition to others, they build the very identity of the nurse as a professional.

The behaviour is for mankind a way of behaving, characterized by a set of observable reactions in response to an internal or external stimulation. It is a way of acting which is the observable part of our actions and reactions. It is important to consider following phenomena: The part which is more inside of us as self-knowledge, self-esteem and self-confidence and on the other side a more external behaviour like work organization or how the person will present her/himself.

Professional aptitudes and soft skills:

- self knowledge/ self esteem/ self-confidence
- assertiveness / leadership
- meta cognition
- professionalism
- personal Statement
- relationship (patient, family, colleagues or other stakeholders)
- sense of ethics
- sensitivity to other
- independence of judgment and action
- sense of observation and analysis of situations
- sense of planning and organization
- be able to master the own emotions
- be rigorous methodological
- be able to listen to the different interlocutors
- be able to work in a team
- be able to assure the quality with external services
- be attentive with the patient and his/her family
- respect of the patient/ accept his ethical values
- respect of the material and the environment

[11] Margot Phaneuf, RN., Ph.D. Infiressources, August 2010

— self respect
— be discreet
— accept the prescribed dress
— be able of discernment
— be able to adapt him/herself to changing
— be punctual
— be disposable
— be able to situate his/ her place in the team
— be able to transfer his/her own competencies
— be emphatic
— be able to communicate

The Centre of Nurse and Midwife Postgraduate Education operates within an **all-Polish** program "Interpersonal Announcing in Nursing" (No. 09 / 07) which states that caregivers should be able to:

- listen actively
- paraphrase patient's statements
- reflect verbally emotions of the patient
- confirm that they understand the patient and keep a conversation
- adapt one's statements to the current way of reflecting reality by the patient
- recognize dominating systems of representing reality: own and of a patient (visual, aural, kinestatic)
- facilitate expressing difficult emotions by a patient
- express views assertively
- accept assertively the criticism and opinions of other people
- apply creative manners of problem solving
- avoid applying communication crash barriers (verbal and non-verbal)
- apply the partner style of the intercommunication
- control own emotions
- solve emotional problems of the patient and his family in therapeutic relations.

One of the most important condition/practice HRM oriented way in caregivers' working is their satisfaction from work. Polish examination about satisfaction from the work of nurses performed among 600 randomly selected nurses, registered in the regional centers.
The survey shows a relatively high satisfaction level in case of five out of eleven investigated job aspects, and a very low satisfaction level in case of two of them ("Possibility of professional promotion", "Salary"). 26% of the nurses had considered going abroad to work as a nurse in the general health care system, and 17% in the OHS system. Almost 25% of them would not choose a profession of nurse once again, including 10% who would not choose a nurse job at all. There is a statistically significant correlation between the general job satisfaction and satisfaction with other aspects of nursing work. A strong correlation was observed in case of "Scope of performed tasks" and "Cooperation with employers (clients of the occupational medicine service units)". There is a statistically significant correlation of average strength between the decision concerning choosing an occupational nurse job in case of taking a decision on professional carrier once again and "General job satisfaction".
Polish nurses are satisfied with their job, however only 26% are fully satisfied. In their work there is place for improvement. The areas which definitely need attention and improvement are "Possibility of professional promotion" and "Salary". Improvements in cooperation between occupational nurses and physicians can make it close to the best practice.

Also, performed a questionnaire survey in 100 nurses working in the province of Podkarpackie. More than half of the surveyed nurses (56%) declared that they chose their job to help others, while 15% gave priority to the prestige of this profession. According to 80% of the respondents, lack of respect for the nurse represents the most stressful factor at work. This is followed by complaints from patients and their families (71%), patients under the influence of alcohol (44%), and fast pace of work (27%). 39% of the nurses diagnosed themselves with burnout, while 35% believed they were at risk of burnout.

In 2004, 102 nurses, employed in hospitals, outpatient clinics, hospices and old people's homes, were administered three questionnaires: 1) the Hospital Anxiety and Depression Scale-Modified; 2) the Life Satisfaction Scale; and 3) the job Satisfaction Scale. The survey was a closing part of the course on psychology carried out under the postgraduate education program.
The statistical analysis of the results showed the increased level of anxiety in the youngest group of nurses, whereas the level of depression and aggression ranged from medium to low in the whole sample. The nurses' level of job satisfaction was higher than that of their life

satisfaction and the differences were statistically significant in each of the three seniority categories. The evaluation of the relationship between life and job satisfaction and anxiety, depression, aggression and job seniority showed: (a) the effect of anxiety and depression, as self-contained factors, on life satisfaction, regardless of job seniority; (b) the effect of aggression interrelated with job seniority on job satisfaction.[12],[13],[14]

Anxiety is the major factor affecting life satisfaction; job satisfaction is less prone to the influence of negative emotions than life satisfaction. Bearing in mind a tendency shown by nurses to suppress their emotions as well as their stressful work environment, they should receive psychological support in its broadest sense.

≈

To establish sustainable workplace health promotion, Ingrid Spicker, team leader for workplace health promotion **in Vienna**, suggests different measures like a pragmatic approach towards health promotion, the use of external assistance, employee sensitisation for their own health, and others.[15] Eva Kürzl, head of care supervision in **Lower Austria**, points out, that workplace health promotion starts in the education of professional health care and nursing personnel. Also, advanced training for nursing staff is important to provide the necessary tools for handling the high demands of their work.[16]

In nursing schools, soft skills are mostly taught in a theoretical way. A practice-oriented approach would be more suitable for gaining experience in the psychosocial field. Often nurses have been neither instructed for situations that require e.g. communicational skills, nor given feedback about their social competences.

[12] Kliszcz J, Nowicka-Sauer K, Trzeciak B, Sadowska A., *The level of anxiety, depression and aggression in nurses and their life and job satisfaction*, Med Pr. 2004;55(6):461-8.

[13] Lewandowska A, Litwin B., *Burnout as an occupational risk for nurses*, Ann Acad Med Stetin. 2009;55(3):86-9.

[14] Sakowski P., *Job satisfaction of occupational medicine nurses in Poland*, Int J Occup Med Environ Health. 2012 Mar;25(1):51-8. doi: 10.2478/s13382-012-0006-x. Epub 2012 Jan 5.

[15] Spicker I., *Betriebliche Gesundheitsförderung (BGF) in der mobilen Pflege und Betreuung. Beiträge zur Fachtagung*, „Gesund pflegen und gesund bleiben! – Betriebliche Gesundheitsförderung in der mobilen und stationären Pflege“ vom 20. Mai 2008 in Wien, Vienna (Austria), May 2008, p. 28 - 30

[16] Jelenko M., *Unternehmerische, politische und gesellschaftliche Herausforderungen für die Betriebliche Gesundheitsförderung in der Pflege – Ergebnisse der Podiumsdiskusion. Beiträge zur Fachtagung,* „Gesund pflegen und gesund bleiben! – Betriebliche Gesundheitsförderung in der mobilen und stationären Pflege“ vom 20. Mai 2008 in Wien, Vienna (Austria), May 2008, p. 35

In a workplace environment, factors like limited personal resources and competences as well as a lack of a basic structure to exercise soft skills in a clinical setting have a negative effect on the acquisition of social skills.[17]

The achievement of educational objectives during the practical education of nurses has to be controlled and confirmed by educational or professional nurses according to the *Austrian Health Care and Nursing Act.* The Viennese Hospital Association has published a document for this purpose which includes assessments of classical hard skills as well as soft skills like self-competences (e.g. autonomy, goal-orientation, reflection about the care process, etc.) and social and communicative competences (e.g. communication skills, the ability to recognise problems, the ability to identify the expectations of the patients, etc.). However, the main focus of these assessments is on hard skills, which is also shown by the fact that the document comprises 49 pages of assessments, of which only 9 are dedicated to soft skills and the remaining 40 pages are dedicated to hard skills.[18]

A recent study published by the *Austrian Chamber of Labour* shows that the home care and nursing personnel is a high risk group in terms of overworking and burn out. More than half of the people (54,45 %) that responded to the questionnaire used in this study judge the working conditions to have deteriorated in the past six years. 51,88 % of the people anticipate further decline. The study also shows that 38,9 % of caregivers show initiating or advanced symptoms of burnout, such as emotional exhaustion or increased depersonalisation.[19]

There are various Institutions in Austria, like the Austrian network of health promoting hospitals and healthcare institutions (ONGKG), the federal ministry of health, the Fonds Gesundes Österreich (FGÖ), the alliance for health promoting healthcare institutions in Vienna and the Ludwig Boltzmann institute for health promotion research that try to improve workplace health promotion.

Different projects concerning workplace health promotion in Austrian healthcare institutions exist, but only few scientific studies concerning this topic have been published.[20] In a project carried out in a hospital in Vienna, a health promoting effect in kinaesthesia trainings for nurses concerning dorsal pain and spinal conditions was found.[21]

---

[17] Mayer M., *Personenzentrierte Pflege. Implementierungsschwierigkeiten psychosozialer Konzepte*, Vienna (Austria) 2010, page 35, 44, 60 and 116

[18] LKH Feldkirch, Kompetenznachweis – Nachweis über die praktische Ausbildung. Feldkirch (Austria) Nov. 2010

[19] Dressler S., et al., *Ergebnisse der Studie*, „Arbeitsbedingungen in den Gesundheits- und Sozialberufen". Vienna (Austria) 2014

[20] Ullrich J., *Älter werden im Pflegeberuf – Gesundheitsförderung als eine Strategie, um als Pflegeperson im Krankenhaus langfristig gesund im Beruf arbeiten zu können,* Vienna (Austria) 2011, p. 84 - 85

For care and nursing professions, the Austrian Social Insurance for Occupational Risks (AUVA) provides information and training mainly aimed towards physical health and occupational safety. With an informational brochure on ergonomics in nursing jobs they try to raise self-awareness among health care and nursing staff for their own posture and motion, the problems that frequently occur in their work, the consequences of false posture and the limitations of physical resilience. They also give advice on how to disburden your body and do compensational exercises for physical strain in order to increase occupational health among care personnel.[22]

A thesis by Ingrid Spicker concerning the professionalization of health care and nursing services in Austria and bringing them up to an academic level pointed out that nursing staff themselves criticize an authoritarian leadership, a low willingness to provide information and a lack of social competence (e.g. handling of criticism, ability to communicate and reflection skills) mainly in head nurses. It is also stated that a professionalization of caregivers, which is desired in Austria, cannot exclusively be reached by more detailed medically relevant education but through teaching psychosocial and communicative skills. A lack of those competencies also results in a perception of caregivers as being unprofessional.[23] The curriculum for nursing schools in Austria contains mostly medically relevant subjects, but there are also courses like professional ethics, sociology, psychology, educational theory and social hygiene and communication, conflict resolution, supervision and creativity training which are necessary for developing soft skills.[24]

The curriculum for professional nurses, provided by the GÖG in 2003, defines the content for the different subjects that are taught in nursing schools. The course 'professional ethics' contains fundamentals of ethics as well as professional ethics, transcultural aspects of care, care management, care organisation, quality assurance and nursing pedagogy. In total, 80 hours of this course are included in the three years of education for nurses. In the subject 'sociology, psychology, educational theory and social hygiene' the human development and human relationships across the whole span of life are covered. Also the human handling of

---

[21] Burns E., *Effizienz- und Gesundheitsentwicklung in der Pflege mit Kinästhetik*, Projekt am Krankenhaus Hietzing mit Neurologischem Zentrum Rosenhügel der Stadt Wien, Pressbaum (Austria) 2007

[22] Allgemeine Unfallversicherungsanstalt (Social Insurance for Occupational Risks, AUVA): Ergonomie in helfenden Berufen – Sicherheitsinformation der Allgemeinen Unfallversicherungsanstalt. Vienna (Austria), Jun. 2006

[23] Spicker I., *Professionalisierung der Pflege. Die Sicht von Pflegenden in der Praxis – Eine qualitative Untersuchung zu Wahrnehmung und Einschätzung ausgewählter Professionalisierungsaspekte durch Pflegende in Wien*, Vienna (Austria) 2001, p. 82 and 109-110

[24] §42 Bundesgesetz über Gesundheits- und Krankenpflegeberufe (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013

continuous health, illness and disability is part of this subject, which is scheduled with 90 hours of classes during the three years of nursing school. In the course 'communication, conflict resolution, supervision and creativity training' classical soft skills like communicational skills, working with and instruction of caregivers, conflict theory and conflict management, establishing professional relationships, interdisciplinary cooperation, accompanying persons and groups, practical reflection, stress management and fundamentals of supervision. 120 hours of this this subject are included in the three year training for nurses.[25] These three subjects that focus on soft skills combine to a total of 290 hours during three years of nursing school. This is only 14,5 % of the 2000 hours of theoretical training. The remaining 85,5 % of training are aimed towards hard skills.

≈

Geva-Institut- **Germany**- (2011) announces that health care facilities suffer from the competition for qualified staff. The turnover rates are remarkable and trainees and trained professionals are difficult to recruit. Unattractive working conditions within German health care facilities make it hard for the management to recruit and retain employees for a longer period of time. The management has to react to the needs and expectations of care givers in order to handle the competition on the labour market successfully.[26] A recent survey of Kienbaum (2009) adds that one of five hospitals face the above mentioned challenges within the Human Resource Management. Therefore the recruitment and retention of professionals and executives as well as the further qualification of the employees stands on the top of the agenda of the HR managers in charge. This statement refers to the study "Value deriving HR work in hospitals" (2009) of the management consultant Kienbaum, in which 66 hospitals participated.[27] According to the Institute of Work and Technology IAT are "Work and Qualification" critical competitive factors in the future of the health care industry. It mentions that structured trainings and qualification have a great impact on a solution of the problem.[28]

[25] Pogatscher P., *Standortbestimmung: Die Pflegeausbildung in Österreich. Welche Problemfelder sind im Zusammenhang mit der Akademisierung der Pflegeausbildung zu erkennen*?, Graz (Austria), Jul. 6, 2011, page 20 and 90-92

[26] *Deutscher Berufsverband für Pflegeberufe (DBfK) Zahlen – Daten – Fakten „Pflege";* Hintergrundinformationen. Page 12. Berlin (Germany). 2012.

[27] Kienbaum Studie: Download unter www.kienbaum.de.

[28] Ibidem 2012

In the following selection different methods of trainings are listed:

- Tutorials that provide the educational foundation in each subject area
- Interactive simulation, which offers opportunities to make decisions (i.e. practice) in a simulated clinical situation
- Case studies providing an opportunity to apply knowledge of soft skills to clinical situations

As already mentioned, the HR management needs to provide incentives within the competition on the labour market to attract employees, to successfully recruit workforce and to retain care givers. One Best Practice example shall be explained in the following which is conceptualized for attracting new talents in the health care sector.

DASA Working World Exhibition

The DASA permanent exhibition in Dortmund offers 12 exhibition units for visitors to access. The exhibition takes the shape of a themed interior that whisks the visitor away on a trip into all kinds of different work environments.

"The DASA Working World Exhibition in Dortmund presents past, present and future worlds of work on an exhibition area covering no less than 13.000 square metres. It is the permanent educational facility of the Federal Institute for Occupational Safety and Health Care (Bundesanstalt für Arbeitsschutz und Arbeitsmedizin) and informs the general public about the world of work, its status for the individual and society, and the importance of tailoring work to human requirements." [29]

One environment of DASA is named "Healing and Care" and refers to visitors that are interested in the occupational work of care giving. To arouse the visitor's interest and to particularly target children and young people, different special attractions are provided in the exhibition, such as:

- Operating like the professionals: the minimal invasive surgery simulator
- Muscles in balance: the back check
- Spinning in outer space: the space curl[30].

[29] http://www.dasa-dortmund.de/en/about-dasa/was-ist-die-dasa/. Date of access: 1Jan 2014.
[30] http://www.dasa-dortmund.de/en/dasa-permanent-exibition/ausstellungseinheiten/heilen-und pflegen/. Date of access: 1Jan 2014.

The concept of DASA is to provide individual sensual experience to the visitor. Students shall gain knowledge and ask questions within a real everyday environment. The exhibition is especially interesting for a younger target group. New talents can take a look into the work of care givers and examine the job under real situations. In this way curiosity is created, first experiences are made and knowledge can be gained.[31]

In the occupational field of nursing in German literature, there are often sequences of skills or a simplified classification of the term to be found. Here scientists often refer to the following expressions:

- professional competence
- personal competence
- social skills
- methodological expertise.[32]

Within this classification social competence occupies the main part of nursing expertise.
Another approach discussing the concept of competence in nursing is found by Olbrich (1999). It refers to the term divided into four dimensions of nursing. Every dimension matches with different competencies. Finally Olbrich summarizes a selection of skills that can be identified as components of the nursing competence:

- ability to apply knowledge
- understanding and perception
- self-reflection
- personal strength.[33]

Given the demographic change it shall now be summarized which competencies care givers need to meet the future challenges. As above mentioned, there will be an increasing demand for nurses in the field of elderly care and nursing. This professional focus must be included within the apprenticeship. The ability to handle the own cooperation and organization of the workload will be as important as teamwork and cooperation skills. The main focus shall now be placed on personal and social skills. The following important skills are taken into consideration:

[31] Ibidem
[32]Sahmel, Karl-Heinz. Pflegepädagogische Grundlagen und Konzepte. „Pflegerische Kompetenzen fördern“. Stuttgart (Germany) 2009.
[33]Olbrich C., *Pflegekompetent*. Bern (Germany) 1999.

Personal competence:

- Independence
- Willingness to assume responsibility
- Higher tolerance of frustration

Social Skills:

- Balance between self-realization and adaptation to social realities
- Interaction with patients and colleagues
- Conflict solving skills

Now that the concept of relevant soft skills is summarized, a practical implementation within the educational system of care givers has to be made. "We are referring now to the theoretical framework, combined education, application to clinical practice, and multiple assessment modes. Specialists and educated care givers have to support the students, so that they gain the knowledge, skills, and attitudes needed to stay healthy and manage work-related stress, convey professional behaviours and attitudes, and serve as leaders and patient advocates"[34].

≈

In Greece, in general, informal care is common in Greece and formal care was practically non-existent until the early eighties. A unique formal certification system of caregivers is lacking in Greece.

Only few projects exist concerning directly caregivers in Greece. The most famous effort to harmonize caregivers' market is a European project carried out in Greece, Cyprus, Lithuania, Spain and Hungary named *Elderly Care Vocational Skill Building and Certification* (ECVC). ECVC is the most relevant one, as it provides an e-training -theoretical and practical training- for caregivers of elderly. It introduces the distinct qualification "ECV Certificate" within the vocational education and training (VET) sector at the post-secondary, pre-tertiary level (ISCED 4VOC).The project developed a system for the recognition of competencies acquired in the non-formal and formal vocational training environment. The originality of the program stems from he fact that it can be by informal and

[34] http://www.minoritynurse.com/article/soft-skills-nursing. Date of access: Jan 1, 2014.

migrant caregivers, which is crucial for the Greek market of care.

Another remarkable initiative is the European project of *Athens Association of Alzheimer's disease and Related Disorders* named "Set care, self-study, e-learning tool for the social home-care sector". This project aims to improve the skills of care workers in Greece and Bulgaria by adapting an innovative Italian methodology of work qualification and recognition of competencies of professionals engaged in the field of home care assistance. It takes into account the specific needs of these workers, such as language barriers and lack of time, as well as opportunities and resources to access traditional courses. The training tool that has been developed in Italy, provides training on elderly care by making use of e-learning (in order to be available anytime and to be cost-effective).

A large portion of the care time involves social skills rather than technical/professional skills. Nursing competencies are very important but social ones are often most crucial for patients. Good communication skills and interpersonal capacity (listen closely and give careful consideration to the patients' needs) are central for a professional who spends many hours a day with the patient.

All new projects about training opportunities and certification of caregivers in Greece focus on:

- Vocational awareness
- Basic pathology (i.e. age-related pathology) or polypathologies
- Environmental Care
- Basic body care, Hygiene, Nursing, Handling incontinence, First aid
- Physiotherapy
- Mobility and entertainment
- Tools and materials for management

Nevertheless, we can see that basic education of nurses is more centred upon the provision of “technical” knowledge (healthcare techniques, medication, etc) than directed towards the teaching of social skills (crises management, awareness etc.). Management or communication skills are developed only during training periods or during specialized Master degrees.

Especially during crisis, some soft skills of caregivers need to be improved. The Eurofound report on Greece[35] points to the isolation of health and social professionals and their increased needs for psychological support. However, the report focuses on the need for stress management training and enhanced communication with the assisted person, and reveals that since the beginning of crisis NGOs, local public or private organizations, often do develop mitigating strategies, in order to provide support to formal and informal caregivers. We can argue that informal group training of caregivers and psychological support by specialists, in order to cultivate body awareness (by paying attention to patients' body reactions such as breathing rapidly, sweating, racing heart etc.) are very significant.

One brilliant example of soft skills training of both formal and informal caregivers is the one provided by the *Psychogeriatric Association of Nestor* in Athens. The organization offers:

- *individual counselling* for caregivers by qualified psychologists (for caregivers in the early and middle stages of dementia); nurses (for caregivers in seriously stages of dementia) offer caregivers information on dementia and tips on caring for caregivers .
- *individual psychotherapy for caregivers by q*ualified psychologists. This service is particularly important and is determined by the very substantial burden the caring for dementia patients constitutes.
- *Psycho-education groups* for caregivers by specialized social workers aiming to provide information and guidance on many issues concerning personal coaching, education of caregivers about the disease and its management, the treatment of any psychological burden.
- *Group exercise to improve the caregivers' emotional state (c*aregivers of patients with dementia, with the aim of identifying negative emotions and their impact on everyday life of the person through cognitive - behavioral techniques.

[35] Zafiropoulou M., Kaitelidou D., Siskou O., Katsikas D., Oikonomoy Ch., *Impacts of crisis on access on healthcare services: Greek report*, Eurofound editions, September 2014.

- *Courses on dementia and depression (theoretical seminars*) by qualified scientists (doctors and other health professionals) in the hall of the Alzheimer Centre on a monthly basis. These courses are conducted in collaboration with the Association of Carers of Patients with dementia and related disorders.

≈

The **Italian** health care sector requires trained professionals, able to engage in multi-disciplinary teams and to take the responsibilities for their own actions, being aware of the consequences that may result from their decisions and of the proper way to manage cares.
Accordingly, a safe, sustainable and HR oriented management of health care facilities is more than necessary. Prevention is becoming increasingly important as a cost effective strategy in a situation of escalating health care costs[36]. Experiences in Italy show that this kind of approach determines the following advantages:

— recognition of the motivations, even ethical, to the commitment to the prevention and management of clinical risks in daily professional practices;
— implementation of better professional practices by:
  - early identification of risks and related clinical determinants;
  - early recognition and reporting of adverse events;
  - better analysis of the causes of active and latent infections;
  - early interventions for the prevention of risks and better management of adverse events and their consequences;

Such approach requires:

— proper documentation, handling and storage of key information;
— clear identification of job profiles closer to risks and their responsibilities;
— education of patients, family members, volunteers and workers about the identification, prevention of and protection from risks, as well as about the management of the damage and its consequences;

[36] *Investing in the Future of Jobs and Skills. Scenarios, implications and options in anticipation of future skills and knowledge needs*, Sector Report Health and Social Services, May 2009.

— communication to patients and family members of any adverse events, using effective methods and tools;
— identification of the implications in terms of clinical risks related to health technologies;
— recognition of the organizational and economic implications of clinical risks[37].

Continuous training enables caregivers to report lower levels of burden, stress and distress, thus improving their professional outcomes.

The most important *soft skills* that *caregivers* should own include the capabilities to: monitor, interpret, make decisions, take action, adjust to changing needs, access resources, and negotiate. Skills such as monitoring and interpreting require complex reasoning[38]. Nurses and social workers should assess the care situation and, in turn, help families and parents to develop the skills they need. Moreover, caregivers need to perform complex medical tasks, supervise patients, make decisions, solve problems, provide emotional support and comfort, and coordinate care services.

Family caregivers also typically manage the household. In order to be able to improve the safety of patients, caregivers may need to modify the environment and acquire equipment and assistive devices. Caregivers also need to learn to monitor patients for new signs and symptoms, adverse events, and positive responses to treatment. Notwithstanding the above mentioned, we must stress that the level of caregivers' knowledge and skills vary depending on patient acuity, illness type, or both.

Different European projects, involving Italian partners, are ongoing with the aim to develop new skills and competences of caregivers:

• careNET: the CareNET project aims at developing a set of ICT competences in two identified 'at risk' target groups: care-workers and older persons. The project is designed to work in a synergistic way to tackle identified problems in the low skilled and under professionalized care-worker sector, promoting at the same time social inclusion and enhancing the quality of life of older people.

[37] Sicurezza del paziente e gestione del rischio clinico: manuale per la formazione degli operatori sanitari. Ministero della Salute – Dipartimento della Qualità, Direzione generale della Programmazione Sanitaria, dei livelli di Assistenza e dei Principi Etici di sistema – Ufficio III.

[38] Given C.W., *What knowledge and skills do caregivers need?*, Michigan State University. P. R. Sherwood, University of Pittsburgh.

• CARER+: will create a unique a list of ICT knowledge and skill-based competences for domiciliary care workers with related certification process for digital competences of care-workers.

• ELSA: intends to explore the use of Web 2.0 to reach two target groups: family and professional caregivers caring for frail elderly people, including those who live with Alzheimer disease and with dementia. The main aim of ELSA project is to create videos, slides, texts which can give support and information to those (professionals and relatives) caring for frail elderly people.

≈

In Spain, in the last ten years, appeared many publications, which focus on some programs and interventions to support non- professional caregivers and which arise out of some professionals worries for care providers health and quality of life. Most programs of intervention of support the informal caregivers published in national territory have been achieved in entities and public institutions, there being a scarce representation of private entities. The origin of the studies is very distributed by the Spanish geography, developing the biggest number of studies in the provinces of Barcelona and Madrid. Fact that coincides with the existence of a major population density and a major number of the best dependent persons. Nurses are the professionals who propose more studies of intervention or of support to the informal caregivers. These ones, together with the rest of the multidisciplinary team, have an important role, since the formal given cares go to both: to the dependent persons and to their familiar caregivers. In spite of the numerous initiatives and interest of the different professionals, there are few and scarce evidence of the results. This can be because the big majority of the analysed publications deal with the description of the contents of programs, but they do not show a scientific evaluation of the efficacy of skills, in addition to present methodological.

4. Health and safety legislation

In addition to general occupational health and safety legislation, there are some acts that are relevant especially for health care personnel. These different acts originate either from a European Union, national or federal state basis.

