



Social inclusion through Meaningful ageing

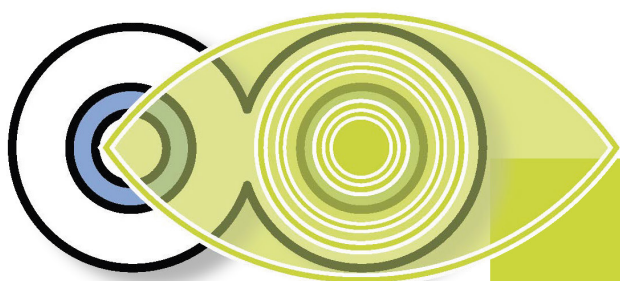
European research report 2:

"Optimising caregiving competences and skills of professional, volunteer and informal caregivers.

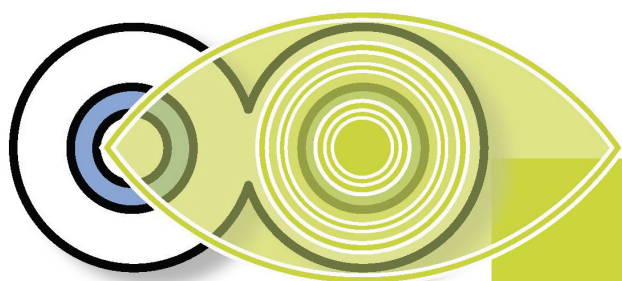
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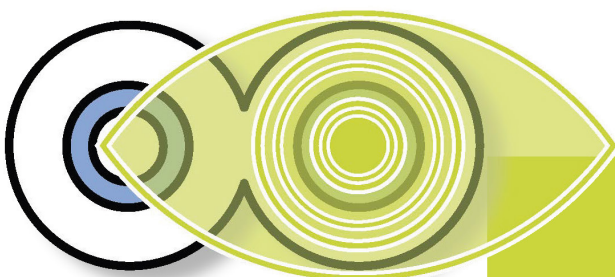
1. Introduction

The population in Europe is ageing, and the number of older citizens is growing. Consequently, projections predict an increase in care needs. The literature points towards two main challenges. First, older adults with care needs are susceptible to social exclusion.

Second, there are growing challenges in professional care services (i.e., overburdened workforce, budget cuts). Currently, professional care focuses on the medical and physical aspects of care from a deficit approach (looking at what older adults cannot do anymore). However, many caregivers claim that an innovative paradigm shift is needed towards a positive approach (looking at the potentials of older people) and towards caring for social and meaning needs (Machielse et al., 2022). However, they often lack the competences for this as this is not part of their professional training. Nor does a lifelong learning course on these topics exist.

The SeeMe project aims to improve the quality of care for older adults by contributing to the knowledge on the needs of older adults and by increasing the skills and competences of different groups of caregivers to respond to that needs. The emphasis here is on caregivers' competences to 'see' care as something more than physical and medical care, to 'see' the older person behind the patient, 'see' social and meaning needs, and 'see' the positive talents and dreams of older adults, not only their needs. In this way, the SeeMe project contributes to the social inclusion of older adults. This report focuses on caregivers' competences and skills to 'see' older adults. It is based on an extensive literature review complemented by qualitative interviews with caregivers. The report starts with a summary of recent developments regarding the care systems in European countries (Chapter 2). Then, we describe some innovative trends in healthcare to meet the needs of older adults and the consequences for caregiving in general (Chapter 3). Next, we describe the different types of caregivers involved in the care of older people (Chapter 4).

Subsequently, we address the competences and skills of professional caregivers, volunteers, and informal caregivers, respectively (Chapter 5). After that, we present the perspectives of the SeeMe informants (Chapter 6). We conclude with some points of attention for caregivers and a summary of required competences and skills for caregivers (Chapter 7).



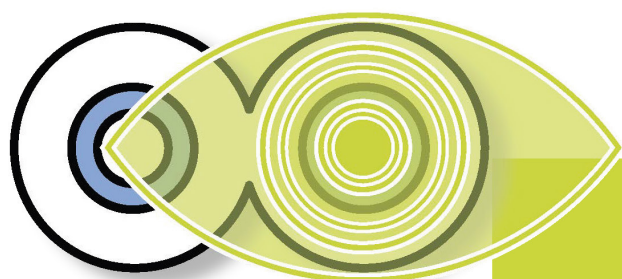
2. Transitions in the care systems in European countries

In many European countries, there have been significant transitions in care in recent decades, leading to shifts in the care division and the care roles of professionals and informal caregivers.

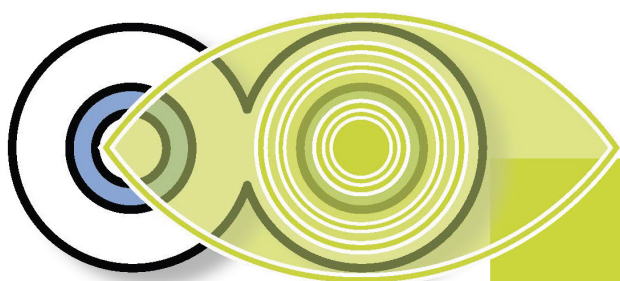
¹ Critical points in the transitions are:

- In most countries, the criteria for admission to institutional care have been tightened, and institutional care is now only for persons who cannot independently compensate for or cope with physical, cognitive, or mental impairments or health-related burdens or demands. Different care degrees are distinguished, determined by an independent medical service.
- In institutional care, the emphasis is mainly on medical care, based on the biomedical model, which views the person as the recipient of health care, focusing on health variables. In recent years, more attention has been paid to aspects of person-centred care.
- The quality of nursing care is controlled by audits from the (central or federal) government. Based on national and international scientific findings, expert standards are binding for all nursing homes and nursing services and follow a uniform, internationally coordinated procedure. They apply to both inpatient and outpatient care. However, every nurse is also obliged to check the appropriateness of every nursing intervention for the person in need of care.
- Due to the shift from institutional care to home care, more and more older people continue to live independently in their private homes for as long as possible, even when they experience health problems. In addition to the benefits of long-term care insurance, various concepts and models have been developed to ensure that ageing people - even with health restrictions - can live in their familiar living environment. This led to developing a wide range