European Union Acts - EU Directive 2010/32

The European Union directive 2010/32/EU deals with the handling of sharp objects in healthcare institutions in order to avoid pinprick injuries. The guideline was transferred into national legislation on January 3rd 2013. Its key points are that employees in the health care sector have to be provided with safe instruments and that they have to be sufficiently trained for those instruments and that all pinprick injuries have to be reported.[39]

National acts in partners' countries

In France since 1950, the *International Labour Organization* (ILO) and the *World Health Organization* (WHO) have shared a common definition of occupational health. It was adopted by the Joint ILO/WHO Committee on Occupational Health at its first session in 1950 and revised at its twelfth session in 1995. The definition reads:

- "Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities; and, to summarize, the adaptation of work to man and of each man to his job.
- "The main focus in occupational health is on three different objectives: (i) the maintenance and promotion of workers' health and working capacity; (ii) the improvement of working environment and work to become conducive to safety and health and (iii) development of work organizations and working cultures in a direction which supports health and safety at work and in doing so also promotes a positive social climate and smooth operation and may enhance productivity of the

[39] www.nadelstichverletzung.at (Section Gesetzgebung), date of access: Jan. 23, 2014

undertakings. The concept of working culture is intended in this context to mean a reflection of the essential value systems adopted by the undertaking concerned. Such a culture is reflected in practice in the managerial systems, personnel policy, principles for participation, training policies and quality management of the undertaking."

≈

In France, the National Occupational Health Plan (PNS) is placed under the authority of the Ministry of Labor (DIRRECTE). The Occupational Health Regional Plans (PRST) are placed under the responsibility of the regional Prefect and the DIRECCTE. Approval of occupational health services is issued by the DIRECCTE. In addition to any departmental initiatives, exchanges are provided between the regional health agencies and the regional committees for prevention of occupational risks when developing regional health plans and regional schemes organization.

Prevention of hardship. The obligation to prevent the hardship is widespread:

• By completing the general principles of prevention (Article L. 4121-1 of the Labour Code): "The employer has to take the necessary measures to ensure the safety and protect the physical and mental health. These measures include (...) prevention of occupational risk prevention and painfulness at work".

• By expanding the missions of the CHSCT (Article L. 4612-2 of the Labour Code): "The CHSCT undertakes the analysis of employees' exposition to factors of hardship."

≈

The Art. 32 of the **Italian** Constitution says "The Republic safeguards health as a fundamental right of the individual and collective interest, and guarantees free medical cares to the indigent. No one can be forced to a specific medical treatment unless required by law. The law may in no case violate the limits imposed by respect for the human person".

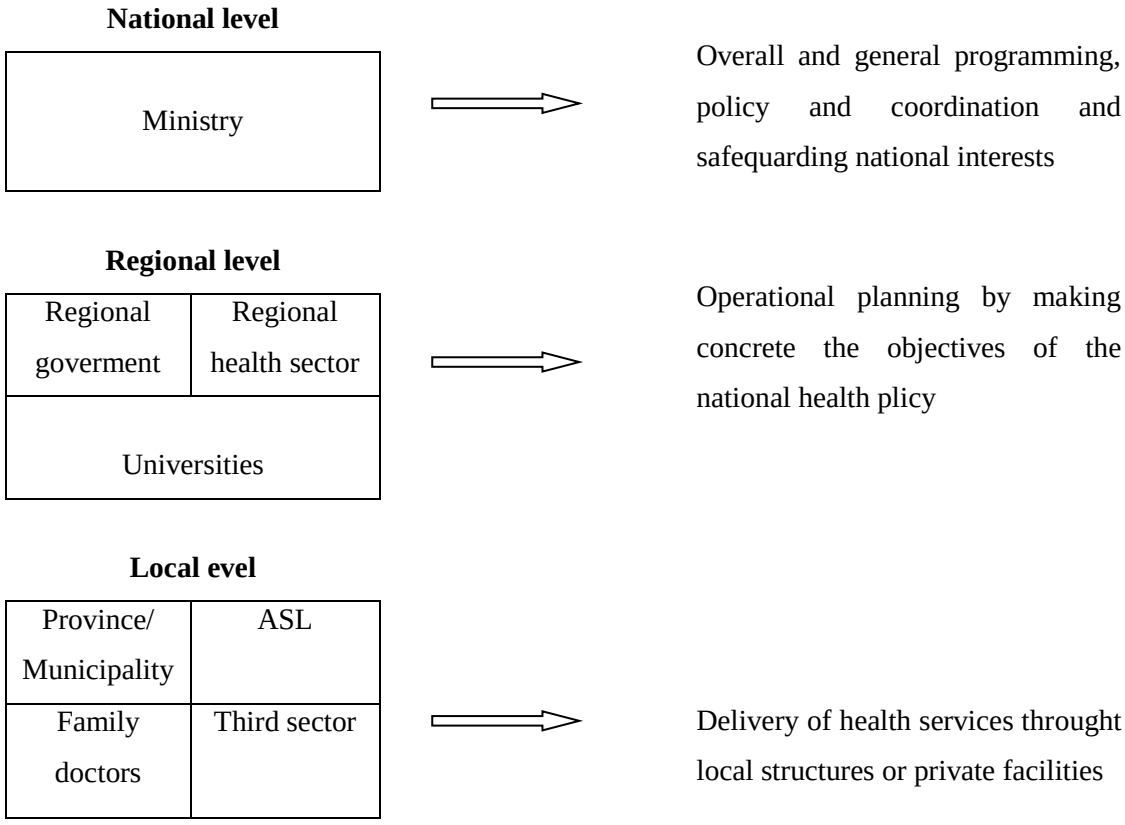
The National Health System was instituted in the 1978 with the Law 833/1978. The inspiring principles of the new Law were:

1. one single body that operates at national level;
2. overall performances: one single body can deliver health services;
3. universality of the recipients: health services for all;

4. equality in the treatment.

The Law 833/1978 was reformed during the following years with the Laws 502/1992, 517/1993, 724/1994 (introducing the private health services and new financing rules) and 229/1999 (reform of the Regional levels).

The following picture explains the organisation of the Itaian Health Service among its 3 levels: National, Regional and Local.



With regards to the professionals, the Decree 739/94 on the determination of the nurse professional profile is a milestone in the process of professionalization of nursing. It recognizes the nurse as the responsible for general nursing, the precise nature of their operations, the operational areas, the methodology of the work, the interactions with other stakeholders, the professional cultural and practical fields, the five areas of specialized training (public health, pediatrics, mental health / psychiatry, geriatrics, critical). The profile outlined by the Decree is that of a intellectual, competent, independent and responsible professional.

≈

In **Poland** under the legal account they are being regulated above all competition of the nurse and the midwife.

Provisions of law connected with working as the nurse and for the midwife

1. ACT of July 1, 2011 about the self-government of nurses and midwives

   The act is defining the organization and tasks of the professional self-government of nurses and midwives and rights and duties of his members.
2. Code of ethics of the nurse and the midwife of the Republic of Poland
3. ACT of July 15, 2011 about the competition of the nurse and the midwife

   The act is defining principles:

   1) of working as the nurse and the midwife;

   2) of getting the right to work as the nurse and the midwife;

   3) of vocational training of the nurse and the midwife;

   4) of postgraduate education of the nurse and the midwife.

   3a. Minister of Health regulation of November 7, 2007 on the kind and the scope of preventive, diagnostic, healing and rehabilitation benefits granted by the nurse or the midwife independently without the medical order

   3b. Minister of Health regulation of October 29, 2003 on the list of fields of the nursing and fields being applicable to a health care, in which the led specialization and qualifying courses can be, and framework programmes of the specialization for nurses and midwives

   3d. Minister of Health regulation of October 29, 2003 on the postgraduate education for nurses and midwives
4. ACT of April 15, 2011 on healing activity and Minister of Health regulations associated with this act.

   The Act is implementing new principles of leading by nurses and midwives traineeships.
5. ACt of November 6, 2008 on patient's rights and the Spokesman of patient's rights
6. ACT of September 8, 2006 on National Medical Rescue
7. ACT of June 27, 1997 on the service of the occupational medicine
8. ACT of August 22, 1997 on the public service of blood
9. Act of November 6, 2008 on consultants in the health care
10. Act of August 19, 1994 on the protection of the mental health
11. Acts of March 12, 2004 on the welfare.

≈

Like many of today's developed countries, **Spain** has in place a national healthcare system that offers a variety of free healthcare services to all Spanish residents. Moreover, because the Spanish system is based on the notion of "universal" healthcare, tourists, non-residents, and even people living in the country illegally are never denied treatment. In some cases, non- resident individuals will be required to pay upfront for the health services they receive, either through direct payment or via their national social security system, but these charges seldom apply when the services rendered are deemed "basic" in nature.

The national healthcare system in Spain, known locally as *Instituto Nacional de la Salud,* covers all Spanish citizens, regardless of their economic standing. To ensure equal access to quality healthcare for the entire Spanish population, the system is decentralized, and thus not merely concentrated in heavily populated urban areas. Reforms in recent years have regionalized the system even more in an ongoing effort to provide greater response time in health-related emergencies.

— Today the Spanish National Healthcare System is made up of three organizational levels: **Organizacion de la Administracion Central**. The Organizacion de la Administracion Central, or Central level of health organization, is administered by the National Ministry of Health. This agency is responsible for creating and issuing health proposals, and developing and executing the government's guidelines with regard to public health. The agency is also active in coordinating programs designed to curb the use of illegal drugs in the country.

— **Organizacion Autonomica**. Oversight and operation of the Organizacion Autonomica, or "Autonomous Organization" level, is the responsibility of each of Spain's 17 Autonomous Communities. Each Autonomous Community must provide integrated health services to its specific population through the centres, services and establishments of that community.

— **Areas de Salud**. The Areas de Salud, literally "Health Areas," represent the local level of health administration. These are the fundamental structures of the national healthcare system and are responsible for unitary management of the health services offered at the level of the Autonomous Community.5 To increase the efficiency of the healthcare system, the Areas de Salud are subdivided into smaller units called "zonas basicas de salud," or "basic health zones.[40]

[40] http://www.msssi.gob.es/ciudadanos/prestaciones/centrosServiciosSNS/home.htm

≈

The occupational health protection system in **Germany** is characterized as the following. The term "occupational safety" is used as a measure to secure safety and health of employees, including the prevention of occupational accidents, occupational diseases and work-related health hazards. The occupational safety also secures the protection of vulnerable groups (young people and pregnant women).

The fundamental legislation in the field of occupational health and safety is to be found in the following Acts:

- Occupational Protection Act,
- Occupational Safety Act,
- the Seventh Book of the Social Code - Statutory Accident Insurance and
- Ordinance on Hazardous Substances.[41]

Occupational Protection Act

The Act provides labor protection obligations for the employer in all areas, the duties and rights of employees as well as the monitoring of labor protection. The law has been implemented as a measure of safety and health to improve the safety and health of the workers at their working place.

The employer must meet the necessary measures that are required under the Occupational Protection Act to ensure health and safety of the worker, to improve the cooperation and to implement protection measures. The workers themselves have to comply with the occupational health and safety instructions of the employer and take care that other people are not endangered by their activities.

Occupational Safety Act

The Act is conducted to occupational physicians, safety engineers and other professionals for work safety.

[41] http://www.baua.de/de/Informationen-fuer-die-Praxis/Rechtsgrundlagen-und-Vorschriften/Arbeitsschutzsystem%20in%20Deutschland.html. Date of access: Jan 1, 2014.

According to this law, the employer shall order occupational physicians and specialists that help him to provide occupational safety. They shall support him due to the Occupational Safety Act. It shall be ensured that:

1. the occupational safety and accident prevention serving rules are applied accordingly to the special operating conditions
2. occupational health and safety knowledge is secured to improve labor protection and accident prevention can be realized
3. the occupational safety and accident prevention control measures achieve the highest efficiency possible.[42]

Employer responsibility

The employer is responsible for the safety and health of his employees at work. He is obliged to take the necessary occupational safety measures considering the circumstances. The employer has to review the measures for their effectiveness and if necessary to adapt to changing circumstances. It is the duty of the employer, to improve the safety and health of the employees.

To assist it, the employer has to name safety representatives and occupational physicians who advise him on health and safety issues. Since Germany consists of federal states, the federal system can also be found within the health and safety legislation. Protective labour legislation is predominantly conducted to the federal law. Regulations, however, are mainly decided by the federal government.[43]

≈

A great majority of carers, essentially the unofficial ones, are not insured to the national social insurance system. Furthermore, there is no legislation in **Greece** covering informal caregivers. Finally, caregivers' formal occupation is not considered as a dangerous job by Greek legislation; consequently, health and safety legislation is not sufficient for preventing and regulating dangerous situations.

≈

National and federal acts in **Austria:**

National Acts:

— Occupational Safety and Health Act

[42] http://www.bmas.de/DE/Service/Gesetze/arbschg.htm. Date of access: 1 Jan 2014.
[43] http://www.baua.de/de/Publikationen/Faltblaetter/F2.html. Date of access: 1 Jan 2014.

— Medical Institutions Working Hours Act
— Radiation Protection Act
— Health Care and Nursing Act
— Healthcare Institution Act

Federal State Acts:

— Healthcare Institution Act (Federal State Implementation)

General workplace health and safety in Austria is regulated in the Occupational Safety and Health Act based on the guidelines of the European Union. It contains the rights and obligations of employers as well as employees for creating a safe working environment. The organisation of workplaces, the handling of working utensils, the exposure to dangerous working materials, health control, work processes, health and safety supervision, reporting and recording obligations and the contribution of the employee to occupational safety and health are the main points of this act.[44]

The Medical Institutions Working Hours Act regulates the working hours and rest time of health care personnel. Employees in healthcare institution may only work up to 13 hours a day and 60 hours a week at maximum. Also the average weekly working time for a period of 17 weeks may not exceed 48 hours. An exception is made for situations in which the employee is not occupied during the whole working period. The maximum working time for nursing personnel in this situation is 25 hours at a time with the working hours for the whole week not exceeding 72 hours and the average for a period of 17 weeks not exceeding 60 hours.[45]

The Radiation Protection Act covers the usage and handling of ionising radiation that is relevant in medical imaging and nuclear medicine. Basic protective regulations, authorisation and reporting obligation, protection from natural sources of radiation, protection and safety measures for radiological contingency situations, central register for radioprotection and environmental observations by the authorities are regulated within this act.[46]

[44] BMASK Bundesministerium für Arbeit, Soziales und Konsumentenschutz, Federal Ministry of Labour, Social Affairs and Consumer Protection: Arbeitsschutz. Sicherheit und Gesundheitsschutz am Arbeitsplatz - das ArbeitnehmerInnenschutzgesetz. Vienna (Austria), Feb. 2009

[45] §2 - §4 Krankenanstalten-Arbeitszeitgesetz (KA-AZG). BGBl. I Nr. 8/1997, zuletzt geändert durch BGBl. I Nr. 89/2012

[46] Strahlenschutzgesetz (StrSchG). BGBl. Nr. 227/1969, zuletzt geändert durch BGBl. I Nr. 106/2013

The Health Care and Nursing Act not only regulates the education and field of activities for caregivers but also health and safety relevant topics like hygiene. It states that nurses are co-responsible for evaluating and keeping up good hygiene standards in health care institutions.[47]

Technical safety in healthcare institutions is covered in the *Healthcare Institution Act* on a national and federal state basis, where federal state laws represent a specified implementation of the federal law. According to this act, the operator of the institution has to make sure that technical safety of medical devices is guaranteed and that a technical safety officer is appointed.[48] The Healthcare Institution Act also gives the basic framework for house rules for healthcare institutions.

These basic guidelines have to be furthermore specified by the federal states of Austria and in the end individually implemented by the healthcare institutions. Apart from the organisational structure, also obligations of employees and employee briefings and cooperation guidelines for interdisciplinary wards have to be incorporated into the house rules.[49]

[47] §22 Bundesgesetz über Gesundheits- und Krankenpflegeberufe (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013

[48] §8b Bundesgesetz über Krankenanstalten und Kuranstalten (Krankenanstalten- und Kuranstaltengesetz – KAKuG). BGBl. Nr. 1/1957, zuletzt geändert durch BGBl. I Nr. 81/2013

[49] §6 Bundesgesetz über Krankenanstalten und Kuranstalten (Krankenanstalten- und Kuranstaltengesetz – KAKuG). BGBl. Nr. 1/1957, zuletzt geändert durch BGBl. I Nr. 81/2013

5. Analysis of system conditions (systemic factors)

In different countries there are different professions performing the caregivers' functions. It is not possible in this study to examine all of the mentioned professions, so we decided to describe the most important in each partners' country (in the first part describing the types and formal qualifications, the second number and statistical forecasts of selected caregivers).

5.1. Types of caregivers and their formal qualifications

In **France** you can consider that around 20 different professions are considered as caregivers:

- Nurse (with different specificities as psychiatry, anaesthetist, gerontology, operating, …)
- Nurse auxiliary
- Sterilizing agent
- Qualified hospital agent
- Medical and psychological Help
- Child Care Auxiliary
- Brancardier
- Dietician
- Ergo therapist
- Manipulator medical electro radiology
- Physiotherapist
- Orthophoniste
- Pharmacy technician hospital
- Psycho- mortician
- Radio physicist in radiotherapy
- Biomedical Laboratory Technician
- Home Assistant
- Gerontology Auxiliary

The caregivers are mostly employed in hospitals, retirement homes or other medical institutions. However due to the demographic change, the society needs more and more caregivers who assure the maintain of autonomy at home, this means, these caregivers are working for different private care associations.

The most important are: *nurse, nurse auxiliary and home assistant*

Formal qualifications of nurses

To access the nursing profession it is necessary to obtain the state nursing diploma. It is prepared in 3 years in an institute of nursing education (IFSI) accessible after the baccalaureate and after an entrance examination.

50% of the training will be theoretical and the other 50% will be practice.

Training, free is now recognized grade license in the curriculum master license doctorate. Thus, in 2012, the nursing students will graduate to the rank of state university license. This academic recognition provides an opportunity for nurses to continue their studies towards a Masters and eventually a doctorate. Several specializations allow the nurse to change his/her profession and find other missions , particularly in hospitals : nurse anesthetist , operating room nurse , pediatric nurse ... After a few years of practice and training in the health system, the nurse can progress to supervisory service or training functions in the training institute. After 2 years in hospital, the nurse can also practice in private associations or can become self employed. A nurse may be employed in health centers, businesses, schools and humanitarian association, etc.

The nurse performs treatments designed to maintain or restore the health of the sick person. He/ she monitors the health status of patients and coordinate care during hospitalization and afterwards. He/ she acts on his own initiative or as prescribed by the doctor.

She/ he talks with the patient and the family, prepares and distributes drugs, gives technical care (bandages, levies, taking blood , injections ...) participates drafting and updating of record of the patient , as well as information and support for the patient and his entourage. She/he works closely with the medical staff and supervises sometimes a team of caregivers. She/ he transmits written or oral information about patients to ensure patient follow-up in the best conditions. The nurse may be required to work nights, weekends and holidays. The nursing profession is extremely varied: the nurse may be required to work alone or in a team. The profession can be very technical or very relational (Department of Psychiatry). Nurses can also register, if they wish, in the "sanitary reserve", then they are called to intervene in areas affected by disasters to provide first aid areas. Great physical and psychological resistance is essential for this profession.

Formal qualifications of nurse auxiliary

The Nurse Auxiliary operates under the responsibility of the nurse. Integrated in care team, she/ he assist in the daily care activities. He/she contributes to the well-being of patients, accompanying them in all activities of daily life and helping to maintain their autonomy. In collaboration with the nurse and under its responsibility, the nurse auxiliary provides patients with personal care and comfort: toilet, meals, and rehabilitation of beds, reception, installation and transfer of patients ... He/she transmits its observations to ensure continuity of care. He participated in the creation of animations to people admitted to treatment centres and rehabilitation immediately.

The caregiver cannot act alone.

Nurse Auxiliary need a professional diploma "Nurse Auxiliary" (DPAS), which is prepared during 10 months in a recognized training institute. The minimum age needed is 17 years.

<u>The training:</u>

During a period of 10 with 1435 hours and is divided into 17 weeks theoretical courses and 24 weeks of practice.

<u>The training structure:</u>

8 theoretical modules each corresponding to one skill to acquire: the clinical condition, care, hospital hygiene, relationship - communication, work organization, etc. ...

6 courses in different disciplines: medicine, surgery, mental health, with the elderly, e.g.

Formal qualifications of home assistant

In recent years, the home help sector is flourishing. The auxiliary for social life intervenes with people that cannot perform alone their daily tasks. (Elderly, family, children, disabled persons, sick...).

The carer in general is directly involved with the people: he helps to maintain at home in the restoration and preservation of autonomy. He/she must respect the privacy of each and carry out any action that might prevent or overcome difficulties.

An interest in the human and social problems of some families in difficulty, but also the taste to perform tasks and activities of daily life, are required for this profession.

Physical fitness, adaptability and initiative taking are essential qualities to meet the needs and the expectations of the people assisted.

≈

In **Italy** health professions placed under the supervision of the Health Ministry engaged in prevention, diagnosis, care, treatment and rehabilitation are:

- Nurses
- Psychologists – Psychotherapists
- Physiotherapists
- Technical rehabilitation psychiatrics
- Almoners

Along with the health professions, there are also other health professionals, non-university, which are:

- Socio-healthcare workers
- Caregivers

Such profiles can be employed both at public and private levels.

Formal qualifications

The health professions in Italy are all those professions whose practitioners, by virtue of a license issued, certified / recognized by the Italian Republic, work in the health field. They own a university level education, are placed under the supervision of the Ministry of Health, and in order to exercise their profession they must own a bachelor's degree and have passed a state examination.

Next to them, there are also other professions, with servants and auxiliary functions, whose education does not take place at the university, in accordance with Law 43/2006. According to such Law, to the Regions are allowed to identify and train operators of public health, whose professional training is of secondary non-tertiary level.

The Socio-Healthcare workers meet the basic needs of a person, within their areas of expertise, in an environment which attains both social and sanitary aspects, promotes the well-being and autonomy of the care beneficiaries.

In particular, we show below the main activities the Socio-Healthcare workers[50] implement:

a) direct care and domestic help:

assist the person, especially if not self-sufficient or bedridden, in daily activities and personal hygiene; implement simple activities to support diagnostic and therapeutic co-workers in activities aimed at maintaining the residual psychomotor performances, re-educating,

[50] http://www.regione.veneto.it/web/sanita/operatore-socio-sanitario - March 2010.

reactivating and functional recovering; promote entertainment activities and socialization of individuals and groups; assist the medical staff and social assistance; help the users in the management of their area of life; care cleaning and environmental hygiene.

b) sanitary and social intervention:

look and work at the recognition of the needs and conditions of users risk- injury and collaborate in the implementation of welfare interventions; assess, to the extent applicable, the most appropriate interventions to be proposed; collaborate in the monitoring of the systems of interventions; and recognize and use the languages and communication systems most appropriate in relation to the operating conditions; enact relations and communications with the user and help the families in the fields of social integration, maintenance and recovery of personal identity.

c) management support, organization and training:

make use of the information tools commonly widespread for recording the findings during the service; collaborate in the assessment of the quality of the service; contribute, together with operators from the same profile, to the organisation of internships and their evaluation; collaborate at the definition of the training needs and attend updating courses and participate, even in non-patient care services, in the implementation of simple tasks.

≈

In **Poland** there are several professions that can be categorized as caregivers:

- Nurse (with different specialities)
- Midwives
- Medical career
- Assistant of a disabled person
- Medical and psychological helper
- Brancardier
- Dietician
- Physiotherapist

Yet, the most important are: nurses, midwives and medical carers.

Caregivers are mostly employed in hospitals, retirement homes or other medical institutions (house, sanatorium, protective plants, plants of the welfare, boarding houses, halls of residence). However, due to the demographic change, the society needs more and more

caregivers who assure the maintenance of patient autonomy at home; these caregivers work for different private care associations.

Formal qualifications of Nurses[51]

At present, the only way to get the nurse qualification is graduate from the college/university offering education on nursing.

Colleges/universities offer learning under the two-stage procedure:

1. studies of the first degree - last 3 years - end with obtaining a Bachelor's degree in nursing with a possibility to continue education on graduate courses leading to a master's degree
2. schools of the second degree - last 2 years - end with getting the Master of Nursing degree with the possibility of continuing of educating on doctoral studies.

Curricula include courses of anatomy, physiology, pharmacology, pedagogy, sociology, basis of nursing, health promotion, neurology, palliative care, medical rescue, surgeon's nursing, geriatric nursing and so.

In case (accidentally) these nurses, who finished unexisting school, additionally 12-months undergoing the postgraduate internship is required in the healthcare centre.

In order to enhance professional entitlements, nurses are able to finish specialization trainings in the following fields:

- anaesthesiological nursing and of intensive care
- surgeon's nursing
- diabetes nursing
- epidemiological nursing
- geriatric nursing
- cardiological nursing
- neonatal nursing
- neurological nursing
- oncological nursing
- operational nursing

[51]Principal Chamber of Nurses and Mid-wives in Poland, www.nipip.pl – 12.2013

– nursing of the long-term care
– nursing of the palliative care
– pediatric nursing
– psychiatric nursing
– nursing rescue
– family nursing
– the nursing of the teaching environment and upbringings
– nursing in the health care working
– conservative nursing
– the promotion of health and the health education
– the organization and the management

Additionally, nurses can improve their skills also on specialist, training and qualifying routes. Qualifications of nurses who completed medical schools or medical vocational schools at present are being disregarded in the European Union but are still recognized in Poland. However, the nurses can acquire entitlements to practising a profession in the EU thanks to bridge studies. The nurses who have the high school final exams certificate and the diploma of the following nursing vocational/medical school are entitled to start bridge studies:

- 5-year medical school
- 2-year medical vocational school or
- 2,5-year medical vocational school or
- 3-year medical vocational school.

The minimum duration of bridge studies are as follows:

- three semesters or 1,633 hours for graduates of 5-year medical schools who started education in medical school in 1980 / 81 or later
- five semesters or 3,000 hours for graduates of 5- year medical schools who started medical education before the school year of 1980 /81
- three semesters or 2,410 hours for graduates of 2-year medical vocational schools
- three semesters or 1.984 hours for graduates of 2,5-year medical vocational schools
- three semesters for graduates of 3-year medical vocational schools.

In Poland graduates of the above mentioned schools do not have to take up bridge studies because professional qualifications acquired by them still are in force. They are, however,

entitled to improve their skills and to obtain the title of the graduate with a Bachelor's degree in nursing, and hence to continue learning on graduate courses leading to Master's degree.

Formal qualifications of Midwives[52]

At present, the only way to acquire qualifications of a midwife is to graduate from the college/university offering midwives education.

Colleges/universities offer education under the two-stage procedure:

1. first degree studies - last 3 years - end with a Bachelor's degree with a possibility of continuing education on Master's degree graduate courses
2. second degree studies - last 2 years - end with a Master's degree in midwifery.

During studies future midwives acquire knowledge in such fields as anatomy, physiology, embryology and genetics, microbiology and parasitology, radiology, pharmacology, bases of the obstetric care, gynaecology and the gynaecological care, the neonatology, the surgery, dietetics or examinations in obstetrics. Theoretical science is supplemented with compulsory practical training held, among others, on maternity wards, labour wards, antenatal classes, branches of the oncological gynaecology ward. Upon the completion of the studies a midwife acquires the right to practise a profession, issued by the circuit council of nurses and midwives, and can start to work in the profession. In case (accidentally) these midwives, who finished unexisting school, additionally 12-months undergoing the postgraduate internship is required in the healthcare centre.

Midwives can participate in specialization trainings, qualifying courses, specialist courses and in-service training courses which constitute different forms of postgraduate education.

Midwives can receive the following titles:

- midwife, a specialist in organization and management
- midwife, a specialist in epidemiological nursing
- midwife, a specialist in gynaecological nursing
- midwife, a specialist in neonatal nursing
- midwife, a specialist in obstetric nursing
- midwife, a specialist in family nursing
- midwife, a specialist in the promotion of health and health education.

[52] Principal Chamber of Nurses and Mid-wives in Poland, www.nipip.pl -12.2013

As a result of legal changes and the liquidation of previously existing forms of education in the profession, midwives who completed medical vocational schools are not entitled to practise midwifery in the European Union. Bridge studies are an option to midwives who completed:

- the 2-year medical vocational school specializing in midwifery or
- the 2.5 year medical vocational school specialising in midwifery

In the case of midwives who completed the 2-year school, bridge studies have to last at least three semesters or 1,479 hours, in the case of the completion of the 2.5 – year school – at least two semesters or 1,086 hours.

Graduates of abovementioned schools in Poland do not have a duty of completing bridge studies because professional qualifications acquired by them are still in force. They are, however, entitled to improve their skills and to obtain currently required degrees.

Formal Qualifications of Medical career (opiekun medyczny)[53]

A medical career is a person who, in a professional way, helps patients and dependent persons to satisfy necessities of life. The medical career recognizes and solves protective problems of ill and dependent patients who are at different stages of disease development and at different ages. The medical career assists medical personnel while providing care services, and simultaneously supports ill and dependent patients. It is a profession of public trust, therefore personal and social competences such as very good communications skills, teamwork competences and empathy are essential in this job.

A medical career is a profession which has been on the educational map of Poland since July, 2007. According to the lregulations a medical career acquires qualifications during 2-semester vocational courses, having completed high school education. The diploma is based upon external examination and authorizes a graduate to perform the profession in the European Union countries.

[53] www.apedukacja.pl/opiekun-medyczny,822.html - 12.2013

Formal qualification of Assistant of the disabled person (Asystent osoby niepełnosprawnej)[54]

The assistant of the disabled person work helps a person in need in acquiring the greatest possible self-reliance and independence. The assistant of the disabled person supports a charge in completing the programme of social and professional rehabilitation. He initiates supportive activities in the environment closest to the disabled in order guarantee the most effective help.

The work of the assistant of the disabled person is performed in the whereabouts of a charge (house, sanatorium, hospital, protective plants, plants of the welfare, boarding house, hall of residence).

Entitlements to practising a profession of the assistant of the disabled person are being acquired on the completion of medical college (extramural system, 1 year studies). During this period students acquire theoretical knowledge and practical skills in the fields of psychology, sociology and pedagogy, human anatomy and physiology, social policy, first aid and motor rehabilitation.

≈

Definitions for Caregivers in **Spain** are several, although we can differ them into two big groups:

1.PROFESSIONAL CAREGIVERS*, those who exercise a professional work in organisms, institutions or companies.

1.1.Technical caregivers of Care Services, They are workers who being in possession of a Diploma (Bachelor, Superior Vocational Training or equivalent professional category recog- nized in Labor Ordinance or Collective Agreement), are in charge of programs or activities on the assistance and integral care: activities of personal and occupational development, general well-being, etc. ....of people with any disability. They will achieve programs prepared by management and/or technical qualified personnel.

In the social area they will achieve support functions for the users in medical visits, as well as in walks, excursions, and other types of educational visits doing the necessary supports to obtain their full participation.

[54] Ibidem

In exceptional cases and in absence of the Nurse, they will administer medicines previously pre- pared by Nurses. Collection and restoration of the materials that disabled people need in their personal life and in their activities of the daily life[55]

2. NOT PROFESSIONAL CAREGIVERS, in this group, we can find relatives, friends, volunteers, etc. But all of them devoted to people's care who, by physical, sensory or psychic disabilities, cannot achieve the activities of the daily life with proper autonomy Cares imply a high commitment of time and energy. Generally, the tasks achieved by caregivers are neither simple nor nice. When they have to take care of their relatives, it is normal that the situation has not been foreseen and the caregiver is not ready for it. Caregivers face more health problems than not-caregivers population: both physical and psychological ones.

   The most common tasks:

   - To help and to support for the achievement of activities in their daily life (to eat, per- sonal cleaning, etc.).
   - To help and to support for instrumental activities in the daily life (medical visits, home maintenance, administration of the money, etc.).
   - To help and to support for the displacement so much inside their homes as out.
   - To monitore the medication-takings and their relatives' health care .
   - To do some „ nursery tasks“

   2.1. Familiar caregivers of senior dependent people - They are those people who, because of different reasons, coincide with the work to which they spend big part of their time and efforts: to allow that other people can be developed in their daily life, helping them to adapt themselves to the limitations that their functional disability (understood with wide sense) are imposed on them.

   2.2. Informal caregiver - They are the people who do not belong to any healthy institution not socially and who take care of not autonomous persons who live in their homes.

Formal qualifications

Concerning to the Health Centers Managers, they must be provided with University qualifications and have achieved complementary training in dependency, disability, geriatrics,

[55] Law of Dependency. Law 39/2006, of December 14th, of Promotion of the Personal Autonomy and Attention to People in Situation of Dependency.
(http://www.seg- social.es/Internet_1/Normativa/index.htm?dDocName=146822&C1=1001&C2=20099)

gerontology, management, or other areas of knowledge related to attention to the dependency, with a minimum of 3 years of experience in the sector.

The Elder cares, caregivers or similar professional categories, will be demanded to be provided with a Vocational Training Diploma " Technician in Nursery Auxiliary Cares" established by the RD 546/1995 of April 7th or " Technician in Nursery Auxiliary Cares" established by the RK 496/2003 of May 2nd, or of the Certificate of Professionalism " Socio-Health Attention to Dependent People in Social Institutions ", regulated by the Royal decree 1379/2008 of August 1st.

It is understood that a person is qualified when s/he is competent, that is to say s/he is capable to achieve a certain work. All in all, when s/he has the knowledge and capacities for a correct performance that this job demands. Being able to acquire these competences through training or labour experience. In turn, the referred rule conceptualises the Unit of Competences as the minimal addition of professional competences with significance for the employment which can be recognized and credited.

The National System of the Qualifications and Professional training (SNCP)

The SNCP must fulfil six basic principles:

1. Vocational Training must be faced so much to the personal development and to the exercise of the right to work as to the free election of profession and to the satisfaction of the needs of the productive system and for the lifelong employment.
2. The access, in conditions of equality of all the citizens, to the different ways of vocational training.
3. The participation and cooperation of social agents with Public Institutions in the training policies for vocational training.
4. The adequacy of training and qualification to EU criteria, according to the targets of the single market and free movement of labour.
5. The participation and cooperation of the different public administrations according to their respective competences.
6. The promotion of the economic development and the adequacy to the different territorial needs of the productive system.[56]

The Spanish SNCP demands the comprehension of the technical and scientific essentials of the activities and the evaluation of the factors of the process and their economic after-effects.

[56] http://www.educacion.gob.es/educa/incual/ice_ncfp.html

The development of the Qualification Systems answers to the effect combined by a series of economic, social and political factors. Among the first ones, it is necessary to indicate the need to face the training and the qualification of the work-people towards the demands of the productive system, often slightly defined and attended in the frame of the educational conventional systems. In this way, it is actuated on human capital, which is the most important resource of the companies for the supported progress of their competitiveness and perspectives of population employment can be improved. Among the social ones, it is necessary to emphasize the recognition of the labour experience of those that, for lacking studies related to the educational system, possess a low or null level of academic qualifications and, nevertheless, they are highly qualified for the performance of a profession or occupation. Among the politicians, the need to give response to the challenge raised by the European Union with the approved European Qualification Framework, which will benefit the target of free movement of labour in the E. Union All this justifies the given attention and the need to advance in the Spanish System of qualifications.[57]

≈

In **Germany** the following occupational groups are to be found within the care sector:

- The so called "Classical Nurse" works in the medicine dominated hospital sector.
- The "Health and Care Giving Nurses" are responsible for advising and instructing patients. She is responsible within the area of the connection of outpatient and stationary care as well as discharge management and transition management. So far there is an imbalance between theory and practice present, because the practice of health care is not fully developed yet.
- Another occupational group appears to be the so called "Care Expert". The Care Expert is a studied nurse with a university degree. There are just a few trained experts present.
- The "Classical Geriatric Nurse" is specialized in working with patients that are accommodated in nursing homes.

[57] http://www.empleo.gob.es/es/publica/pub_electronicas/destacadas/revista/nume ros/81/89.pdf

— The last group that shall be mentioned is the "Volunteer". A growing number of volunteers complete the mix of skilled and less skilled personnel in nursing. The volunteer has several different skills and qualifications.[58]

F*ormal qualifications*

Basic requirement of the apprenticeship of care givers is a high-school diploma. Applicants are required to attend a minimum of 2 years of vocational training. Furthermore it is recommended to do an internship before the start of the training. In some vocational schools the internship is mandatory. According to the new law, there is no minimum age for a commencement of training.

Education, qualifications and competence of care givers in Germany

The training is completed after three years with a state-approved examination; the so called state exam for nursing. The focus of the training is on Health and Medicine. Additionally skills are taught in the following areas:

- Care (life-saving emergency treatment, legal framework)
- Nursing & Hygiene
- Medicine (anatomy, surgery, pathology …)
- Arts and Sciences (education, psychology and sociology)

Care givers are able to take advantage of many further training opportunities offered. It is possible to make a jump in the career and to work as the director of nursing (stationary management) or as a specialist caregiver in additional medical areas (further education is necessary). Motivated nurses and care givers also have the option to gain a degree. They might be willing to study medicine or to start their studies in the major of nursing or health care.[59]

≈

[58] Sahmel K.,*Vortrag auf der Tagung der Bundesarbeitsgemeinschaft der freien Wohlfahrtspflege*, „Wandel der Pflege – Neue Kompeztenzen für Pflegekräfte". Berlin (Germany) 2011.

[59] http://www.bildung-news.com/bildun-und-karriere/ausbildung-und-lehre/ausbildung-zur krankenschwester-zum-krankenpfleger, Date of access: Jan 2, 2014.

In **Greece** at present, there are several ways to become *a professional caregiver:*

— The first way, and the longest one, is to get a nurse qualification or to get a technical degree for nurses. Technological Universities and Universities offer 4 year learning for nurses. After the bachelor degree the possibility is offered to continue their education on Master of Nursing degree.

— The second way to become a caregiver is to follow some specialized technical courses (lasting from 1 to 3 years). These are the main specialized professions (http://epagelmata.oaed.gr/show.php):

- *"Home caregiver for elderly" : she*/he works as a sole practitioners in adults residence. Related studies are offered in public and private schools (IEK) of Health and Social Services, with duration of studies ranging from two to four semesters of study and going till level 3 +.
- *"Carer for minors*": she/he works both in hospitals and clinics, and at home for minors or in orphanages. The majority of workers in this occupation are women. Related studies are offered in public and private schools (IEK) of Health and Social Services, with duration of studies ranging from two to four semesters of study and going till level 3 +.

The last way is to obtain a certification by EOPPEP. *EOPPEP is the National Organisation for the Certification of Qualifications and Vocational Guidance,* an all-encompassing statutory body investing on better quality and more efficient and reliable lifelong learning services in Greece. EOPPEP aims at quality assurance in inputs, outputs-learning outcomes and vocational guidance & counseling services.

The occupational profile of "*attendant to personal care",* provided by EOPPEP, concerns only caregivers working in public organizations such as KAPI (semi residential centers), public services such as "ambulant home care services", a few NGO's and Charity organizations. These caregivers are the less qualified of all professional caregivers. In order to be registered and certified by EOPPEP one has to be a graduate of secondary education (basic general or vocational undergraduate schools) and must be trained in the field for a period lastingbetween 6 and 18 months.

Nowadays, professional caregivers in Greece do represent the minority of caregivers in the care system. Social security compensates the patients for the cost of professional carers only for in-hospital services, covering only 30% of the total cost (this procedure is extremely long). *Informal caregivers* include mainly relatives, but also close friends and neighbors. It is important to note, that migrants occupy a central place in the market of formal and informal caregivers. Indeed, in Greece, families have taken benefit of massive female migration during 80's. They are paid but the majority of them are not formally qualified.

According to the Eurofamcare report (2003-2009), the *educational level of carers* is relatively low in Greece: 37.4% of interviewed caregivers had a low level of education; 40.6% an intermediate (typically those who had finished High School / Lykeio) and 22.1% had a high level of education (university, technical schools etc). Their *professional status* is also to be considered: 17.1% of the sample were spouse carers- in this category there was also a high percentage of male family carers. A further 1.8% were siblings of the cared-for older person. 47.2% of family-informal caregivers were also in paid work.

Educational and informational needs of informal caregivers in Greece are high. For example, in Greek literature in-hospital informal caregivers need more informations about care techniques, treatments, nutrition, insurance funds etc. "The mean total scores for health education needs was 53.4 ± 5.7 (range: 50 to 57) for nurses and 57.1 ± 6.9 (range: 52 to 63) for the in-hospital informal caregivers" (Sapountzi et al., 2006).

Finally, it is important to note that the identification of how *current ICT context* (e.g. e-skills, digital competencies, Ambient Assisted Living etc.) has transformed job profiling and influence employment situation in care givers related professions is almost absent from all vocational or technical education study programmes in Greece- according to the findings of the CompAAL LLP project.

≈

The following professions can be found in the care sector in **Austria**:

1. Assistant nurses and Medical Assistants
2. Professional nurses
3. Professional nurses with special qualifications for education or management or a Bachelor's degree/ Midwives / Social Workers
4. Nursing management (Degree in health management or PhD in nursing science)

Ad 1) Assistant nurses and medical assistants

In Austria there are assistant nurses (called "Pflegehelfer" in German), who are intended to assist the professional nurses as well as doctors in the care and supervision of people in need of care. Assistant nurses may only provide care at the instructions and under supervision of professional nurses and/or doctors.[60]

In an attempt to assign Austrian health care professions to the different levels of the European Qualification Framework (EQF), a workshop amongst experts has shown that the assistant nurses could most accurately be categorized in level 3.[61]

Since 2012 there are so called medical assistant professions (called "Medizinische Assistenzberufe" in German) that comprise disinfection assistants, plastering assistants, laboratory assistants, autopsy assistants, surgery assistants, practitioner's assistants and X-ray assistants.[62] The tasks of medical assistants are mostly not care related. Medical assistants could also most accurately be categorized as level 3 in the EQF.

There is no profession in the Austrian care sector that would be categorized in level 4 of the EQF.

Ad 2) Professional nurses

The main caregivers in the Austrian health care system are professional nurses (called "Diplomkrankenschwester" or "Diplomkrankenpfleger" in German). Their field of activity ranges from the care and supervision of people of all ages suffering from physical and psychological diseases, people with handicaps and terminally ill people to the care aspects of rehabilitation, primary medical care and health promotion and prevention of diseases and illnesses in intramural as well as extramural areas.

Their tasks also include diagnostic and therapeutic treatments ordered by a doctor.[63] In addition to the general nursing, specialised courses in paediatric nursing and psychiatric nursing are provided as specialised basic courses or as advanced courses following basic training in general nursing schools.

[60] §82 Bundesgesetz über Gesundheits- und Krankenpflegeberufe (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013

[61] Schneeberger A., *Internationale Einstufung der österreichischen Berufsbildung – adequate ISCED-Positionierung als bildungspolitische Herausforderung*, Vienna (Austria), May 2010, p.39

[62] §1 Bundesgesetz über medizinische Assistenzberufe (Medizinische Assistenzberufe-Gesetz – MABG). BGBL. I Nr. 89/2012, zuletzt geändert durch BGBL. I Nr. 80/2013

[63] §13 Bundesgesetz über Gesundheits- und Krankenpflegeberufe (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013

At the end of each of these educational paths, a diploma in the general or in a specialised area of health care and nursing is awarded.[64]

Professional nurses also have the opportunity to obtain special qualifications through advanced training. In an attempt to professionalize the education of caregivers, a combined programme in cooperation with universities is offered leading not only to a professional health care and nursing diploma but also the academic degree of Bachelor of Science in Health.[65] Professional nurses are considered to be categorized as level 5 of the EQF.

Ad 3) Professional nurses with special qualifications, midwives and social workers

Professional nurses with special qualifications for education or management as well as graduates of the bachelor's degree for nursing are categorized as level 6 in the EQF. Also midwifery and social work are bachelor studies and therefore to be categorized as level 6 in the EQF. Before the new Midwifery Act was passed in 1993, there was only a diploma for midwifery that could be acquired in a midwife college. Midwives with this qualification could be categorized in level 5 of the EQF, similar to professional nurses with a diploma.

Ad 4) Nursing management

The remaining levels on the upper end of the European qualification framework are considered to correspond with the second and third cycle of higher education studies. In level 7, studies ending with a master's degree, such as public health or health management can be found, whilst level 8 corresponds to a PhD in nursing science.[66] Health care professionals that reach these levels of education mainly go on to work in upper management rather than direct patient care.

Institutions employing caregivers

Most care personnel in Austria works either in hospitals, rehabilitation centres or in long-time care facilities (either institutional or outpatient home care). Most nurses still work in the hospital sector but the demand for outpatient nursing services for long-term care patients is increasing rapidly.

[64] Federal Ministry of Health and Women (BMFG): Public Health in Austria, 4th, updated edition, Dec. 2005, page 92

[65] Pogatscher P., *Standortbestimmung: Die Pflegeausbildung in Österreich*. *Welche Problemfelder sind im Zusammenhang mit der Akademisierung der Pflegeausbildung zu erkennen?*, Graz (Austria), Jul. 6, 2011, p. 23-26

[66] Schneeberger A., *Internationale Einstufung der österreichischen Berufsbildung – adequate ISCED-Positionierung als bildungspolitische Herausforderung*, Vienna (Austria), May 2010, p. 39

At the moment, a lot of these outpatient nursing services are provided by foreign nurses, who work in private households looking after individuals in need of long-term care. It is estimated that about 28.000 to 30.000 foreign nurses are caring for 15.000 patients requiring long-time care in Austria. This would represent 5 to 20 times the number of registered nursing staff in the area of long-time outpatient care. Nevertheless, there are no exact numbers on this issue.[67]

Formal qualifications

The formal qualification required for a caregiver in Austria is a diploma in general health care and nursing or in a specialised area of health care and nursing for professional nurses. For assistant nurses, a certificate of the completion of a training course and a board examination is required.

For the admission to one of 68 nursing schools for the education in professional nursing in Austria, proper state of health and the necessary trustworthiness for the profession as well as the successful completion of ten school years is required. Courses in general health care and nursing as well as specialised courses for paediatric health care and nursing and psychiatric health care and nursing last three years and comprise at least 4.600 hours of theoretical and practical training. Those courses end with a diploma examination. There is also the option of a combined programme that can be attended on a private university of applied sciences, for which a nursing diploma as well as the academic degree of Bachelor of Science in Health Studies (BSc) is awarded. The combined programme can be attended on six private universities of applied sciences in six different federal states in association with 16 different healthcare institutions.

At least half of the 4.600 hours of education in nursing schools have to be practical training. The practical part comprises different topics such as acute care, long-time care and mobile nursing services. The theoretical part focuses on the following areas:

- Care and nursing (e.g. palliative care, geriatric care, home care, etc.)
- Medicine (e.g. anatomy, pathology, pharmacology, etc.)
- Hygiene and nutrition
- Fundamentals of the healthcare system (e.g. structure and institutions, legal basis, etc.)
- Soft Skills (e.g. ethics, sociology and psychology, communication, etc.)

[67] Bauer G., *Die 24-Stunden-Betreuung in Österreich – Motive und Beschäftigungsverhältnisse von osteuropäischen Pflege- und Betreuungspersonen*. 2010, p. 29

The admission to a course for assistant nursing requires a minimum age of 17 years as well as the proper state of health and the necessary trustworthiness alongside the successful completion of nine school years. Theoretical and practical training for assistant nursing staff lasts one year and comprises at least 1.600 hours, ending with a board examination for which a certificate is awarded. Courses for assistant nursing are held at hospitals, nursing homes or facilities of mobile nursing services.[68]

Following a professional health care and nursing diploma, various special and additional trainings can be attended and result in an additional certification that allow using the affix of the area of specialisation. Special trainings for the areas anaesthesia, operating room care, intensive care, paediatric intensive care and renal replacement therapy or for an additional expert certification in one of those areas can be attended as non-degree courses on universities. Additionally, special trainings for educational and management occupations as well as hospital hygiene are held as non-degree courses at universities.

Further advanced trainings offered by different institutions vary greatly in their content, extent and costs. The Austrian health care and nursing association for example offers courses that can last from one day with a cost of about 200 € (e.g. geriatrics and gerontology) up to a whole semester with 200 hours of lessons at a cost of about 1.000 € (e.g. healthcare for dementia). These courses are either offered on a national basis or by sub-organisations of federal states.[69]

The hospital associations of the different federal states offer courses similar to those of the health care and nursing association. These courses are held in the hospital association's educational facilities, in hospitals or even as workshops in hotels.[70] Additionally, different educational institutes and adult education institutions like the Vocational Training Institute (Berufsförderungs Institut, bfi), societies like the Austrian Palliative Association (Österreichische Palliativgesellschaft, OPG) and aid organisations like the Austrian Red Cross (Österreichisches Rotes Kreuz, ÖRK) provide trainings relevant for caregivers.[71]

[68] Abschnitt 4 Bundesgesetz über Gesundheits- und Krankenpflegeberufe (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013

[69] www.oegkv.at (Section Aus- und Weiterbildung), date of access: Jan. 24, 2014

[70] Akademie der Steirischen Krankenanstaltenges.m.b.H – ASK: Bildungskalender 2014. Graz (Austria), Sep. 2013

[71] www.bildungundberuf.at (Section Bereich/Sektor, Pflege), date of access: Jan. 24, 2014

Professional nurses have the possibility to attend a specific training for teaching positions. This training lasts for at least one year and consists of 1.600 hours of theoretical and practical education. At the end there is a board examination for which a diploma is awarded.[72]

Critics of the educational system for caregivers in Austria often point out the fact that the mainly non-academic education for caregivers is not compliant with international standards. Most caregivers are trained in nursing schools and only a very small part is educated on universities and universities of applied sciences. Another criticism that is frequently voiced is the fact that most teachers are not academically educated either, but are nurses who attended the specific training for teaching.[73]

The teaching staff in Austrian nursing schools is almost equally divided with 49% teachers on a free basis and 51 % salaried staff. 45 to 60 % among teachers on a free basis have an academic education. Among the salaried staff, the percentage of teachers with academic background is only at 3 to 9%.[74]

5.2. Statistical forecasts

Table 1. Indicator of the number nurses per 1 thousand of residents

	2007	2008	2009	2010	2011	Last Year
Indicator of nurses employed at the direct patient care						
Australia	10,1	10,2	10,1	….	….	10,1
Austria	7,4	7,5	7,6	7,7	….	7,7
Canada	9,0	9,1	9,3	9,3	….	9,3
Czech Republic	8,0	7,9	8,1	8,1	….	8,1
Denmark	14,5	14,3	14,7	15,4	….	15,4
Estonia	6,4	6,4	6,1	6,1	….	6,1
Finland	9,4	9,6	9,6	….	….	9,6
Germany	10,5	10,7	11,0	11,3	….	11,3
Hungary	6,1	6,2	6,2	6,2	….	6,2
Iceland	14,0	14,8	15,3	14,5	….	14,5
Greece	5,2	5,0	4,5	4,8	4,9	4,9
Netherlands	8,3	8,4	….	….	….	8,4

[72] §71 Bundesgesetz über Gesundheits- und Krankenpflegeberufe (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013

[73] Pogatscher P., *Standortbestimmung: Die Pflegeausbildung in Österreich. Welche Problemfelder sind im Zusammenhang mit der Akademisierung der Pflegeausbildung zu erkennen?* Graz (Austria), Jul. 6, 2011, p. 36

[74] ÖBIG: Österreichischer Pflegebericht, Vienna (Austria), May 2006, p. 86

New Zealand	9,2	9,7	9,7	10,0	….	10,0
Norway	13,9	14,0	14,2	14,4	….	14,4
Poland	5,2	5,2	5,3	5,3	….	5,4
Slovenia	7,8	7,9	8,0	8,2		8,2
Spain	4,4	4,6	4,9	4,9	5,5	5,5
Sweden	11,0	11,0	11,0	11,0	….	11,0
Switzerland	14,7	14,9	15,2	16,0	….	16,0
United Kingdom	9,6	9,7	9,8	9,6	….	9,1
Indicator of nurses employed in direct care management and science						
France	7,6	7,9	8,2	8,5	….	8,7
Portugal	4,9	5,2	5,4	5,7	….	5,7
Slovak Republic	6,3	6,3	6,0	6,0	….	6,0
Ireland	12,8	12,8	12,7	13,1	….	13,1
United States	10,6	10,8	10,8	11,0	….	11,0
Indicator of nurses having an entitlement (licences) to perform a profession						
Belgium	….	….	14,8	15,1	….	15,1
Italy	6,1	6,2	6,3	6,3	….	6,8
Poland	….	….	….	….	….	7,3

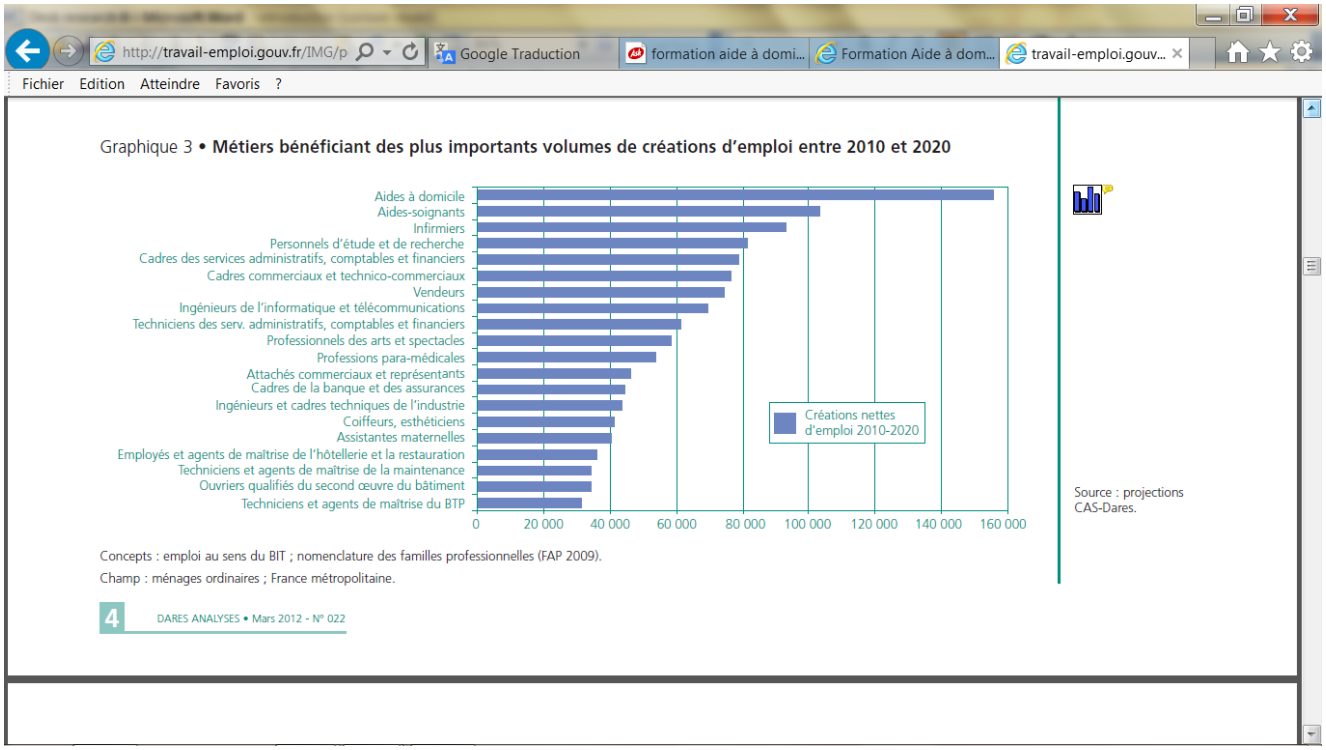
Source: OECD Health Data 2012

http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC

The health professions in **France:**

1. In January 2011, 1 867 900 people are employed in the Health professions in France. Approximately 1 325 000 caregivers work in the hospital sector.
2. In 2011, only 29% of health professionals are male. It is important to remember the health professions are not only for women, but accessible everyone.
3. In the health sector, nearly 350 000 new jobs are forecasted for 2020, with around 150 000 jobs for home assistants, 105 000 nurse auxiliaries and 95 000 nurses.

Chart 1. Caregivers in France



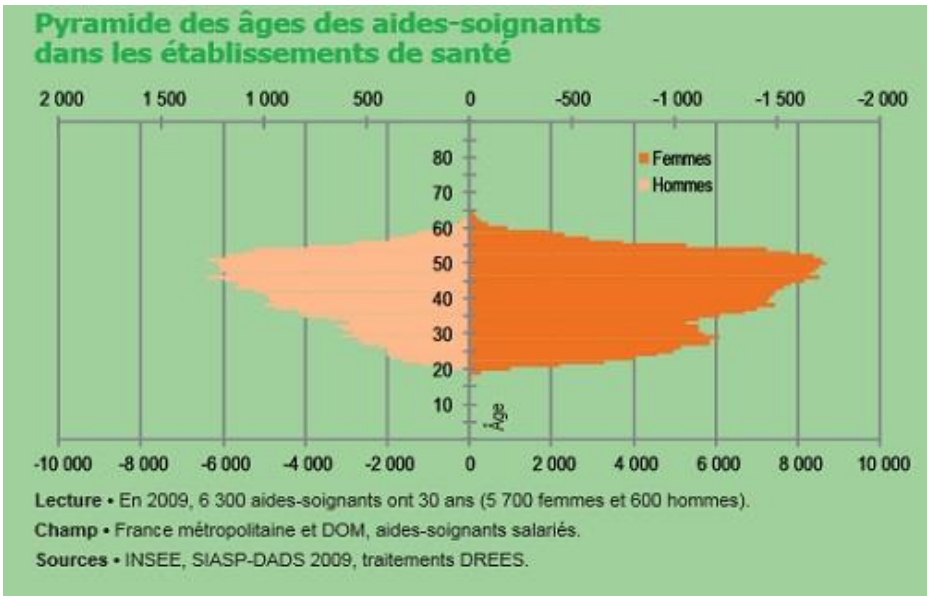
Age structure of caregivers in France

A quarter of care givers are aged over 50 years.

A study published by the DREES (Ministry of Social Politics) the 12th of July 2013 shows that over 25% of personal health facilities are older than 50 years.

25% of caregivers are older than 50 years, this is not the same for nurses, who are younger, actually nurses between 25 and 35 are more represented than nurses between 50 et 60 years.

Chart 2. Age-group structure of nurses in France



In France we can state that the Health sector is one of the most important professional sectors. Giving the aging population, the need of caregivers will grow.

On the other side we can see that caregivers are particularly vulnerable, due to the risks they take every day, but also due to the difficult work conditions, the responsibilities, the high turnover rate, the work in different teams, the under staffing, the patients, the regularly contact with the death, etc.

Studies show that burn out in these professions attempts around 40% and that care givers don't believe in possible positive changing.

New skills for HR managers, soft skills for caregivers, integration of health and safety in their daily work are needed. This will be an advantage for the health economy, the caregivers and the patients, for the whole population.

≈

According to the last statistics, in 2010 in **Italy** there were 360.000 nurses; 270.000 of them working in the National Health Service. They are still few if we consider that the average ratio in Italy is six nurses per thousand inhabitants, while the OECD average is 7 per thousand. According to the IPAVSI, the Italian Federation of Colleges of Nursing, the sector is missing at least 40.000 professionals[75].

[75] www.quotidianosanita.it, "Inchiesta QS. Infermieri d'Italia (prima puntata): quanti sono e cosa fanno" - 01 December 2010.

The last identikit of Italian nurse, elaborated in 2009 from the IPAVSI Federation, corresponds to a woman (75% of the total), rather young (the average age is 42 years), preferably working in the North of Italy (47% of nurses are in the northern regions)[76] 8.

≈

Current State of caregivers in **Poland**

1. The number of registered nurses include persons who actively perform the job, are unemployed, are on maternity leaves and education and all others who have a valid right to do the profession of a nurse.
2. The analysis includes women born after 1951 and men born after 1946.
3. The analysis does not include nurses who waived the right to the profession, ceased practising the profession or who were deprived of the rights to perform nursing by the circuit registers of nurses and midwives for other reasons.
4. The number of nurses provided with analysis amounts to 246 948. The average age within the group is 45.6.
5. The average number of nurses, who hold the legal right to perform the profession was stated, for the first time, in years 2010 - 2012 and adds up to to 3 499.
6. The number of male nurses accounts for 4 620. The average age of these persons is 39,5.
7. The average number of male nurses, who hold the right to practise nursing was stated, for the first time, in years 2010 - 2012 accounts for 155.

Table 2. Staff employed in a primary place of employment

Voivodeship	Number of nurses	Nurses indicator to 1 thousand	Number of mid-wives	Mid-wives indicator to 1 thousand
Poland	186 566	4,84	22 301	0,58
Greater Poland	13 354	3,87	1 952	0,57
Kuyavian-Pomeranian	9 628	4,59	1 206	0,57
Lesser Poland	16 387	4,91	1 938	0,58
Łódź	12 203	4,81	1 478	0,58

[76] Ibidem.

Lower Silesian	14 535	4,99	1 447	0,50
Lublin	4 455	5,30	1 415	0,65
Lubusz	11 540	4,36	590	0,58
Masovian	26 369	5,00	2 983	0,57
Opole	4 775	4,70	478	0,47
Podlaskie	6 169	5,13	803	0,67
Pomeranian	9 317	4,09	1 061	0,47
Silesian	25 978	5,61	2 906	0,63
Subcarpathian	11 110	5,22	1 568	0,74
Świętokrzyskie (Holy Cross)	6 739	5,26	738	0,58
Warmian-Masurian	6 624	4,56	846	0,58
West Pomeranian	7 383	4,29	892	0,52

Source: Principal Chamber of Nurses and Mid-wives, www.nipip.pl

Forecast for the number of nurses for the period of 2015 – 2035

Establishing the forecast about the number of people registered:

1. An average number of persons was accepted registering with every year based on the average number of persons acquiring the law of the practising a profession in 2010-2012 years.
2. Those who acquire retirement age are deducted from the number of the registered employees .
3. The number includes those who perform the profession, are unemployed, are on maternity leaves or in colleges and other nurses who have the right to perform the profession.

Table 3. Forecast of the number of nurses for the years 2015 – 2035

Year	**Population in thousands**	**Number of nurses - state as on 31 December of a given year**			**Indicator registered per 1 thousand of residents**
		Nurses women	Nurses men	Total	
2011	38 511	246 948	4 620	251 568	6,53
2015	38 016	234 541	5 207	239 747	6,30
2020	37 830	226 716	5 889	232 305	6,14
2025	37 438	206 526	6 361	212 887	5,69

2030	36 796	186 968	6 644	196 612	5,34
2035	35 993	164 873	6 751	171 624	4,77

Source: Principal Chamber of Nurses and Mid-wives, www.nipip.pl

Establishing the forecast for the number of people employed:

Maintaining the rate of the number assumed as employed to registered on the level of the indicator from year 2011 which for nurses is taking out 76.47% of the number of registered.

Table 4. Forecast of the number of the employed nurses for years 2015 – 2035

Year	**Population in thousands**	**Number of the employed**	**Indicator the employed to 1 thousand of residents**
2011	38 511	192 383	5,00
2015	38 016	183 344	4,82
2020	37 830	177 881	4,70
2025	37 438	162 802	4,35
2030	36 796	148 062	4,02
2035	35 993	131 247	3,65

Source: Principal Chamber of Nurses and Mid-wives, www.nipip.pl

Age structure of caregivers

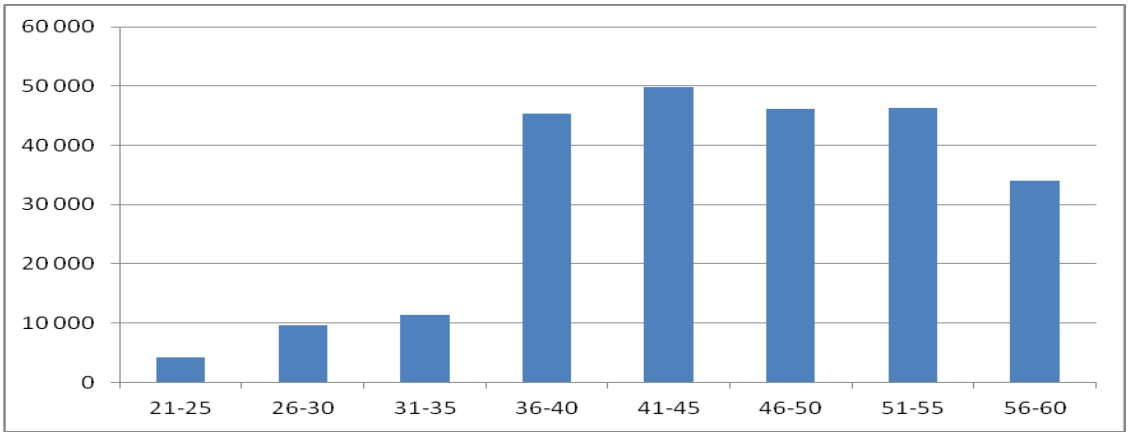
Table 5. Number of nurses and midwives according to the age

Age	**Number of nurses**	**Number of midwives**	**Age**	**Number of nurses**	**Number of midwives**
23	731	-	43	10 362	1151
24	1 468	-	44	9 886	1251
25	2 024	436	45	9 097	1311
26	2 240	458	46	9 036	1380
27	1 806	346	47	9 425	1331
28	1 726	386	48	9 706	1258
29	2 037	388	49	8 886	1129
30	1 819	383	50	9 121	1133
31	1 536	310	51	9 101	1219
32	1 544	290	52	9 657	1108

33	1 886	535	53	9 806	1170
34	2 420	624	54	9 490	1087
35	4 037	732	55	8 231	969
36	7 913	833	56	7 599	796
37	10 853	819	57	7 113	678
38	8 804	778	58	6 322	663
39	8 553	798	59	6 023	687
40	9 209	960	60	6 023	595
41	10 291	1204	Total	**246 948**	30 760
42	10 245	1098			

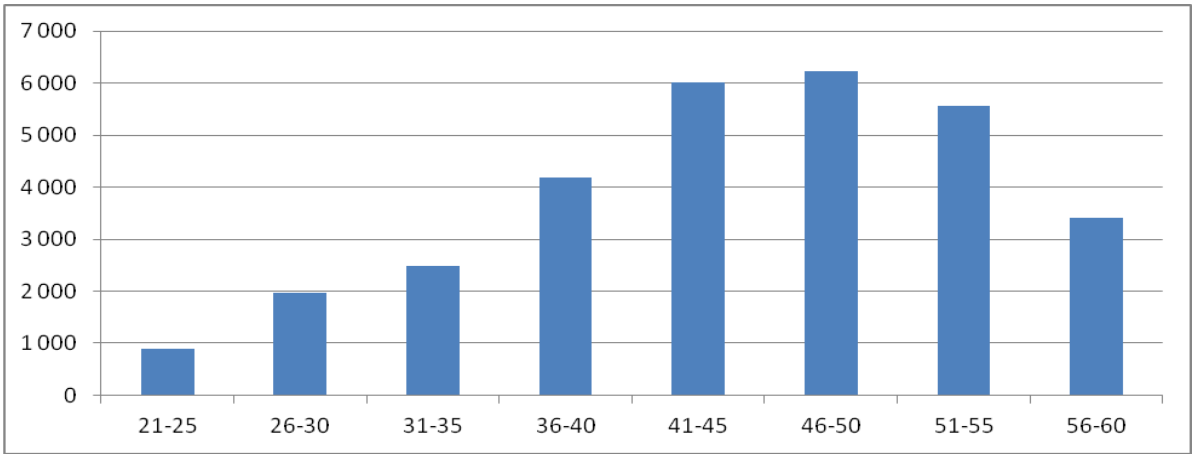
Source: Principal Chamber of Nurses and Mid-wives, www.nipip.pl

Chart 3. Age-group structure of nurses



Source: Principal Chamber of Nurses and Mid-wives, www.nipip.pl

Chart 4. Age-group structure of midwives



Source: Principal Chamber of Nurses and Mid-wives, www.nipip.pl

≈

As far as for the **Spanish** labour market, the year-on-year descent of the affiliations to the Social Security moderated again in the third trimester, up to-2,4 %, for not-professional caregivers. In interquarterly and corrected terms, membership in Social Security system, it was decreased in a 0,3 % in the third trimester Production and employment of 2013, opposite to 0,5 % estimated for the previous trimester After the Royal decree 20/2012 came into effect in November 2012, not professional caregivers stopped having any right to the free quotation to the Social Security from 2013 November. This policy change resulted in a dismissing proportion of 173.000 affiliated to the social security system in October 2013. In relation to the accreditation requirements of human resources in Health Centres, we can see the Professional Qualification System. The Agreement of the Territorial Council of the System on the Autonomy and the Attention to the Dependency, in the Resolution of December 2, 2008 (BOE numbered 303, 17 In December, 2008), it presents, in an explicit way, the targets in material of qualification, as well as the percentages on the entire ones of staff who are detailed in the following picture.

Table 6. Caregiver staff in Spain

Professional category	2012	2015
Caregiver Elder care or similar	35%	100%
Personal Assistant	35%	100%
Home help assistant	35%	100%

Table 7. Age structure and number of caregivers in Spain

	2009		2010		2011		
	Total	Rate 10.000	Total	Rate 10.000	Total	Rate 10.000	%

		inhabitants		inhabitants		inhabitants	Women
Doctors	34642	7,4	34966	7,5	35167	7,6	51,70%
General Practitioner	28405		28461		28753		
Specialist Doctors	6237		6325		6424		
Nurses	28660	6,2	28970	6,2	29470	6,3	76,7%

There has been a relative lack of research examining the distribution of care people in Spain. The aim of this paper is to analyse how formal and informal care is provided to elderly dependent people in Spain and to assess the socio-economic conditions in which the different kinds of care emerge. Methods: This study is based on a sample of the elderly dependent population selected from those who reported the need of care in the 2003 Spanish Health Survey. The distribution of care among older people was cross-tabulated to identify the type of care, while regression models were used to identify the socio-economic characteristics of people receiving formal and/or informal care. Results: Around 7.5% of the elderly people who need care do not receive it. Among those who do receive it, 89.4% receive informal care, 14.8% private care and 8.1% public care. 11.9% of people in the study receive a mix of formal an informal care. Elderly people living in households in which the monthly income exceeds EUR900 are five times more likely than people living in households in which the monthly income is less than EUR 600 to receive private care instead of public care. People older than 84 years are six times more likely to receive public care than people aged between 65 and 74. Conclusions: Men are two times more likely than women to receive exclusively informal care. Women are three times more likely than men to receive both kinds of care simultaneously. Formal care complements informal care. Private care is more common than public care. Men, people living in larger-sized households, and people with fewer socio-economic resources are more likely to receive informal care[77].

[77] http://www.mspsi.gob.es/

≈

In **Germany** statistics show that 4.3 Mio. health care givers have been registered in the year 2010. Those employees are working in 800 professions within the health and care sector. Nevertheless according to the latest report of the Federal Employment Office of the year 2011 the number of care professionals increased in the last decade by one-fifth. One of ten employees with a social insurance contribution is meanwhile working within the health care sector.

Thereby the proportion of women among workers in the health and care sector is significantly larger than in the total employment. Furthermore the statistics show that both part-time and full-time employment has increased. In year 2010 a third of the health care professionals with a social insurance contribution worked part-time. Minijobbers are under-represented in health and social care professions.

Fortunately the unemployment in the health and care professions has declined significantly in the recent years.

The development within the health care sector is critical. Due to the growing proportion of older people, the demand for skilled professional will go up by 140.000 required care givers until 2030. The search for vacancies in the health sector, particularly for doctors, health care workers and geriatric care professionals appears to be increasingly difficult. Skilled-labor shortage shows up in almost all federal states.

Age structure of caregivers in Germany

Referring to the shifted age structure within the health care sector, the group of employees is aging rapidly. From 2000 to 2004 every sixth worker in the health sector was younger than 25 years. In the year 2010 only one in seven cases was this young. However, the proportion of older workers increased due to demographic reasons. The 45 -to 49-year-old employees are the largest professional group in nursing. More than 400,000 workers are at this age. Furthermore the statistics show a great increase in employment for women, especially in the age group 25- to 29-years. [78]

≈

[78] Bundesagentur für Arbeit, *Arbeitsmarktberichterstattung: Gesundheits- und Pflegeberufe in Deutschland*", Nürnberg (Germany) 2011.

In **Greece**, there is a great number of informal carers, especially since economic recession, but there is no official data about the number of employed caregivers. In addition, as demonstrated above, there is not a unified system of certification for formal caregivers and no central registration exists. Nevertheless according to the latest reports and researches the crisis reduced dramatically the number of professionals caregivers. Furthermore part-time employment of formal caregivers has been increased. Unfortunately, the unemployment in health caregivers has been developed in the recent years. For example, the 'Help at Home' programme for older people (founded in 1992) aiming to encourage the elderly to be actively involved in their own healthcare with the help of official caregivers, while remaining within their family and social environment faces a lot of problems since the economic recession. Since 2010, official caregivers and especially certified caregivers (except nurses) can hardly find a job. Public employers cannot afford to pay them and prefer closing important care services.

Age structure of caregivers in Greece

Once again, according to Eurofamcare results (2003-2009), the average age of Greek family caregivers was 51.7 years,. This made them slightly younger than carers in other countries but it should be noticed that Eurofamcare research focused only on family caregivers. The gender dimension is crucial here as 80.9% of family carers are women). Their marital status is to be considered as well: 76.4% of the sample were married or cohabiting; 6% were widowed; 5.7% divorced or separated and 12% were single. Half of family caregivers were still working (average of 40hours/ week) besides offering caregiving as volunteers (in average 11hours/ week). The distribution of hours of caregiving has been influenced by family's financial problems. The quality of life of caregivers is very low compared to other european countries[79]. No official data exists for the age of formal caregivers in Greece.

≈

In 2010, **Austrian** healthcare institutions employed a total of 64 385 caregivers, 54 601 of them being professional nurses and 9 784 of them being assistant nurses. While the number of assistant nurses went back to 9 654 in 2011, the number of professional nurses increased to a total of 55 594, raising the total number of caregivers to 65 248.

[79] http://www.oecd.org/els/health-systems/47884865.pdf

In 2012 there were 56 085 professional nurses and 9 916 assistant nurses employed in Austrian healthcare institutions, leading to a total of 66 001 caregivers.[80] The number of professional nurses has been steadily rising over the last decades, whereas the number of assistant nurses has constantly been somewhere around 10 000 since the start of statistical recordings.

Table 8. Number of caregivers in Austrian healthcare institutions from 1980 to 2012

Profession	1980	1990	2000	2010	2011	2012
Caregivers	**22.186**	**30.842**	**57.367**	**64.385**	**65.248**	**66.001**
Professional nurses	22.186	30.842	46.219	54.601	55.594	56.085
Assistant nurses	-	-	11.148	9.784	9.654	9.916

Source: Statistik Austria

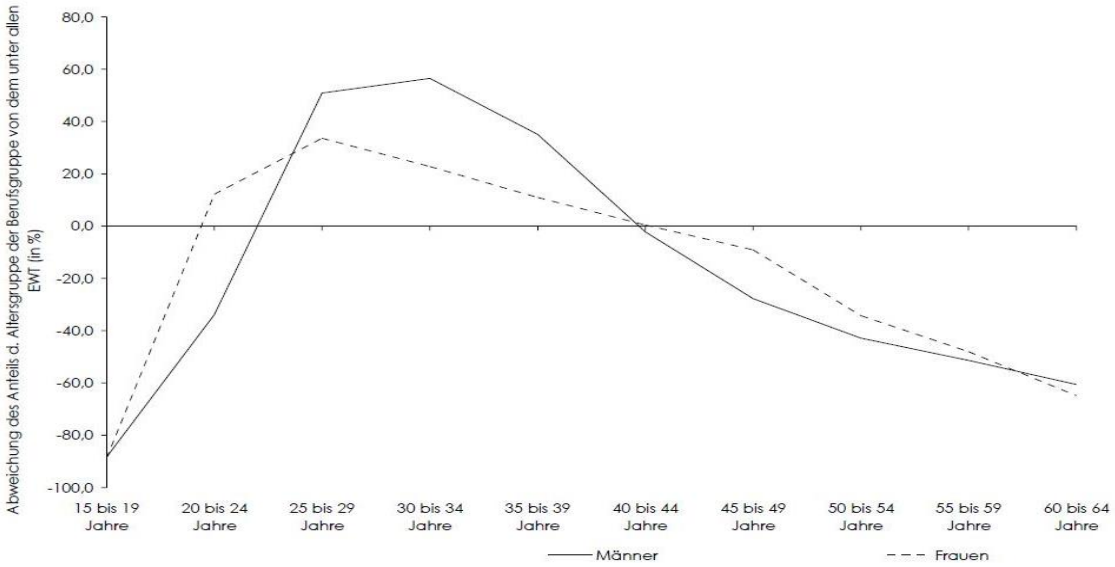
A report for the federal state of Salzburg predicts a shortage of 13 per cent in the hospital sector and 10 per cent in nursing homes for the year of 2020. Unfortunately this is the only federal state such a forecast was published about. Nevertheless, similar numbers can be expected all over Austria.[81]

Age structure of caregivers in Austria

The age structure of caregivers in Austria shows that the personnel in this sector are comparatively young. There is a noticeable concentration of caregivers in the age groups from 25 to 39 years, as can be seen in figure 1. There are hardly any caregivers under the age of 20 years, which is due to age restrictions in the admission process for nursing schools. The care sector is also affected by early career endings after about 20 years of occupation on average.
It is also worth mentioning that male applicants for nursing school are usually older than their female counterparts, as they often decide to start health care and nursing education after they already operated in a different educational path or employment.[82]

[80] www.statistik.at (Section Gesundheit, Gesundheitsversorgung, Personal im Gesundheitswesen), date of access: Jan. 20, 2014
[81] Rottenhofer I., et al., *Prognose des Pflegepersonalbedarfs im Gesundheits- und Sozialbereich des Bundeslandes Salzburg*, Ergebnisbericht, Vienna (Austria), Feb. 2013, p. 2
[82] Biffl G., *WIFO-Weißbuch: Mehr Beschäftigung durch Wachstum auf Basis von Innovation und Qualifikation,* Teilstudie 16: Alternde Dienstleistungsgesellschaft, Nov. 2006, p. 23 - 24

Chart 5. Deviation of the age structure of health care and nursing professionals to that of the total working population, 2001



Source: WIFO Austria

5.3. Conclusions

1. Occupation of caregiver is varied not only in international comparison, but also within each of the countries participating in the Take Care project.

2. In each country exists around 20 different professions considered as caregivers. Also there are informal care givers (mainly, members of families)

3. Improving the quality of both formal and informal care provision has to be the main goal of public policies. A shared vision and an exchange of experience by supporting joint training programs, formal certification of informal caregivers could be the way not only to provide appropriate services to beneficiaries but also to adress vocational and psychological support to formal and informal caregivers. The development of guidelines, policy and strategic documents is crucial in order not only to map the public policy initiatives related to professional regulation of care givers sector, but also to elaborate recommendations for social stakeholders.

4. Furthermore, the development of common quality standards and other ways to ensure greater professionalization of caregivers should be the main objective of each country and of Europe.

5. The focus shall be put on problems and possible solutions in the occupational field. Due to *demographic changes* a greater demand for caregivers will arise in the recent years. Consequently more qualified staff will be needed within the sector to assure the best

patient care possible regarding time and quality management. Since the Human Resource Management of hospitals cuts wages and staff, care givers are facing all different kinds of challenges. Great workload, a lack of sleep due to the shift-working-pattern and emotional stress are just a few of those problems.

6. Because of the lack of qualified workforce the HR managements of hospitals are facing a hard competing labour market situation. Their challenge is now seen in recruiting and retaining talents and qualified workforce. To achieve this target, the Management has to reconstruct its organization and system. Not only talent management is one important part of the new tasks of the management of health care facilities. They must also "take care" of their aging staff, offer qualification and training possibilities and adopt their system to the needs of their highest good – the care givers.

6. Soft skills of caregivers - results of studies conducted in each partner country - comparison of results

Characteristic of the caregivers study group

Gender:

The total number of respondents - 165, including 136 women (82.4%), 27 men (16.4%), 2 respondents (1.2%) missing data.

Age:

- Lack of data - 1 respondent (0.6%)
- 25 - 34 years - 66 respondents (40.0%)
- 34 - 44 years - 32 respondents (19.4%)
- 45 - 54 years – 39 respondents (23.6%)
- 55 - 64 years - 27 respondents (16, 4%)

Working experience:

- Lack of data - 20 respondents (12.1%)
- Less than one year - 10 respondents (6.1%)
- 1 -2 years - 16 respondents (9.7%)
- 3 – 5 years - 31 respondents (18.8%)
- 6 - 10 years - 24 respondents (14.5%)
- 11 – 15 years – 11 respondents (6.7%)
- 16 – 20 years – 15 respondents (9.1%)
- More than 20 years – 38 respondents (23.0%)

Type of caregivers:

- Lack of data – 5 respondents (3.0%)
- Professional nurses – 122 respondents (73.9%)
- Medical assistants – 4 respondents (2.4%)
- Social workers – 16 respondents (9.7%)
- Another – 18 respondents (10.9%)

Type of institution:

- Lack of data – 12 respondents (7.3%)
- Hospital/Clinic/Primary Health Care – 121 respondents (73.9%)
- Nursing home – 11 respondents (73.3%)
- Hospice – 18 respondents (10.9%)
- Another – 18 respondents (1.8%)

Importance of specific social skills from the respondents point of view

Communication with patiens

Table 9. The importance of Communication with patients skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with patients PL	22	0	5	4,91	1,101
Communication with patients IT	20	0	5	4,76	1,146
Communication with patients EL	21	3	5	4,55	,539
Communication with patients ES	23	4	5	4,55	,288
Communication with patients DE	31	4	5	4,94	,250
Communication with patients AT	27	4	5	4,96	,192
Communication with patients FR	21	5	5	5,00	,000

Source: Based on the results of Take Care research

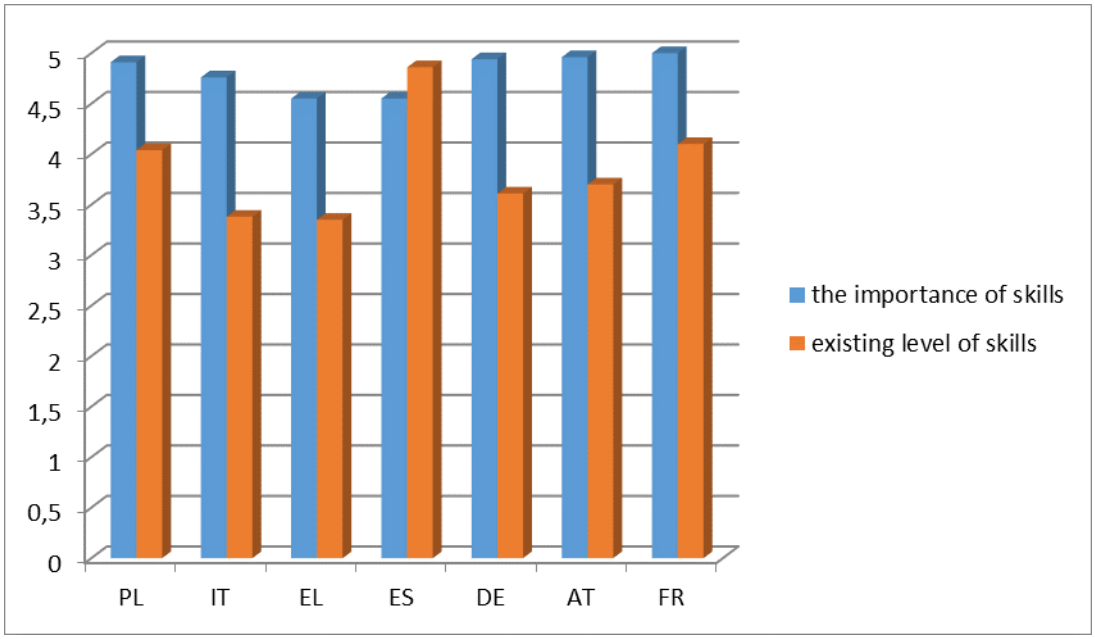
Table 10. The existing level of Communication with patients skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with patients PL	20	0	5	4,04	1,309
Communication with patients IT	21	0	5	3,38	1,244
Communication with patients EL	31	1	5	3,35	,761

Communication with patients ES	27	3	5	4,86	,542
Communication with patients DE	23	3	5	3,61	,706
Communication with patients AT	21	2	5	3,70	,995
Communication with patients FR	22	4	5	4,10	,351

Source: Based on the results of Take Care research

Chart 6. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Communication with doctors

Table 11. The importance of Communication with doctors skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with doctors PL	23	4	5	4,78	,422
Communication with doctors IT	21	3	5	4,43	,676
Communication with doctors EL	20	0	5	4,25	1,209

Communication with doctors ES	22	0	5	4,00	1,718
Communication with doctors DE	31	4	5	4,94	,250
Communication with doctors AT	27	4	5	4,85	,362
Communication with doctors FR	21	5	5	5,00	,000

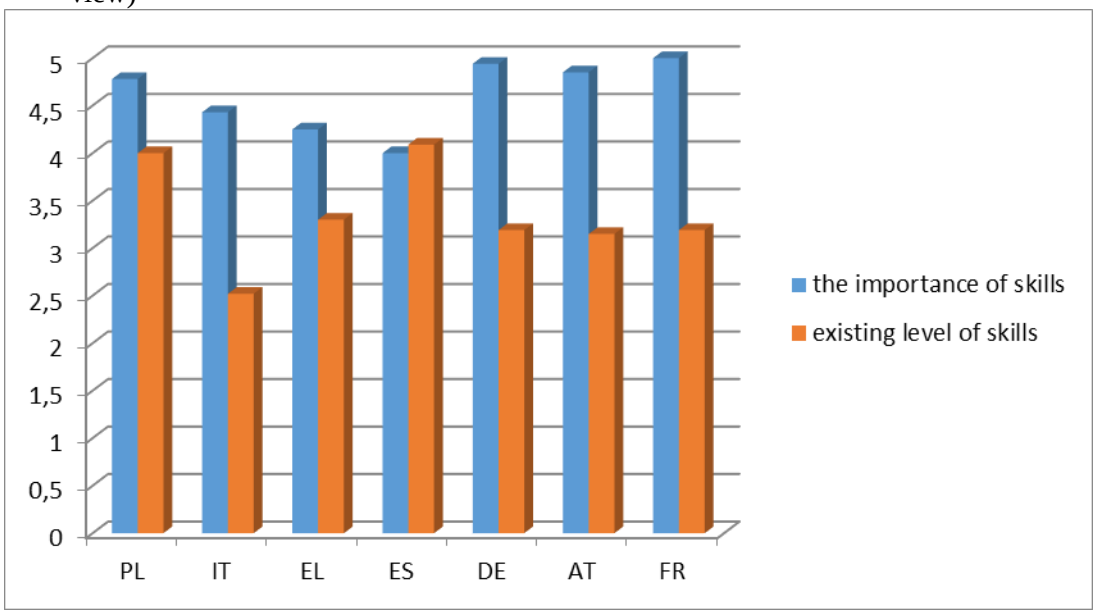
Source: Based on the results of Take Care research

Table 12. The existing level of communication with doctors (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with doctors PL	23	2	5	4,00	,739
Communication with doctors IT	21	0	4	2,52	1,209
Communication with doctors EL	20	0	5	3,30	1,342
Communication with doctors ES	22	0	5	4,09	1,716
Communication with doctors DE	31	1	5	3,19	,910
Communication with doctors AT	27	2	5	3,15	,770
Communication with doctors FR	21	1	5	3,19	1,365

Source: Based on the results of Take Care research

Chart 7. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Being emphatic

Table 13. The importance of being emphatic skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Being emphatic PL	23	3	5	4,61	,583
Being emphatic IT	21	3	5	4,71	,561
Being emphatic EL	20	0	5	4,20	1,240
Being emphatic ES	22	0	5	4,23	1,445
Being emphatic DE	31	3	5	4,58	,620
Being emphatic AT	27	3	5	4,81	,483
Being emphatic FR	21	5	5	5,00	,000

Source: Based on the results of Take Care research

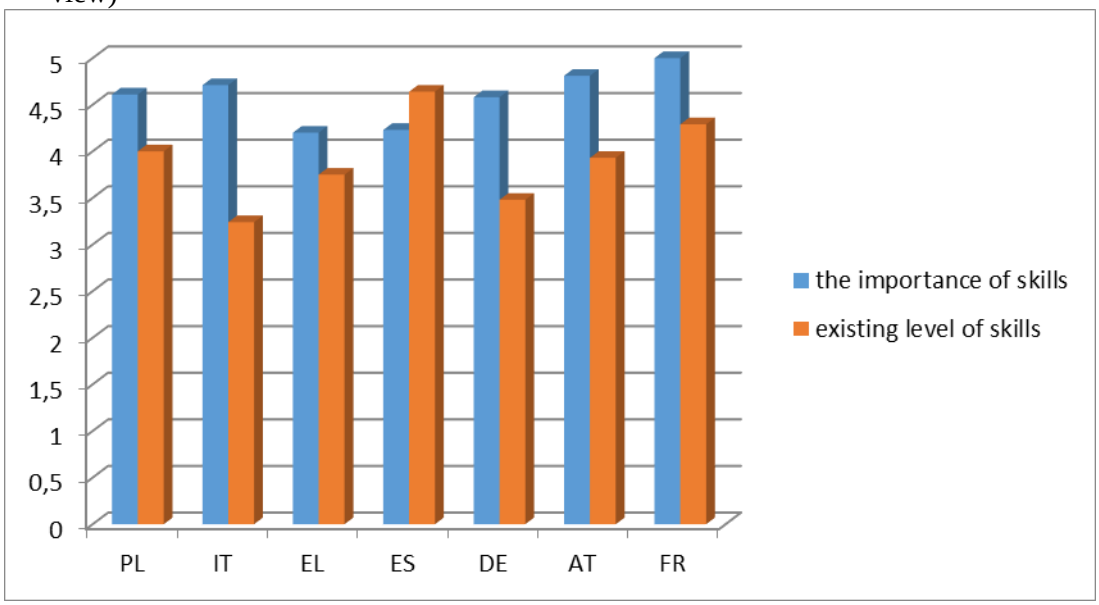
Table 14. The existing level of being emphatic skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Being emphatic	23	3	5	4,00	,674
Being emphatic	21	0	5	3,24	1,411
Being emphatic	20	0	5	3,75	1,118
Being emphatic	22	4	5	4,64	,492
Being emphatic	31	0	5	3,48	1,061
Being emphatic	27	3	5	3,93	,616

Being emphatic	21	2	5	4,29	,902

Source: Based on the results of Take Care research

Chart 8. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Emotional resilience

Table 15. The importance of emotional resilience skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Emotional resilience PL	23	0	5	4,52	1,123
Emotional resilience IT	21	3	5	4,38	,740
Emotional resilience EL	20	0	5	4,40	1,536
Emotional resilience ES	22	0	5	4,14	1,424
Emotional resilience DE	31	4	5	4,84	,374
Emotional resilience AT	27	0	5	4,59	1,047
Emotional resilience FR	21	0	5	4,76	1,091

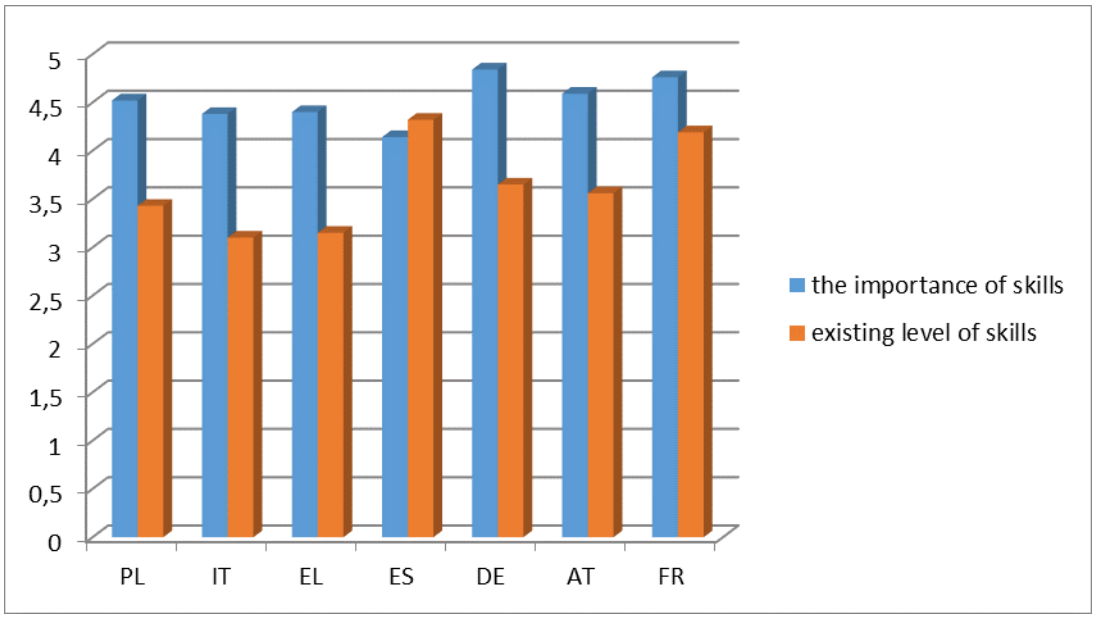
Source: Based on the results of Take Care research

Table 16. The existing level of emotional resilience skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Emotional resilience PL	23	0	5	3,43	1,037
Emotional resilience IT	21	0	5	3,10	1,338
Emotional resilience EL	20	0	5	3,15	1,268
Emotional resilience ES	22	3	5	4,32	,568
Emotional resilience DE	31	2	5	3,65	,950
Emotional resilience AT	27	2	5	3,56	,847
Emotional resilience FR	21	2	5	4,19	,873

Source: Based on the results of Take Care research

Chart 9. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Good judgment

Table 17. The importance of good judgment skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Good judgment PL	23	1	5	4,48	,994
Good judgment IT	21	3	5	4,52	,602
Good judgment EL	20	0	5	4,25	1,585
Good judgment ES	22	0	5	4,55	1,101
Good judgment DE	31	4	5	4,68	,475

Good judgment AT	27	4	5	4,74	,447
Good judgment FR	21	5	5	5,00	,000

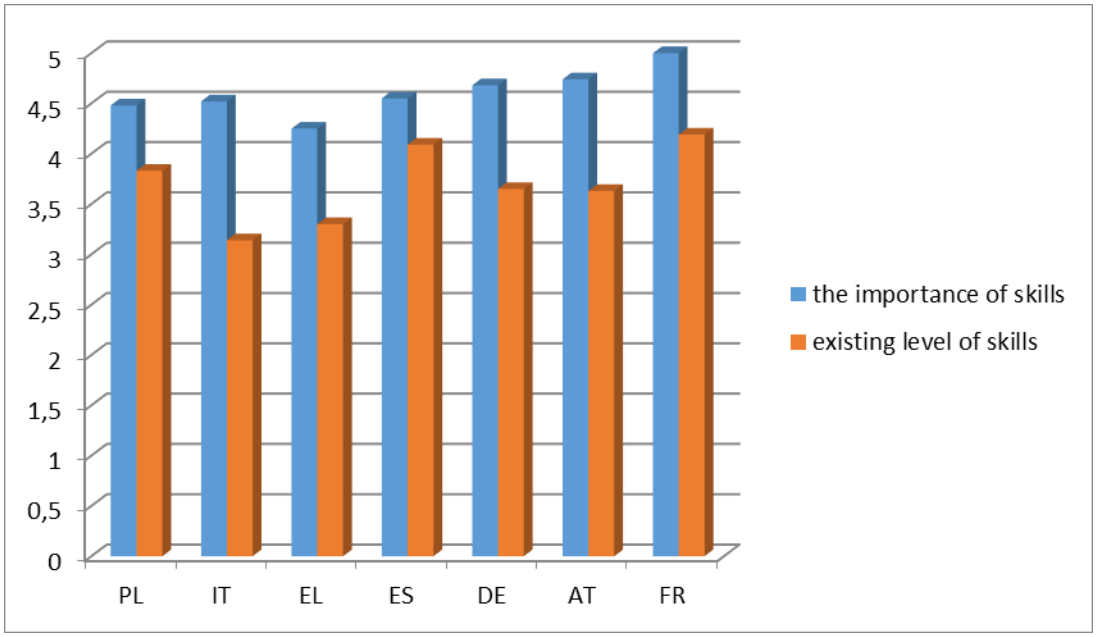
Source: Based on the results of Take Care research

Table 18. The existing level of good judgment skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Good judgment	23	0	5	3,83	1,029
Good judgment	21	0	5	3,14	1,389
Good judgment	20	0	5	3,30	1,081
Good judgment	22	0	5	4,09	1,065
Good judgment	31	2	5	3,65	,915
Good judgment	27	2	5	3,63	,688
Good judgment	21	2	5	4,19	,873

Source: Based on the results of Take Care research

Chart 10. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Leadership

Table 19.The importance of leadership skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Leadership PL	23	1	5	3,74	1,137
Leadership IT	21	3	5	4,10	,700
Leadership ET	20	0	5	3,60	1,231
Leadership ES	22	0	5	3,68	1,249
Leadership DE	31	3	5	3,87	,718
Leadership AT	27	2	5	4,11	,847
Leadership FR	21	5	5	5,00	,000

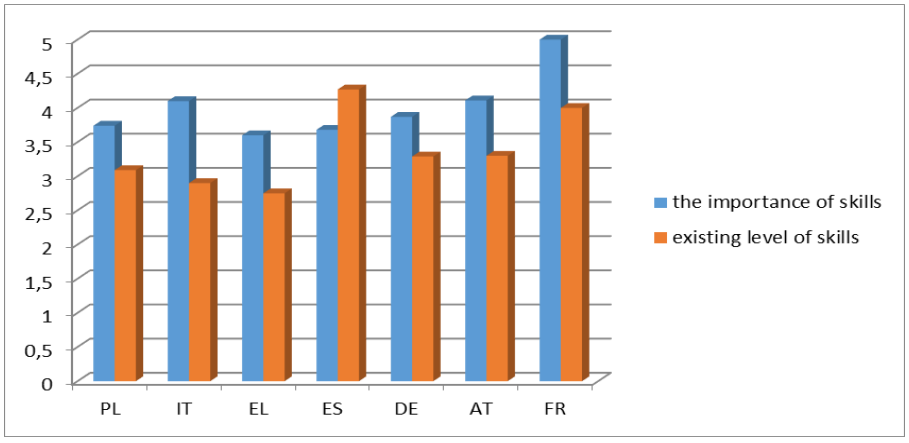
Source: Based on the results of Take Care research

Table 20. The existing level of leadership skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Leadership PL	23	0	5	3,09	1,276
Leadership IT	21	0	5	2,90	1,300
Leadership EL	20	0	5	2,75	1,293
Leadership ES	22	0	5	4,27	1,077
Leadership DE	31	1	5	3,29	,938
Leadership AT	27	1	5	3,30	1,068
Leadership FR	21	2	5	4,00	,894

Source: Based on the results of Take Care research

Chart 11. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Teamwork across seniority

Table 21. The importance of teamwork across seniority skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Teamwork across seniority PL	23	1	5	4,43	,896
Teamwork across seniority IT	21	3	5	4,43	,746
Teamwork across seniority EL	20	0	5	4,05	1,538
Teamwork across seniority ES	22	0	5	3,64	1,217
Teamwork across seniority DE	31	1	5	4,55	,850
Teamwork across seniority AT	27	3	5	4,52	,643
Teamwork across seniority FR	21	5	5	5,00	,000

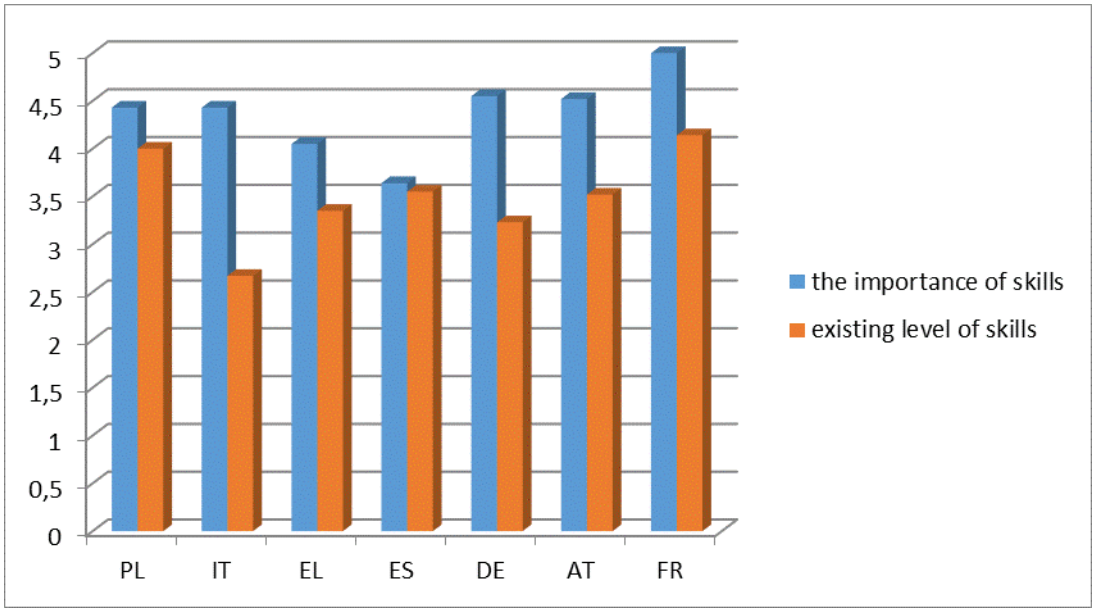
Source: Based on the results of Take Care research

Table 22. The existing level of teamwork across seniority skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Teamwork across seniority PL	23	2	5	4,00	,739
Teamwork across seniority IT	21	0	5	2,67	1,354
Teamwork across seniority EL	20	0	5	3,35	1,137
Teamwork across seniority ES	22	0	5	3,55	1,371
Teamwork across seniority DE	31	1	5	3,23	1,023
Teamwork across seniority AT	27	2	5	3,52	1,087
Teamwork across seniority FR	21	1	5	4,14	1,195

Source: Based on the results of Take Care research

Chart 12. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Assertiveness in building relationships with patients and colleagues

Table 23. The importance of assertiveness in building relationships with patients and colleagues skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Assertiveness in building relationships with patients and colleagues PL	23	0	5	4,35	1,152
Assertiveness in building relationships with patients and colleagues IT	21	3	5	4,38	,590
Assertiveness in building relationships with patients and colleagues EL	20	0	5	4,15	1,226
Assertiveness in building relationships with patients and colleagues ES	22	0	5	4,32	1,171
Assertiveness in building relationships with patients and colleagues DE	31	1	5	4,16	1,036

Assertiveness in building relationships with patients and colleagues AT	27	2	5	4,37	,792
Assertiveness in building relationships with patients and colleagues FR	21	0	5	4,76	1,091

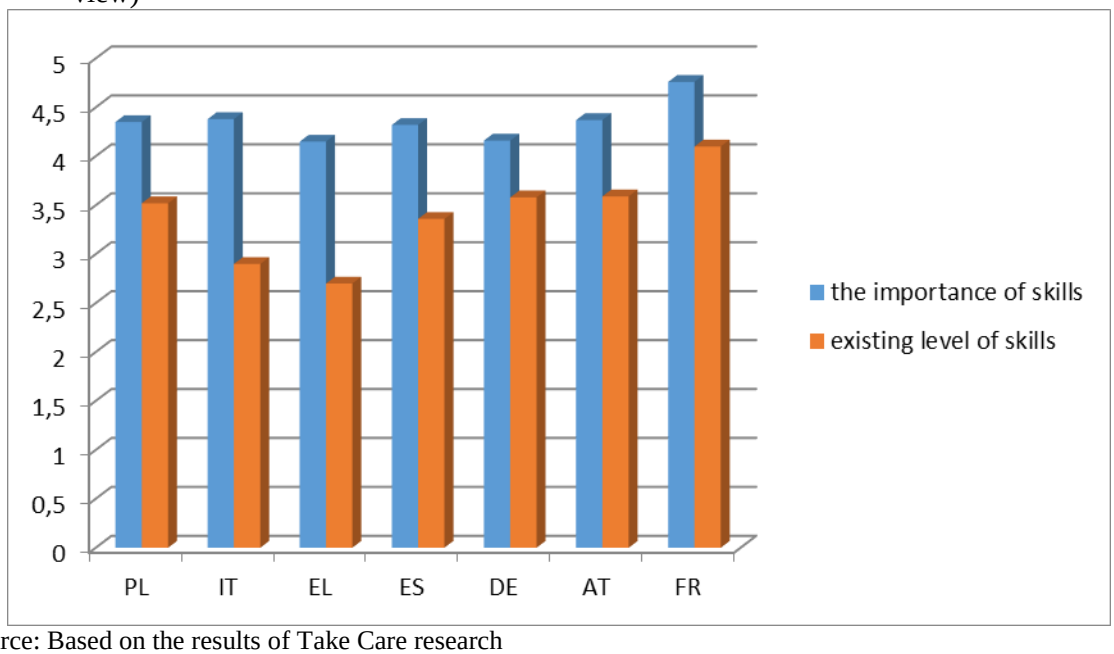
Source: Based on the results of Take Care research

Table 24. The existing level of assertiveness in building relationships with patients and colleagues skills

	N	Minimum	Maximum	Average	Standard deviation
Assertiveness in building relationships with patients and colleagues PL	23	0	5	3,52	1,039
Assertiveness in building relationships with patients and colleagues IT	21	0	5	2,90	1,261
Assertiveness in building relationships with patients and colleagues EL	20	0	5	2,70	1,380
Assertiveness in building relationships with patients and colleagues ES	22	0	5	3,36	1,329
Assertiveness in building relationships with patients and colleagues DE	31	2	5	3,58	,807
Assertiveness in building relationships with patients and colleagues AT	27	2	5	3,59	,844
Assertiveness in building relationships with patients and colleagues FR	21	1	5	4,10	1,091

Source: Based on the results of Take Care research

Chart 13. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Work - life balance

Table 25. The importance of work - life balance skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Work - life balance PL	23	3	5	4,39	,656
Work - life balance IT	21	3	5	4,24	,831
Work - life balance EL	20	0	5	4,35	1,268
Work - life balance ES	22	0	5	3,64	1,649
Work - life balance DE	31	3	5	4,68	,541
Work - life balance AT	27	3	5	4,56	,698
Work - life balance FR	21	5	5	5,00	,000

Source: Based on the results of Take Care research

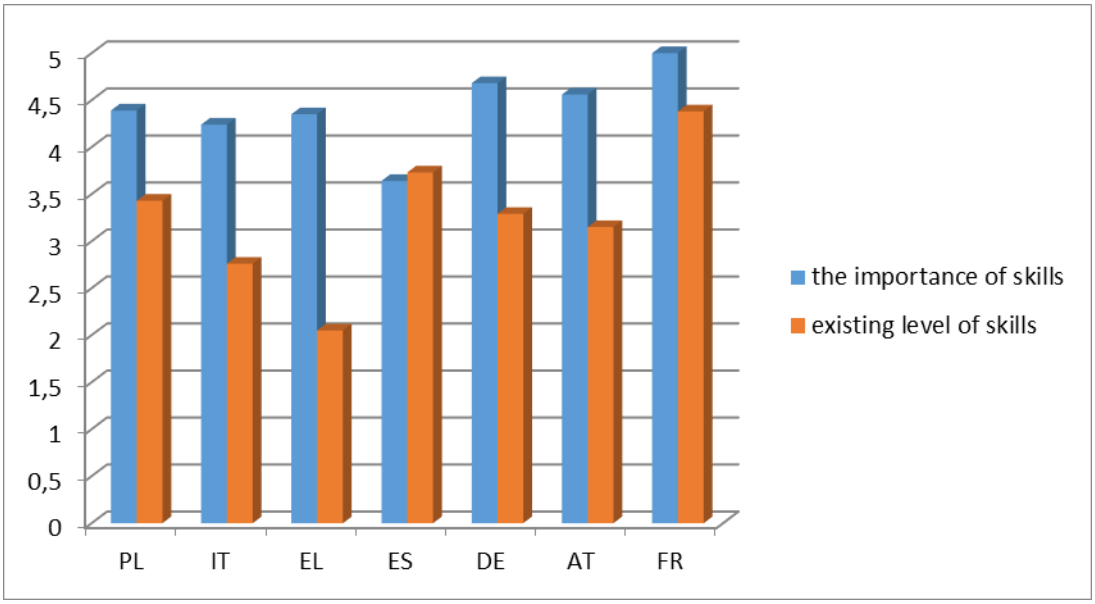
Table 26. The existing level of work - life balance skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Work - life balance	23	0	4	3,43	,945
Work - life balance	21	0	5	2,76	1,446
Work - life balance	20	0	5	2,05	1,276
Work - life balance	22	0	5	3,73	1,077
Work - life balance	31	1	5	3,29	,864

Work - life balance	27	2	5	3,15	,818
Work - life balance	21	2	5	4,38	,865

Source: Based on the results of Take Care research

Chart 14. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Ability to prevent burnout

Table 27. The importance of ability to prevent burnout skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Ability to prevent burnout PL	23	0	5	4,17	1,072
Ability to prevent burnout IT	21	0	5	4,10	1,300
Ability to prevent burnout EL	20	0	5	4,10	1,483
Ability to prevent burnout ES	22	0	5	3,68	1,427
Ability to prevent burnout DE	31	2	5	4,61	,715
Ability to prevent burnout AT	27	3	5	4,70	,542
Ability to prevent burnout FR	21	5	5	5,00	,000

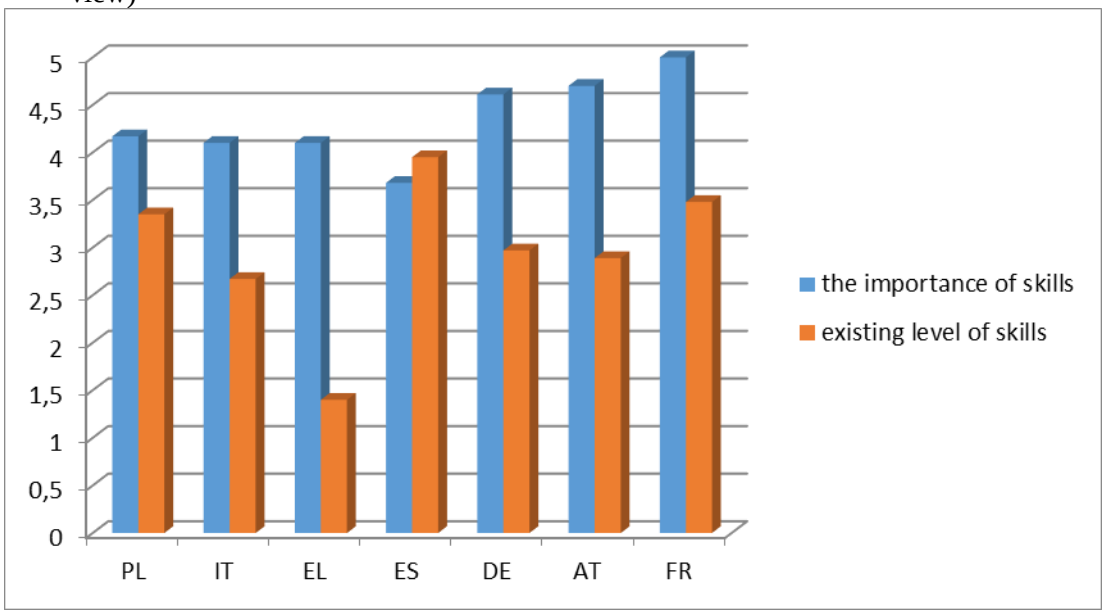
Source: Based on the results of Take Care research

Table 28. The existing level of ability to prevent burnout skills (caregivers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Ability to prevent burnout PL	23	2	5	3,35	,832
Ability to prevent burnout IT	21	0	5	2,67	1,065
Ability to prevent burnout EL	20	0	2	1,40	,598
Ability to prevent burnout ES	22	3	5	3,95	,844
Ability to prevent burnout DE	31	1	5	2,97	1,016
Ability to prevent burnout AT	27	1	5	2,89	1,050
Ability to prevent burnout FR	21	1	5	3,48	,981

Source: Based on the results of Take Care research

Chart 15. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (caregivers point of view)



Source: Based on the results of Take Care research

Hierarchy of specific social skills based on all respondents points of view

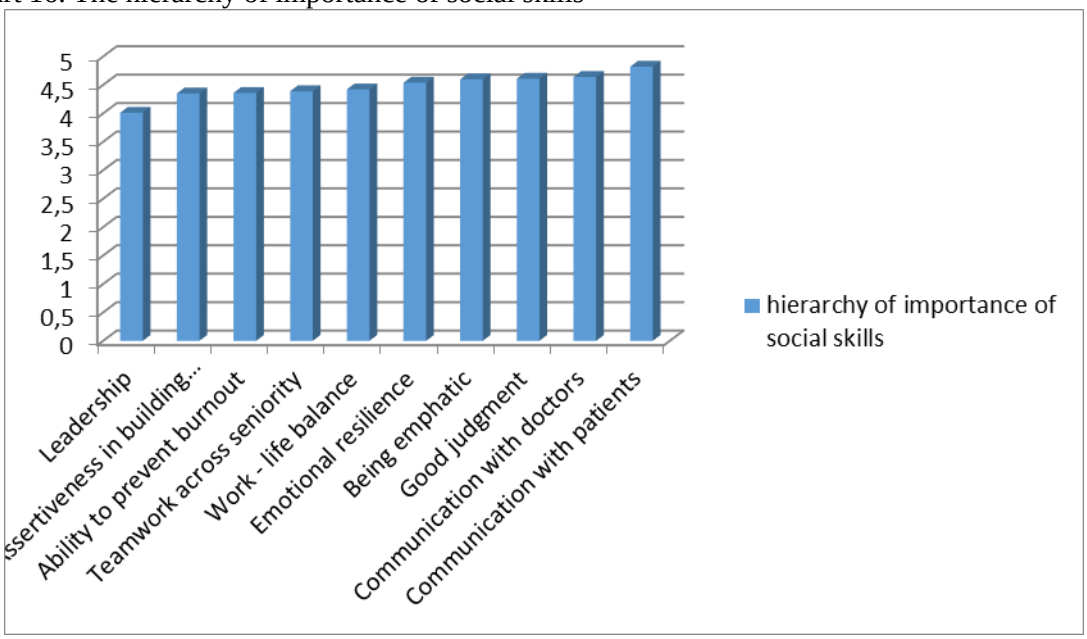
Table 29. The hierarchy of importance of social skills

	N	Minimum	Maximum	Average	Standard deviation
Leadership	165	0	5	4,01	,997
Assertiveness in building relationships with patients and colleagues	165	0	5	4,35	1,022
Ability to prevent burnout	165	0	5	4,36	1,088
Teamwork across seniority	165	0	5	4,39	,991
Work - life balance	165	0	5	4,42	,976

Emotional resilience	165	0	5	4,54	1,079
Being emphatic	165	0	5	4,60	,840
Good judgment	165	0	5	4,61	,860
Communication with doctors	165	0	5	4,64	,884
Communication with patients	165	0	5	4,82	,634

Source: Based on the results of Take Care research

Chart 16. The hierarchy of importance of social skills



Source: Based on the results of Take Care research

Existing level of specific social skills based on all respondents' point of view

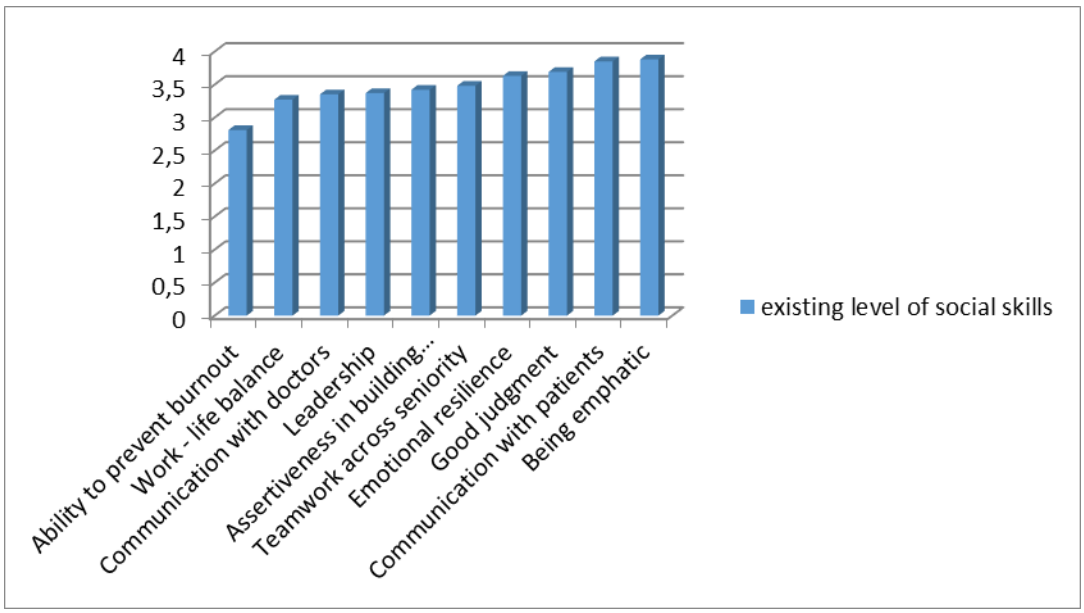
Table 30. The existing level of social skills

	N	Minimum	Maximum	Average	Standard deviation
Ability to prevent burnout	165	0	5	2,81	1,431
Work - life balance	165	0	5	3,27	1,205
Communication with doctors	165	0	5	3,35	1,243
Leadership	165	0	5	3,37	1,206
Assertiveness in building relationships with patients and colleagues	165	0	5	3,42	1,153
Teamwork across seniority	165	0	5	3,48	1,198
Emotional resilience	165	0	5	3,63	1,066
Good judgment	165	0	5	3,69	1,045
Communication with patients	165	0	5	3,85	,983

Being emphatic	165	0	5	3,88	1,015

Source: Based on the results of Take Care research

Chart 17. The existing level of social skills



Source: Based on the results of Take Care research

Table 31. Differences between the average level of social skills and the validity of their existing level (One - way analysis of variance – *ANOVA)*

		sum of squares	df	Average square	F	statistical significance
Communication with patients	Between grops	77,576	1	77,576	113,384	,000
	Within groups	224,412	328	,684		
	Total	301,988	329			
Communication with doctors	Between grops	137,482	1	137,482	118,205	,000
	Within groups	381,491	328	1,163		
	Total	518,973	329			
Being emphatic	Between grops	42,194	1	42,194	48,660	,000
	Within groups	284,412	328	,867		
	Total	326,606	329			
Emotional resilience	Between grops	68,182	1	68,182	59,250	,000
	Within groups	377,442	328	1,151		
	Total	445,624	329			
Good judgment	Between grops	70,012	1	70,012	76,442	,000

	Within groups	300,412	328	,916		
	Total	370,424	329			
	Between grops	33,409	1	33,409	27,297	,000
Leadership	Within groups	401,442	328	1,224		
	Total	434,852	329			
	Between grops	67,276	1	67,276	55,669	,000
Teamwork across seniority	Between grops	396,388	328	1,208		
	Within groups	463,664	329			
Assertiveness in building	Total	70,936	1	70,936	59,743	,000
relationships with patients and	Between grops	389,455	328	1,187		
colleagues	Within groups	460,391	329			
	Total	110,548	1	110,548	91,897	,000
Work - life balance	Between grops	394,570	328	1,203		
	Within groups	505,118	329			
	Between grops	200,148	1	200,148	123,871	,000
Ability to prevent burnout	Within groups	529,976	328	1,616		
	Total	730,124	329			

significance level $\alpha = 0,05$

Source: Based on the results of Take Care research

Conclusion

From the point of view of the staff the most important features are:

- good judgment
- communication with doctors
- communication with patients

The least important:

- leadership
- assertiveness in building relationships with patients and colleagues
- ability to prevent burnout

At the highest level personel assess their existing skills:

-good judgment
- communication with patients
- being emphatic

The lowest level of their skills represented:

- ability to Prevent Burnout
- work - life balance
- communication with doctors

Analysis of variance indicated the existence of significant differences between the characteristics possessed by the staff, and the features which, according their own opinion should possess.

Managers

Characteristic of the managers study group

Gender:

The total number of respondents - 149, including 96 women (64.9%), 51 men (34.5%), 1 respondents (0.7%) missing data.

Age:

- Lack of data - 2 respondent (1.3%)
- 25 - 34 years - 6 respondents (4.0%)
- 34 - 44 years – 65 respondents (24.7%)
- 45 - 54 years – 35 respondents (43.3%)
- 55 - 64 years - 4 respondents (2.7%)

Working experience:

- Lack of data - 1 respondents (0.7%)
- Less than one year - 2 respondents (1.3%)
- 1 -2 years - 11 respondents (7.3%)
- 3 – 5 years - 25 respondents (16.7%)
- 6 - 10 years - 36 respondents (24.0%)
- 11 – 15 years – 24 respondents (16.0%)
- 16 – 20 years – 18 respondents (12.0%)
- More than 20 years – 32 respondents (21.3%)

Education:

- Lack of data – 8 respondents (5.3%)
- Legal – 8 respondents (5.3%)
- Management – 73 respondents (48.7%)
- Medicine – 27 respondents (18.0%)
- Social sciences – 20 respondents (13.3%)
- Another – 13 respondents (8.7%)

Type of institution:

- Lack of data – 2 respondents (1.3%)
- Hospital/Clinic/Primary Health Care – 101 respondents (67.3%)
- Nursing home – 11 respondents (7.3%)
- Hospice – 17 respondents (11.3%)
- Another – 18 respondents (12.0%)

Importance of specific social skills from the respondents point of view

Communication with patients

Table 32. The importance of ability to communication with patients skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with patients PL	22	4	5	4,91	,294
Communication with patients IT	22	3	5	4,36	,581
Communication with patients EL	20	4	5	4,75	,444
Communication with patients ES	5	0	5	4,00	2,236
Communication with patients DE	28	0	5	4,46	1,478
Communication with patients AT	30	4	5	4,90	,305
Communication with patients FR	22	5	5	5,00	,000

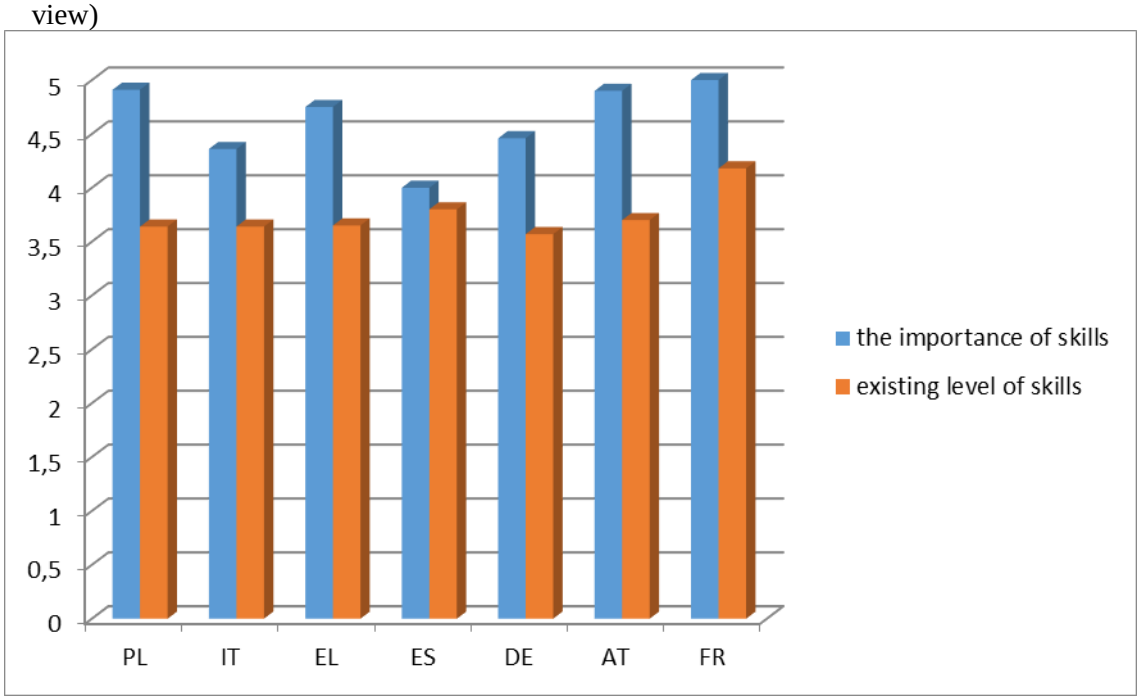
Source: Based on the results of Take Care research

Table 33. The existing level of communication with patients skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with patients	22	2	5	3,64	,848
Communication with patients	22	3	5	3,64	,727
Communication with patients	20	0	5	3,65	1,226
Communication with patients	5	0	5	3,80	2,168
Communication with patients	28	0	5	3,57	1,200
Communication with patients	30	3	5	3,70	,596
Communication with patients	22	2	5	4,18	,853

Source: Based on the results of Take Care research

Chart 18. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Communication with doctors

Table 34. The importance of ability to communication with doctors skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with doctors PL	22	0	5	4,55	1,101

Communication with doctors IT	22	4	5	4,73	,456
Communication with doctors EL	20	4	5	4,85	,366
Communication with doctors ES	5	0	5	3,80	2,168
Communication with doctors DE	28	0	5	4,36	1,471
Communication with doctors AT	30	3	5	4,73	,521
Communication with doctors FR	22	1	5	4,41	1,221

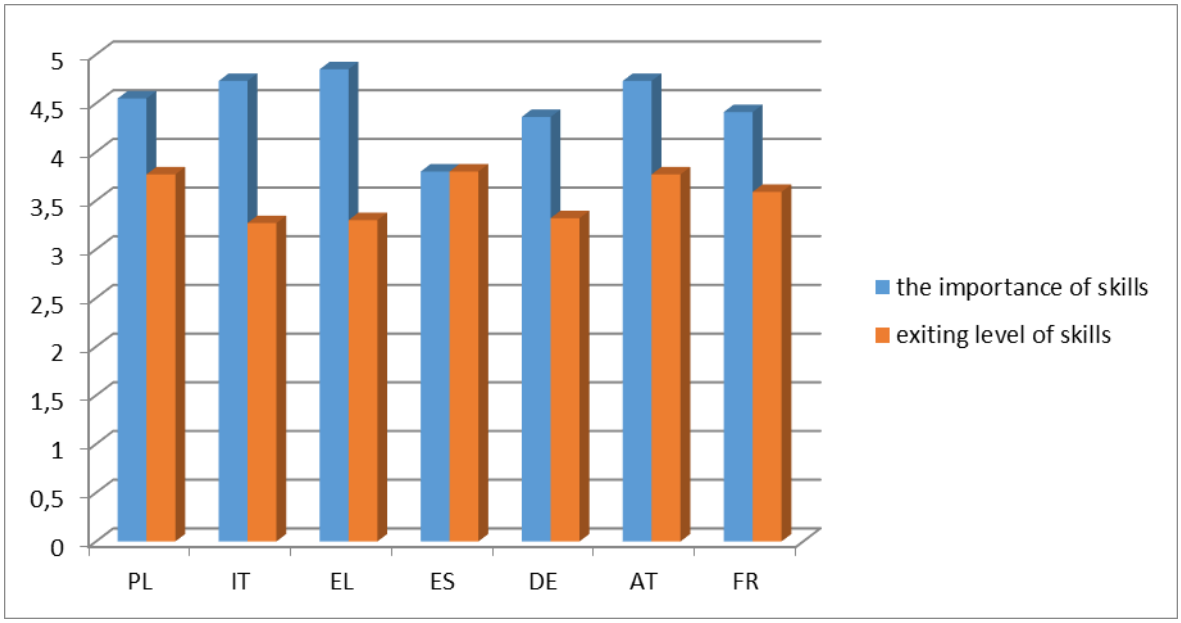
Source: Based on the results of Take Care research

Table 35. The existing level of communication with doctors skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Communication with doctors PL	22	2	5	3,77	,922
Communication with doctors IT	22	2	5	3,27	,703
Communication with doctors EL	20	0	5	3,30	1,129
Communication with doctors ES	5	0	5	3,80	2,168
Communication with doctors DE	28	0	5	3,32	1,090
Communication with doctors AT	30	2	5	3,77	,817
Communication with doctors FR	22	1	5	3,59	1,297

Source: Based on the results of Take Care research

Chart 19. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Being emphatic

Partners from Germany and Austria in the national reports have declared lack of item concerning "being emphatic" in online questionnaire second part.

Table 36. The importance of ability to being emphatic skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Being emphatic PL	22	4	5	4,91	,294
Being emphatic IT	22	3	5	4,32	,716
Being emphatic EL	20	0	5	4,35	1,137
Being emphatic ES	5	0	5	3,80	2,168
Being emphatic DE	28	0	5	4,39	1,474
Being emphatic AT	30	4	5	4,83	,379
Being emphatic FR	22	5	5	5,00	,000

Source: Based on the results of Take Care research

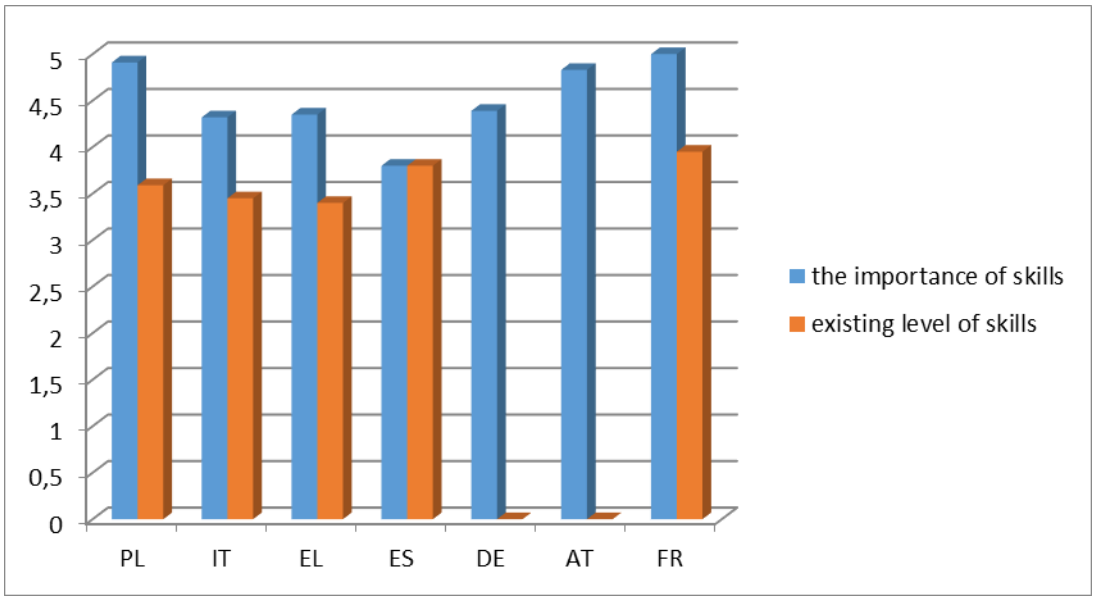
Table 37. The existing level of being emphatic skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Being emphatic PL	22	2	5	3,59	,959

Being emphatic IT	22	2	5	3,45	,858
Being emphatic EL	20	0	5	3,40	1,046
Being emphatic ES	5	0	5	3,80	2,168
Being emphatic DE	28	0	0	,00	,000
Being emphatic AT	30	0	0	,00	,000
Being emphatic FR	22	0	5	3,95	1,174

Source: Based on the results of Take Care research

Chart 20. Cmparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Emotional resilience

Table 38. The importance of ability to emotional resilience skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Emotional resilience PL	22	3	5	4,86	,468
Emotional resilience IT	22	3	5	4,55	,596
Emotional resilience EL	20	0	5	3,85	1,387
Emotional resilience ES	5	0	5	3,40	1,949
Emotional resilience DE	28	0	5	4,43	1,476
Emotional resilience AT	30	4	5	4,87	,346
Emotional resilience FR	22	4	5	4,95	,213

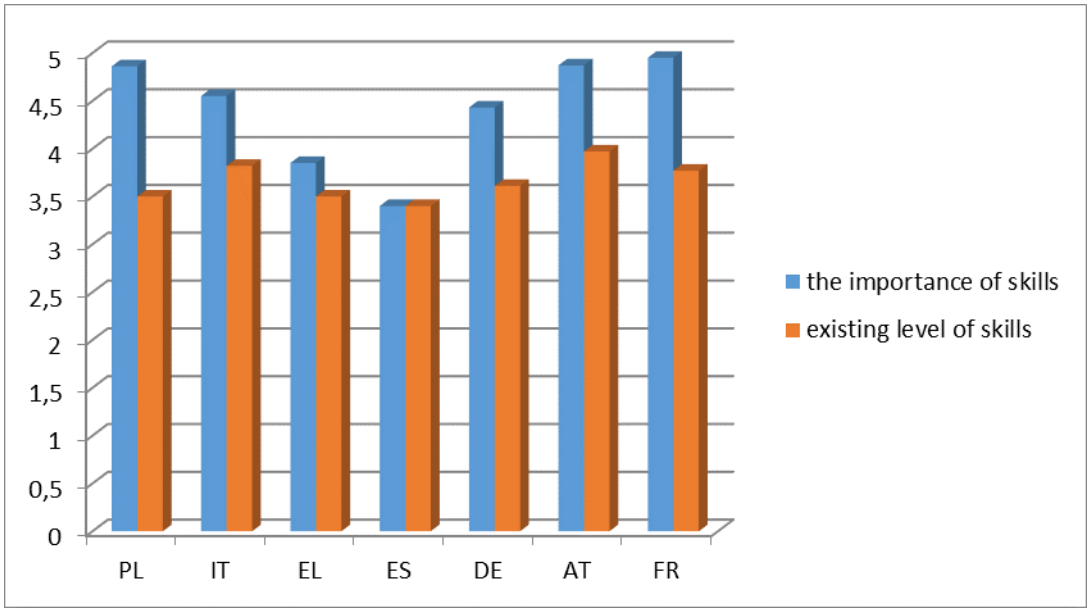
Source: Based on the results of Take Care research

Table 39. The existing level of emotional resilience skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Emotional resilience PL	22	2	5	3,50	,859
Emotional resilience IT	22	3	5	3,82	,588
Emotional resilience EL	20	0	5	3,50	1,051
Emotional resilience ES	5	0	5	3,40	1,949
Emotional resilience DE	28	0	5	3,61	1,227
Emotional resilience AT	30	2	5	3,97	,850
Emotional resilience FR	22	1	5	3,77	1,066

Source: Based on the results of Take Care research

Chart 21. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Good judgment

Table 40. The importance of ability to good judgment skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Good judgment PL	22	3	5	4,77	,528
Good judgment IT	22	4	5	4,50	,512
Good judgment EL	20	0	5	3,65	1,309
Good judgment ES	5	0	5	3,80	2,168
Good judgment DE	28	0	5	4,25	1,481

Good judgment AT	30	4	5	4,83	,379
Good judgment FR	22	5	5	5,00	,000
N Ważnych (wyłączanie obserwacjami)	5				

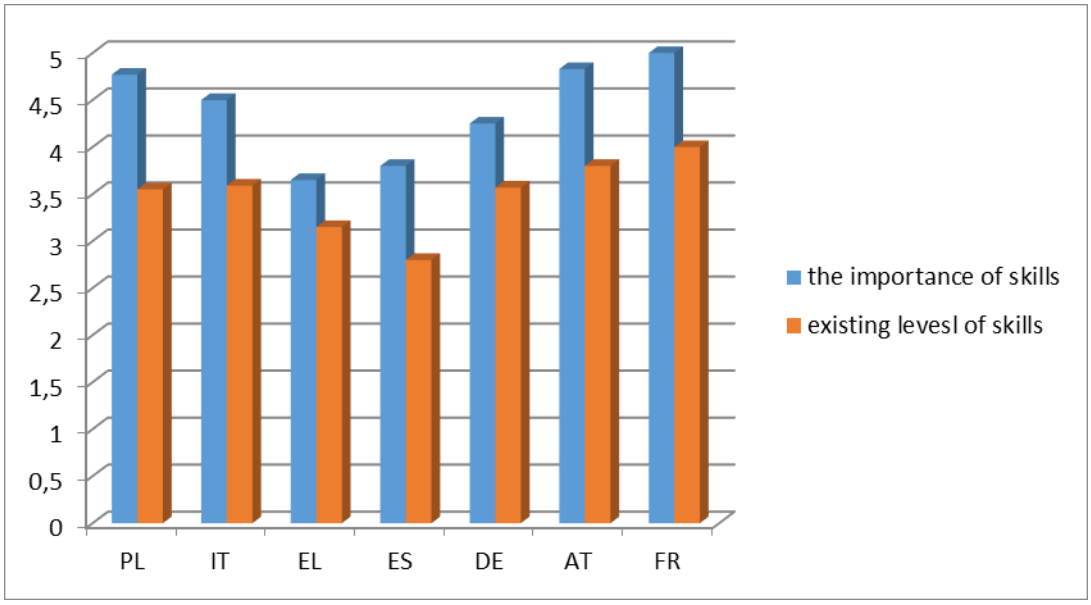
Source: Based on the results of Take Care research

Table 41. The existing level of good judgment skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Good judgment PL	22	2	5	3,55	1,101
Good judgment IT	22	2	5	3,59	,666
Good judgment EL	20	0	5	3,15	1,387
Good judgment ES	5	0	5	2,80	2,588
Good judgment DE	28	0	5	3,57	1,230
Good judgment AT	30	2	5	3,80	,887
Good judgment FR	22	2	5	4,00	,816

Source: Based on the results of Take Care research

Chart 22. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Leadership

Table 42. The importance of ability to leadership skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Leadership PL	22	0	5	3,41	1,368
Leadership IT	22	0	5	3,50	1,406
Leadership EL	20	0	5	4,25	1,585
Leadership ES	5	0	5	3,00	1,871
Leadership DE	28	0	5	3,18	1,467
Leadership AT	30	3	5	4,07	,868
Leadership FR	22	1	5	4,68	,894

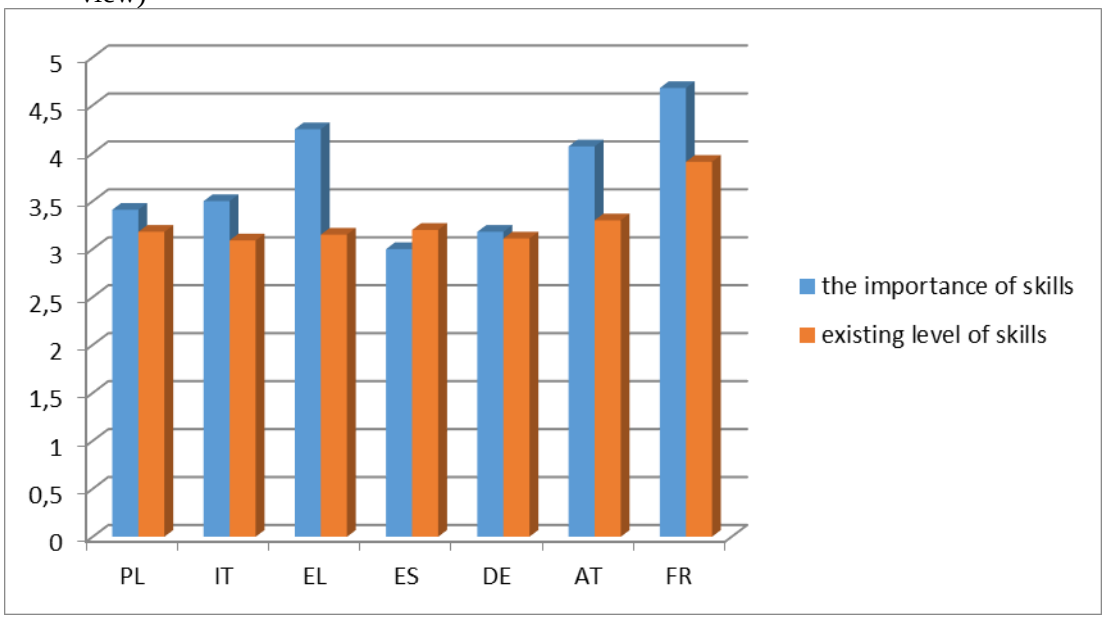
Source: Based on the results of Take Care research

Table 43. The existing level of leadership skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Leadership PL	22	1	5	3,18	1,097
Leadership IT	22	2	4	3,09	,750
Leadership EL	20	0	5	3,15	1,387
Leadership ES	5	0	5	3,20	1,924
Leadership DE	28	0	5	3,11	1,197
Leadership AT	30	1	5	3,30	,952
Leadership FR	22	2	5	3,91	,921
N Ważnych (wyłączanie obserwacjami)	5				

Source: Based on the results of Take Care research

Chart 23. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Teamwork across seniority

Table 44. The importance of ability to teamwork across seniority skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Teamwork across seniority PL	22	4	5	4,82	,395
Teamwork across seniority IT	22	0	5	4,00	1,272
Teamwork across seniority EL	20	0	5	4,15	1,137
Teamwork across seniorIty ES	5	0	5	3,20	1,924
Teamwork across seniority DE	28	0	5	3,89	1,571
Teamwork across seniority AT	30	0	5	4,70	,952
Teamwork across seniorIty FR	22	3	5	4,86	,468

Source: Based on the results of Take Care research

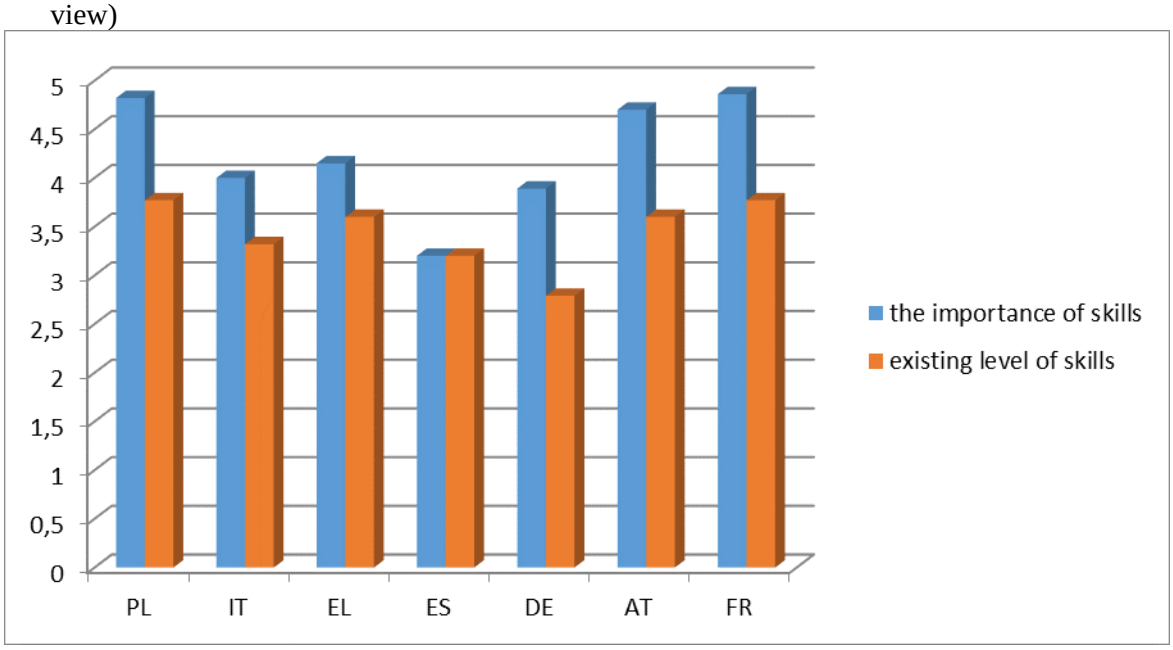
Table 45. The existing level of teamwork across seniority skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Teamwork across seniority PL	22	2	5	3,77	,922
Teamwork across seniority IT	22	0	5	3,32	1,041
Teamwork across seniority EL	20	0	5	3,60	1,231
Teamwork across seniority ES	5	0	4	3,20	1,789

Teamwork across seniority DE	28	0	5	2,79	1,595
Teamwork across seniority AT	30	0	5	3,60	1,070
Teamwork across seniority FR	22	1	5	3,77	1,110

Source: Based on the results of Take Care research

Chart 24. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Assertiveness in building relationships with patients and colleagues

Table 46. The importance of ability to assertiveness in building relationship with patiens and coulleagues skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Assertiveness in building relationships with patients and colleagues PL	22	3	5	4,68	,568
Assertiveness in building relationships with patients and colleagues IT	22	0	5	4,05	1,463
Assertiveness in building relationships with patients and colleagues EL	20	0	5	3,70	1,302
Assertiveness in building relationships with patients and colleagues ES	5	0	4	3,00	1,732

Assertiveness in building relationships with patients and colleagues DE	28	0	5	3,96	1,290
Assertiveness in building relationships with patients and colleagues AT	30	0	5	4,13	1,042
Assertiveness in building relationships with patients and colleagues FR	22	3	5	4,82	,501

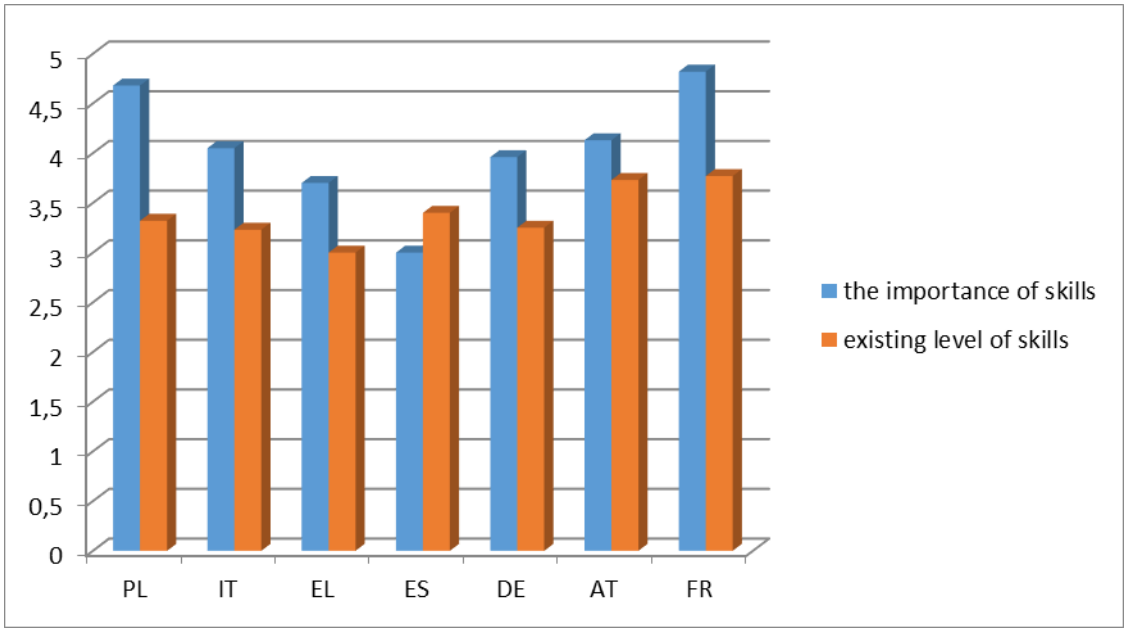
Source: Based on the results of Take Care research

Table 47. The existing level of ability to assertiveness in building relationship with patiens and coulleagues skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Assertiveness in building relationships with patients and colleagues PL	22	1	5	3,32	1,041
Assertiveness in building relationships with patients and colleagues IT	22	0	4	3,23	1,020
Assertiveness in building relationships with patients and colleagues EL	20	0	5	3,00	1,487
Assertiveness in building relationships with patients and colleagues ES	5	0	5	3,40	1,949
Assertiveness in building relationships with patients and colleagues DE	28	0	5	3,25	1,206
Assertiveness in building relationships with patients and colleagues AT	30	3	5	3,73	,691
Assertiveness in building relationships with patients and colleagues FR	22	1	5	3,77	1,020

Source: Based on the results of Take Care research

Chart 25. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Work - life balance

Table 48. The importance of ability to work life – balance skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Work - life balance PL	22	0	5	4,55	1,143
Work - life balance IT	22	3	5	4,14	,834
Work - life balance EL	20	0	5	3,95	1,276
Work - life balance ES	5	0	4	3,20	1,789
Work - life balance DE	28	0	5	4,14	1,353
Work - life balance AT	30	0	5	4,23	1,135
Work - life balance FR	22	4	5	4,95	,213

Source: Based on the results of Take Care research

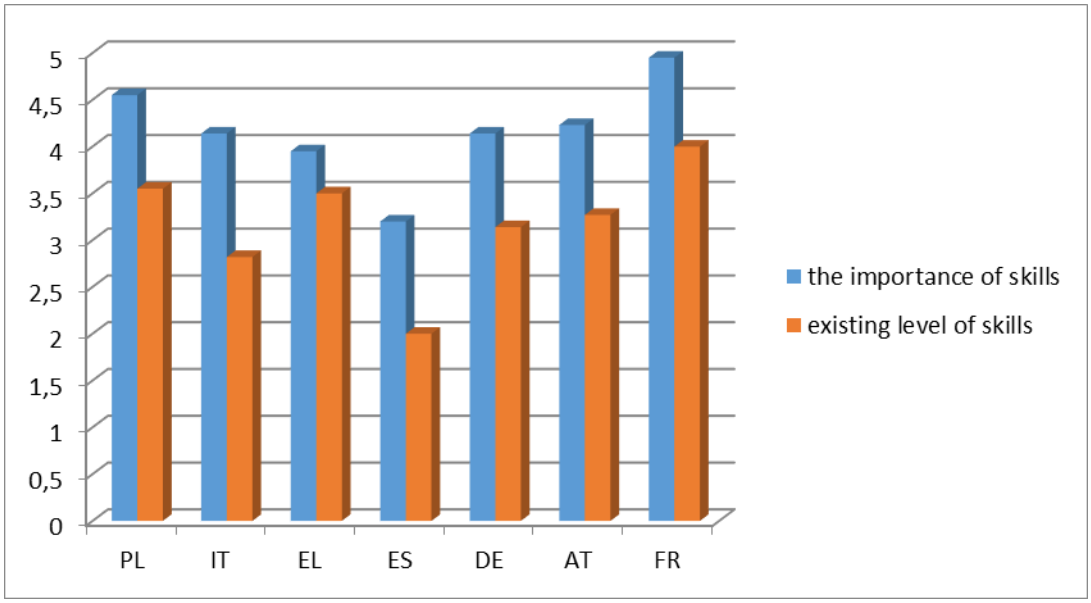
Table 49. The existing level of work – life balance skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Work - life balance PL	22	0	5	3,55	1,184
Work - life balance IT	22	0	5	2,82	1,220
Work - life balance EL	20	0	5	3,50	1,051
Work - life balance ES	5	0	4	2,00	1,871
Work - life balance DE	28	0	5	3,14	1,079

Work - life balance AT	30	1	5	3,27	,907
Work - life balance FR	22	2	5	4,00	,976

Source: Based on the results of Take Care research

Chart 26. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Ability to prevent burnout

In the excel sheet with the results of Spain and Greece, there was no data.

Table 50. The importance of ability to prevent burnout skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Ability to prevent burnout PL	22	3	5	4,73	,631
Ability to prevent burnout IT	22	2	5	4,36	,902
Ability to prevent burnout EL	20	0	0	,00	,000
Ability to prevent burnout ES	5	0	0	,00	,000
Ability to prevent burnout DE	28	0	5	4,11	1,423
Ability to prevent burnout AT	30	2	5	4,37	,850
Ability to prevent burnout FR	22	0	5	4,68	1,086

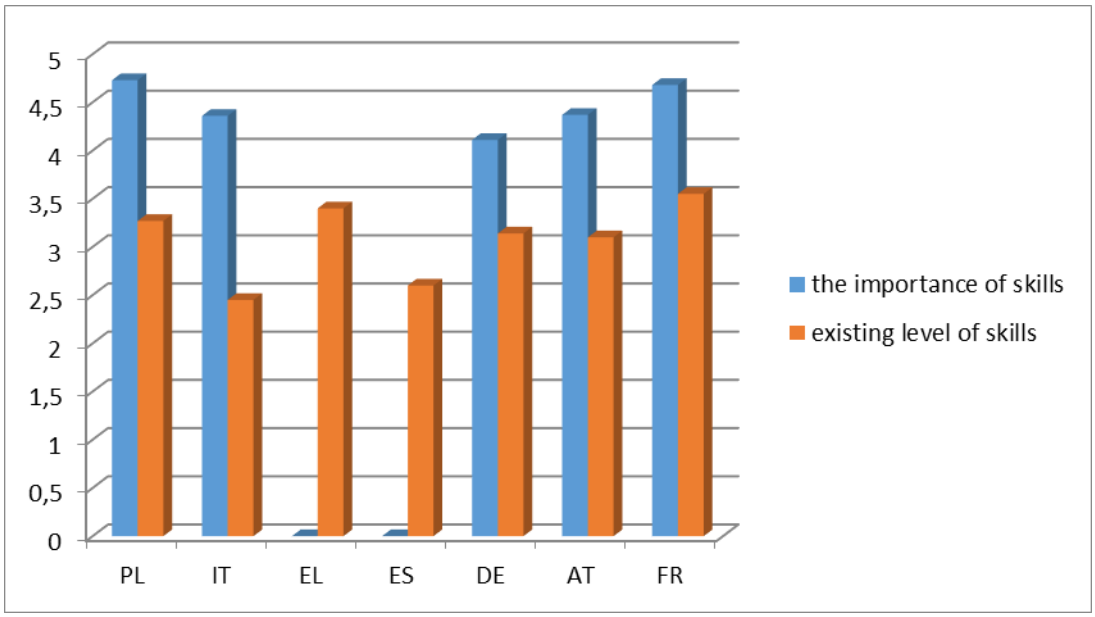
Source: Based on the results of Take Care research

Table 51. The existing level of ability to prevent burnout skills (managers point of view)

	N	Minimum	Maximum	Average	Standard deviation
Ability to prevent burnout PL	22	1	5	3,27	,985
Ability to prevent burnout IT	22	1	4	2,45	1,057
Ability to prevent burnout EL	20	0	5	3,40	1,142
Ability to prevent burnout ES	5	0	5	2,60	2,408
Ability to prevent burnout DE	28	0	4	3,14	1,113
Ability to prevent burnout AT	30	0	4	3,10	,923
Ability to prevent burnout FR	22	2	5	3,55	,963

Source: Based on the results of Take Care research

Chart 27. Comparison between the perception of the importance level of social skills and the existing level of social skills among health care personnel in individual countries (managers point of view)



Source: Based on the results of Take Care research

Hierarchy of specific social skills based on all respondents points of view

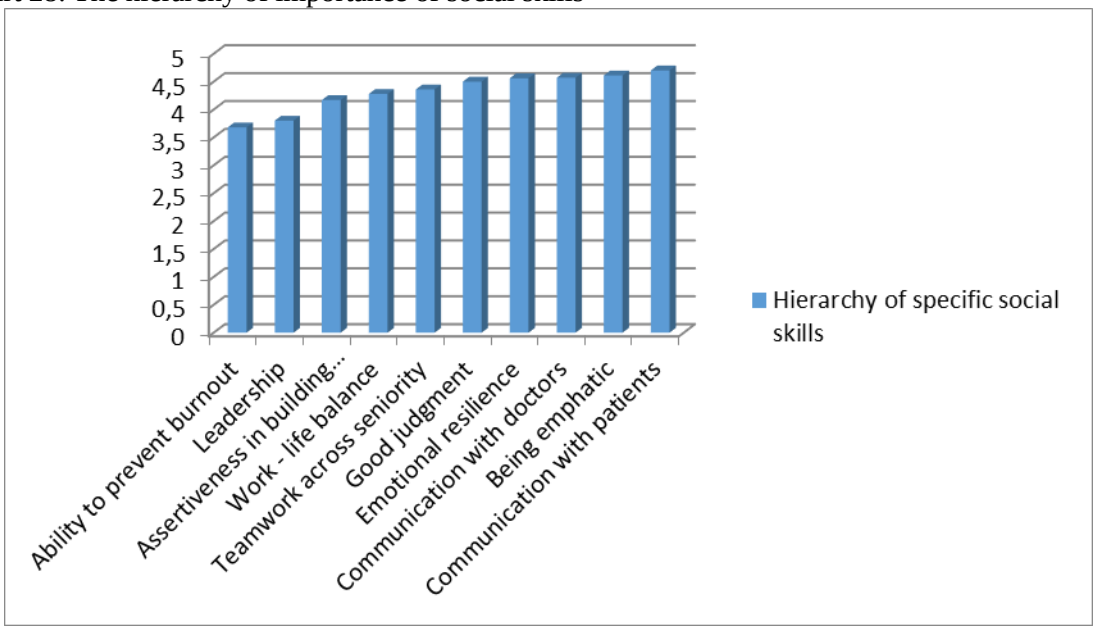
Table 52. The hierarchy of importance of social skills

	N	Minimum	Maximum	Average	Standard deviation
Ability to prevent burnout	149	0	5	3,68	1,910
Leadership	149	0	5	3,80	1,380
Assertiveness in building relationships with patients and colleagues	149	0	5	4,17	1,178

Work - life balance	149	0	5	4,28	1,145
Teamwork across seniority	149	0	5	4,36	1,175
Good judgment	149	0	5	4,50	1,024
Emotional resilience	149	0	5	4,56	1,016
Communication with doctors	149	0	5	4,57	1,028
Being emphatic	149	0	5	4,61	,949
Communication with patients	149	0	5	4,70	,842

Source: Based on the results of Take Care research

Chart 28. The hierarchy of importance of social skills



Source: Based on the results of Take Care research

Existing level of specific social skills based on all respondents' point of view.

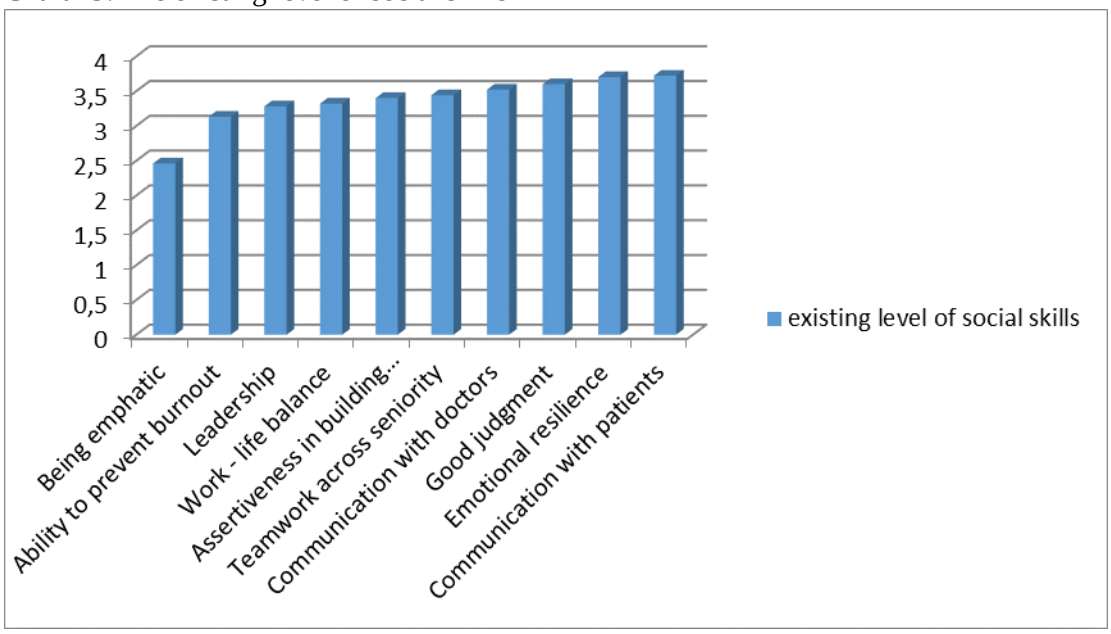
Table 53. The existing level of social skills

	N	Minimum	Maximum	Average	Standard deviation
Being emphatic	149	0	5	2,46	1,912
Ability to prevent burnout	149	0	5	3,13	1,123
Leadership	149	0	5	3,28	1,109
Work - life balance	149	0	5	3,32	1,157
Assertiveness in building relationships with patients and colleagues	149	0	5	3,40	1,127
Teamwork across seniority	149	0	5	3,44	1,243
Communication with doctors	149	0	5	3,52	1,056

Good judgment	149	0	5	3,60	1,127
Emotional resilience	149	0	5	3,70	1,005
Communication with patients	149	0	5	3,72	,985

Source: Based on the results of Take Care research

Chart 29. The existing level of social skills



Source: Based on the results of Take Care research

Table 54. Differences between the average level of social skills and the validity of their existing level (One - way analysis of variance – *ANOVA)*

		sum of squares	df	Average square	F	statistical significance
Communication with patients	Between grops	425,289	1	425,289	703,508	,000
	Within groups	178,940	296	,605		
	Total	604,228	297			
Communication with doctors	Between grops	27,181	1	27,181	27,347	,000
	Within groups	294,201	296	,994		
	Total	321,383	297			
Being emphatic	Between grops	361,020	1	361,020	111,052	,000
	Within groups	962,268	296	3,251		
	Total	1323,289	297			
Emotional resilience	Between grops	98,124	1	98,124	78,866	,000
	Within groups	368,282	296	1,244		
	Total	466,406	297			
Good judgment	Between grops	218,205	1	218,205	123,049	,000

	Within groups	524,899	296	1,773		
	Total	743,104	297			
	Between grops	150,819	1	150,819	155,457	,000
Leadership	Within groups	287,168	296	,970		
	Total	437,987	297			
	Between grops	94,711	1	94,711	72,765	,000
Teamwork across seniority	Within groups	385,275	296	1,302		
	Total	479,987	297			
Assertiveness in building	Between grops	108,725	1	108,725	100,175	,000
relationships with patients and	Within groups	321,262	296	1,085		
colleagues	Total	429,987	297			
	Between grops	116,094	1	116,094	97,953	,000
Work - life balance	Within groups	350,819	296	1,185		
	Total	466,913	297			
	Between grops	139,651	1	139,651	120,929	,000
Ability to prevent burnout	Within groups	341,826	296	1,155		
	Total	481,477	297			

significance level $\alpha = 0{,}05$

Source: Based on the results of Take Care research

Conclusion

From the the management staff point of view the most important social skills are:

- communication with the patient,
- being empathic,
- communication with doctors.

The least important skills are:

- ability to prevent burnout,
- leadership,
- assertiveness in building relationships with patients and colleagues.

The existing skills of the personel at the lowest level are:

- being emphatic
- ability to prevent burnout
- leadership

At the highest level personel represents:

- communication with patients
- emotional resilience
- good judgment.

Analysis of variance indicated the existence of significant differences between the characteristics possessed by the staff, and the features which, according to managers, staff should possess.

7. Possible incentives that could motivate health institutions to invest in soft skills training - international comparison

Possible incentive that could motivate health institutions to invest in soft skills training						
France	**Italy**	**Poland**	**Spain**	**Germany**	**Greece**	**Austria**
- Better know how - Stabilize employment - Stabilize competitiveness - Improve competencies - Improve the satisfaction of the employees and the patients - Reduce illness of the employees	- Improve the relationship between doctor/nurse and patient, especially concerning the medical-legal litigation - Possibility to receive updated and quality training - Higher margins/ lower costs - Training organised in a more practical way - Economy: training reduces the frequency of adverse events - Legal issues related to information to be provided to the patient - Possibility to fully achieve the goals	- Financial effects - Raising qualifications of the staff - Improvement the institution's image - Formal requirements - Improvement the quality of services - Getting the certificate attesting to the high quality of services - Greater availability to EU financial means		- Starting deterioration of the health status among the staff - Training of social competence - Crises, patients' complaints - Lack of staff, above average staff turnover - Future-oriented strategies - Care givers gain a better certainty in their job, satisfaction and motivation with the job rises - High chance of success due to seated activities and arrangements, costs and	- Lack of staff, above average staff turnover - Lack of interest of the staff and lack of evaluation system - Informal internal groups of employees detain a lot of power in the healthcare organizations. - Lack of knowledge on behalf of the central administration - Problems of staff motivation - Reduce downtimes of staff - empowerment of caregivers by a	- Support from the government or educational institutes - Lower costs - Increasing health among staff - Less absence cause by burnout - Extension of professional and social skills - Training that is held nearby on suitable dates (e.g. Saturday) - Better motivation among the staff - Caregivers learn to interact better with patients and next of kin - Awareness raising (among

	thanks to a motivated and prepared team - Number of prepared human resources - Hospital performances improved - Psychological aspects of patient support			reasonable expenditure of time, interesting and innovative concepts with sustainability - High number of absend staff (sick days because of burn out, stress, …) - Reduce downtimes of staff	fair system of evaluation of staff - Unique and homogeneous evaluation system of all greek hospitals - Creation of bonus system for more education and training (i.e. days off) - Direct state funding of educational and vocational projects	managers and caregivers)

Source: Based on the results of Take Care research

8. Main problems faced by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practices implementation - international comparison

Main problems faced by managers of health institutions, e.g. in order to perform daily tasks in terms of HR management and safe and sustainable practices implementation						
France	**Italy**	**Poland**	**Spain**	**Germany**	**Greece**	**Austria**
- Turnover - Lack of time - The training propositions are not interesting - Lack of staff - Budget - Lack of interest	- Bad communication/relationship with patients - Lack of filter between patient and doctor - Personal difficulties in dealing with single nurses - Frustration due to the incapacity to reach the goals - Difficulties in strategic management due to lack of human and material resources - Lack of autonomy of managers in managing the nurses	- Finances - Lack of mutual integration, - Small number of staff, - Lack of the knowledge of current methods the personnel management (human resource management), - Routine approach towards put tasks, - Professional burnout, - Low		- Motivation of employees regarding preventive measures, - Lack of willingness and interest/misconception - Because of constant care for acute patients: processes have to be modified according to new priorities within the team and other professional groups - Factor time (Human Resource); Lack of workforce and therefore lack of time to optimize care documentation - The focus is still on hard skills	- Lack of motivation of employees and lack of willingness and interest - Lack of human resources and consequently lack of time in order to optimize services and personal skills and competencies - The focus for professional caregivers is still on hard skills. - A problem of management/balance of professional-personal life. - Lack of certified	- Time management - Organisational structure - Qualified personnel - Lack of funds - Long distances to training locations - Low motivation among staff but high demands from the patients - Lack of personal responsibility among the staff - Lack of communication

		remuneration, - Legal answers, - Problems with National Health Found.		Qualification not soft skills qualification - Such projects need to be equally implemented in the hospitals in order to reach every employee. Therefore resources and resilience of the responsible staff is missing (support of arrangement, evaluation) - Costs and lack of appropriate offers, concern for sustainability	caregivers.	

Source: Based on the results of Take Care research

9. Conclusion

The most important skill in the staff's perception is communication with patients, at an average level of 4.82. The medical staff rated their actual level of this quality at 3.85 The second most important skill in the evaluation of staff is communication with physicians. Respondents rated the importance of having this skill at an average level of 4.64 In the case of communication with doctors; there also appeared a significant difference in the area of rating the importance of this quality and its actual level. Caregivers evaluated their communication with physicians skills at 3.35. The third most important attribute in the assessment of the medical staff is good judgment. Respondents have identified the importance of this feature at the level of 4.61, while the actual level of having it at 3.69. The fourth and fifth place in terms of importance to the employees are: being emphatic - 4.60 and emotional resilience - 4.54, where the actual levels in the respondents' self-assessment are at the level of 3.88 and 3.63.

Other skills in the hierarchy include: Work - life balance, rated as important at the level of 4.42. In this case, the average result of perceived level of representation of the skill was lower than expected, because it was 3.27. The importance of teamwork across seniority, the medical personnel classified as important at the average level of 4.39, while representing this quality was rated at 3.27. At the end of the list were ability to prevent burnout and assertiveness in building relationships with patients and colleagues, the importance of which were classified at average levels of 4.36 and 4.35. The staff represents these features in their own assessment at the level of 2.81 and 3.42. The list of importance ends with leadership. This is an important feature for medical staff at an average level of 4.01, while their actual representation of leadership is at an average of 3.37.

One cannot say that any of the above mention skills is not important for the medical staff, because all of the features were rated as important at an average level above 4, where the highest value scale was 5. It is worth to pay attention to the self-assessed actual representation of these skills among the staff. All analyzed traits did not exceed 4 on the point scale. Three top rated characteristics in terms of actual representation, communicatiom with patients, physicians, and being emphatic were ranked average on a 5-point scale, which probably indicates a high need to increase the level of representation of these characteristics by medical personnel.

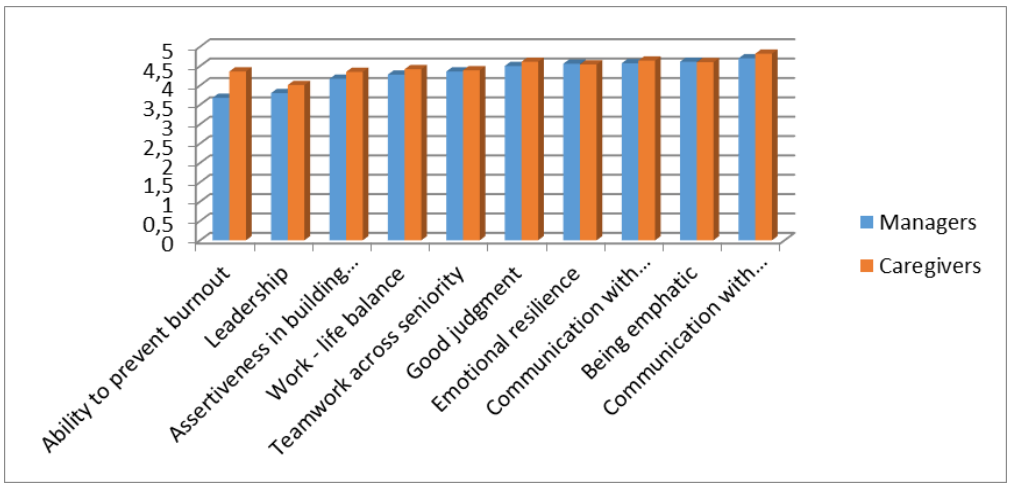
The comparison of the results obtained from medical personnel with an assessment of their competence by managers indicates that the most important skill that medical staff

should have is communication with patients. Managers evaluate the importance of communication with patients at an average of 4.70, while the medical staff represents the feature at 3.72. The importance of being emphatic is second in the evaluation of managers. This is a feature classified average at 4.57, and medical personnel, according to managers, represents being emphatic at an average level of 3.52. Communication with doctors has been rated as important at the level of 4.57. The medical staff represents the feature at 2.46 (this is a feature which, according to managers, is the least represented by medical personnel). Further analysis showed that from the point of view of managers other features that the staff should represent are emotional resilience - 4.56 and good judgment - 4.50.

These features are represented by the medical staff at the levels of 3.70 and 3.60 respectively. Teamwork across seniority was rated by managers as important at the average level of 4.36, while the staff represents the feature at the level of 3,44. Work - life balance was classified as important at an average level of 4.28, while the level of representation of this feature managers rated at an average of 3.32. The least important, according to managers, were: assertiveness in building relationships with patients and colleagues - 4.17; leadership - 3.80 and ability to prevent burnout - 3.68, which in the evaluation of superiors are represented by the staff at the levels of 3.28, 3.13 and 2.46.

The following graph shows that there are slight differences between the perception level of importance of social skills for the work of medical personnel between managers and caregivers. This demonstrates of consciousness the relevance of the use social competences.

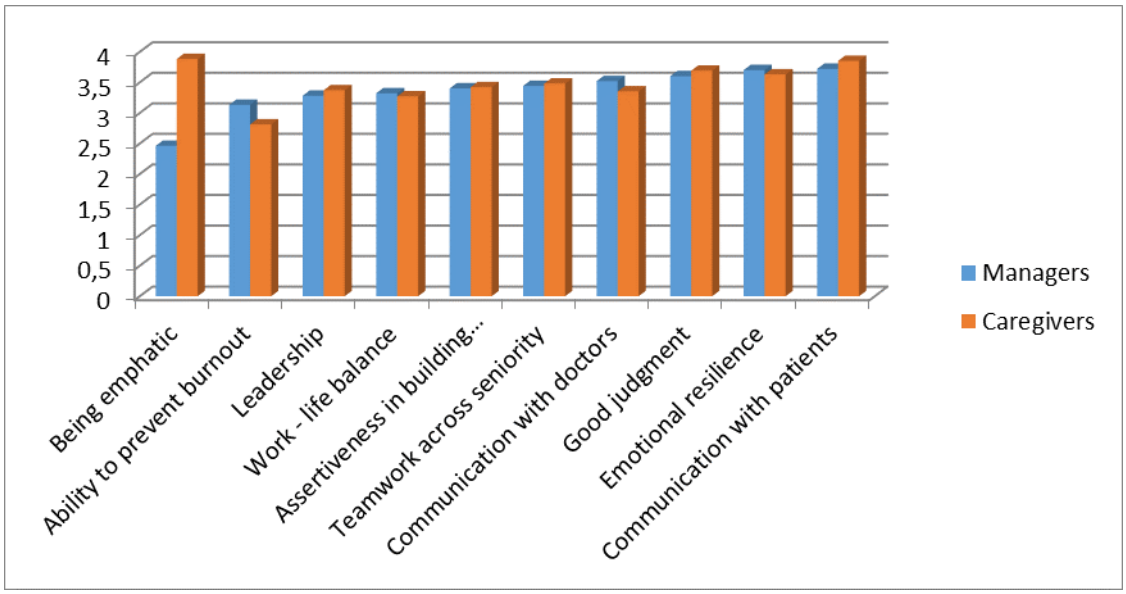
Chart 30. Different classification importance of social skills between caregivers and managers



Source: Based on the results of Take Care research

Being emphatic - managers evaluate this ability much lower level than caregivers. Higher than in the self-assessment staff have been classified: Prevent burnout, work - life balance, communications with doctors, emotional resilience, but here are slight differences.

Chart 30. Different classification importance of existing social skills in caregivers works



Source: Based on the results of Take Care research

10. Literature:

1. Akademie der Steirischen Krankenanstaltenges.m.b.H (ASK), Bildungskalender 2014. Graz (Austria), Sep. 2013.

2. Allgemeine Unfallversicherungsanstalt (AUVA), Ergonomie in helfenden Berufen – Sicherheitsinformation der Allgemeinen Unfallversicherungsanstalt. Vienna (Austria), Jun. 2006.

3. Bauer G., *Die 24-Stunden-Betreuung in Österreich – Motive und Beschäftigungsverhältnisse von osteuropäischen Pflege- und Betreuungspersonen*, 2010.

4. Biffl G., *WIFO-Weißbuch: Mehr Beschäftigung durch Wachstum auf Basis von Innovation und Qualifikation*, Teilstudie 16: Alternde Dienstleistungsgesellschaft, Nov. 2006.

5. Bowles N., Mackintosch C., Torn A., *Nurse's communication skills: An evaluation of the impact of solution-focused communication training*, Journal of Advanced Nursing, 36(3) 2001.

6. Bundesagentur für Arbeit, *Arbeitsmarktberichterstattung: Gesundheits- und Pflegeberufe in Deutschland*, Nürnberg, Germany 2011.

7. *Bundesgesetz über Gesundheits- und Krankenpflegeberufe* (Gesundheits- und Krankenpflegegesetz – GuKG). BGBl. I Nr. 108/1997, zuletzt geändert durch BGBl. I Nr. 185/2013.

8. *Bundesgesetz über Krankenanstalten und Kuranstalten* (Krankenanstalten- und Kuranstaltengesetz – KAKuG). BGBl. Nr. 1/1957, zuletzt geändert durch BGBl. I Nr. 81/2013.

9. *Bundesministerium für Arbeit***,** Soziales und Konsumentenschutz: Arbeitsschutz. Sicherheit und Gesundheitsschutz am Arbeitsplatz - das ArbeitnehmerInnenschutzgesetz. Vienna (Austria), Feb. 2009.

10. *Bundesministerium für Frauen und Gesundheit (BMFG): Public Health in Austria*, 4th, updated edition, Dec. 2005.

11. *Bundesministerium für Gesundheit: Impfungen für MitarbeiterInnen des Gesundheitswesens*, Empfehlungen als Erweiterung des Österreichischen Impfplans. Vienna (Austria), Sep. 2012.

12. Burns E., *Effizienz- und Gesundheitsentwicklung in der Pflege mit Kinästhetik*, Projekt am Krankenhaus Hietzing mit Neurologischem Zentrum Rosenhügel der Stadt Wien, Pressbaum (Austria) 2007.

13. Canadian Institute for Health Information. Canada's Health Care Providers, 2007. Ottawa 2007.

14. Corning S.P., *Profiling and developing nursing leaders*, Journal of Nursing Administration, 32(7/8) 2002.

15. Doctors of the World, Access to Healthcare in Europe in Times of Crisis and Rising Xenophobia, April 2013.

16. Dressler S., et al., *Ergebnisse der Studie „Arbeitsbedingungen in den Gesundheits- und Sozialberufen*, Vienna (Austria) 2014.

17. en.wikipedia.org/wiki/Occupational_safety_and_health.

18. Futurage, *A Road Map for European Ageing Research*, October 2011.

19. Glaser J., Höge T., *Probleme und Lösungen in der Pflege aus Sicht der Arbeits- und Gesundheitswissenschaften*, Dortmund/Berlin/Dresden: Bundesanstalt für Arbeitsschutz und Arbeitsmedizin 2005.

20. Glaser J., Lampert B., Weigl M., *Arbeit in der stationären Altenpflege. Analyse und Förderung von Arbeitsbedingungen, Interaktion*, Gesundheit und Qualität. INQA Bericht Nr. 34. Dortmund/Berlin/Dresden: Bundesanstalt für Arbeitsschutz und Arbeitsmedizin 2008.

21. Jelenko M., *Unternehmerische, politische und gesellschaftliche Herausforderungen für die Betriebliche Gesundheitsförderung in der Pflege – Ergebnisse der Podiumsdiskusion*, Beiträge zur Fachtagung „Gesund pflegen und gesund bleiben! – Betriebliche Gesundheitsförderung in der mobilen und stationären Pflege“ vom 20. Mai 2008 in Wien, Vienna (Austria), May 2008.

22. Jürgen G., Höge T., *Bundesanstalt für Arbeitsschutz und Arbeitsmedizin*, Probleme und Lösungen in der Pflege aus Sicher der Arbeits- und Gesundheitswissenschaften“. Dortmund/Berlin/Dresden, Germany 2005.

23. Karamessini M., *Elderly care in Greece. Provisions and providers*, External report commissioned by and presented to the European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities, Unit G1 ‘Equality between women and men’, 2010.

24. Klachovich M., *Interpersonal communication. An essential skills for nursing students* (2009). Retrieved: http://www.phoenix.edu/profiles/faculty/marilyn-klakovich/articles/interpersonal-communication-an-essential-skill-for-nursing-students.html.

25. Kliszcz J, Nowicka-Sauer K, Trzeciak B, Sadowska A., The level of anxiety, depression and aggression in nurses and their life and job satisfaction, Med Pr. 2004;55(6):461-8.

26. Knüppel J., *Deutscher Berufsverband für Pflegeberufe*, Zahlen Daten Fakten – „Pflege", Berlin, Germany 2012.

27. *Krankenanstalten-Arbeitszeitgesetz* (KA-AZG). BGBl. I Nr. 8/1997, zuletzt geändert durch BGBl. I Nr. 89/2012

28. Lewandowska A, Litwin B., Burnout as an occupational risk for nurses, Ann Acad Med Stetin. 2009;55(3):86-9.

29. *LKH Feldkirch, Kompetenznachweis – Nachweis über die praktische Ausbildung*, Feldkirch (Austria) Nov. 2010.

30. Lyberaki A., *Deae ex Machina: migrant women, care work and women's employment in Greece*, GreeSE Paper No. 20, Hellenic Observatory Papers on Greece and Southeast Europe, London: LSE,2008.

31. Mayer M., *Personenzentrierte Pflege. Implementierungsschwierigkeiten psychosozialer Konzepte*. Vienna (Austria) 2010.

32. Mestheneos E., Triantafillou J. & Kontouka S., *Eurofamcare,national background report for Greece, Department of health services management*, National School for Public health, Athens 2004.

33. National Institute for Occupational Safety and Health (NIOSH). *Exposure to Stress: Occupational Hazards in Hospitals.* NIOSH Publication No. 2008–136. Centers for Disease Control and Prevention, July 2008. Retrieved on December 2, 2008.

34. ÖBIG: Österreichischer Pflegebericht, Vienna (Austria), May 2006.

35. Olbrich C., *Pflegekompetent*, Bern, Germany 1999.

36. Pogatscher P., *Standortbestimmung: Die Pflegeausbildung in Österreich*, Welche Problemfelder sind im Zusammenhang mit der Akademisierung der Pflegeausbildung zu erkennen?, Graz (Austria), Jul. 6, 2011.

37. Principal Chamber of Nurses and Mid-wives, Analiza liczby zarejestrowanych i zatrudnionych pielęgniarek i położnych w roku 2011 oraz prognoza liczby zarejestrowanych i zatrudnionych pielęgniarek i położnych na lata 2015-2035, Warszawa kwiecień 2013.

38. Principal Chamber of Nurses and Mid-wives, www.nipip.pl.

39. Rottenhofer I., et al., *Prognose des Pflegepersonalbedarfs im Gesundheits- und Sozialbereich des Bundeslandes Salzburg*, Ergebnisbericht, Vienna (Austria), Feb. 2013.

40. Sahmel K-H., *Pflegepädagogische Grundlagen und Konzepte*, „Pflegerische Kompetenzen fördern". Stuttgart, Germany 2009.

41. Sakowski P., Job satisfaction of occupational medicine nurses in Poland, Int J Occup Med Environ Health. 2012 Mar;25(1):51-8. doi: 10.2478/s13382-012-0006-x. Epub 2012 Jan 5.

42. Sapoountzi- Krepis D., Raftopoulos V., Sgatzos M., Dimitriadou A., Ntourou I., Sapkas G., *Informal in hospital care in rehabilitation setting in Greece: as estimation of the nursing staff required for substituiting this care*, Disabil Rehabil, 2006.

43. Schneeberger A., *Internationale Einstufung der österreichischen Berufsbildung – adequate ISCED-Positionierung als bildungspolitische Herausforderung*, Vienna (Austria), May 2010.

44. Sissouras A., Ketsetzopoulou M., Bouzas N., Fagadaki E., Papaliou O., Fakoura A., *Providing integrated health and social care for older persons in Greece. ProCare-National Report Greece*.,National Centre for Social Research. EKKE. Athens 2002.

45. *Soft skills research: Aligning Nurse's Touch witch Best Practices,* Assessment Technologies Institute Inc. 2012.

46. Sommer S., *The Soft Skills of Nursing*, *Minority Nurse Writer*, Your (Mental) Health: One Nurse's Story 2012.

47. Spicker I., *Betriebliche Gesundheitsförderung (BGF) in der mobilen Pflege und Betreuung. Beiträge zur Fachtagung,* „Gesund pflegen und gesund bleiben! – Betriebliche Gesundheitsförderung in der mobilen und stationären Pflege" vom 20. Mai 2008 in Wien, Vienna (Austria), May 2008.

48. Spicker I., *Professionalisierung der Pflege. Die Sicht von Pflegenden in der Praxis – Eine qualitative Untersuchung zu Wahrnehmung und Einschätzung ausgewählter Professionalisierungsaspekte durch Pflegende in Wien*, Vienna (Austria) 2001.

49. Spoleczna Akademia Nauk Lodz. Take Care Project. WP 2 State of Arts, Needs and Constraints in the Sector. Methodological Approach – Guidelines for the research and reporting.

50. *Strahlenschutzgesetz* (StrSchG), BGBl, Nr. 227/1969, zuletzt geändert durch BGBl. I Nr. 106/2013.

51. *The Future of Nursing: Leading Change*, Advancing Health, IOM October 5, 2010.

52. Triantafillou J., Mestheneos E., Prouskas C., Goltsi V., Kontouka S. & Loukisis A., *Eurofamcare, services for supporting family carers of older dependent people in Europe: characteristics, coverage and usage*, The national survey report for Greece, Athens 2006.

53. Trochim, William M., *The Research Methods Knowledge Base*, 2nd Edition. Internet WWW page, at URL: <http://www.socialresearchmethods.net/kb/> (version current as of October 20, 2006).

54. Ullrich J., *Älter werden im Pflegeberuf – Gesundheitsförderung als eine Strategie, um als Pflegeperson im Krankenhaus langfristig gesund im Beruf arbeiten zu können*, Vienna (Austria) 2011.

55. World Health Organization, 2003. *Quality and accreditation in health care services*. Geneva http://www.who.int/hrh/documents/en/quality_accreditation.pdf.

56. World Health Organization, 2006. *World Health Report 2006: working together for health.* Geneva: WHO.

57. World Health Organization, 2010. *Classifying health workers*.

58. World Health Organization. *Women and health: today's evidence, tomorrow's agenda*. Geneva, 2009. Retrieved on March 9, 2011.

59. www.auva.at

60. www.baua.de/de/Informationen-fuer-die-Praxis/Rechtsgrundlagen-und-Vorschriften/Arbeitsschutzsystem%20in%20Deutschland.html.

61. www.baua.de/de/Publikationen/Faltblaetter/F2.html.

62. www.bildung-news.com/bildun-und-karriere/ausbildung-und-lehre/ausbildung-zur-krankenschwester zum-krankenpfleger.

63. www.bildungundberuf.at (Section Bereich/Sektor, Pflege).

64. www.bmas.de/DE/Service/Gesetze/arbschg.htm.

65. www.cneh.fr/Portals/2/01FORMATION/RPS/DOCS/FASCICULE_RPS_PRINT.pdf.

66. www.dasa-dortmund.de/en/about-dasa/was-ist-die-dasa/.

67. www.infirmiers.com/actualites/actualites/un-quart-des-soignants-est-age-de-plus-de-50-ans.html.

68. www.infirmiers.com/ressources-infirmieres/nos-collegues/le-metier-aide-soignant-qui-comment-pour-quoi-faire.html.

69. www.inrs.fr/.

70. www.inrs.fr/accueil/secteurs/sante.html.

71. www.lexpress.fr/actualite/societe/burn-out-pourquoi-les-soignants-sont-en-premiere-ligne_1317205.html.

72. www.lifeaftercare.eu/docs/LACbookletfinalGR.pdf

73. www.minoritynurse.com/article/soft-skills-nursing.

74. www.nadelstichverletzung.at (Section Gesetzgebung).

75. www.oecd.org/els/health-systems/47884865.pdf.

76. www.oegkv.at (Section Aus- und Weiterbildung).

77. www.onisep.fr/Mes-infos-regionales/Nord-Pas-de-Calais/Dossiers/Les-formations-du-paramedical-post-bac/Infirmier.

78. www.orientation-pour-tous.fr/Quels-metiers-porteurs-d-ici-2020.html.

79. www.sante.gouv.fr/IMG/pdf/Metiers_de_la_sante_-_Dossier_de_presse120312.pdf.

80. www.statistik.at (Section Gesundheit, Gesundheitsversorgung, Personal im Gesundheitswesen).

81. www.travail-emploi-sante.gouv.fr/IMG/pdf/2012-022.pdf.

82. www.uke.de/extern/eurofamcare/documents/deliverables/nasure_el.pdf.

83. Wynd C.A., *Current factors contributing to professionalism in nursing*, Journal of Professional Nursing, 19(5) 2003.

84. Zafiropoulou M., Kaitelidou D., Siskou O., Katsikas D., Oikonomoy Ch., *Impacts of crisis on*

access on healthcare services: Greek report, Eurofound editions, September 2014.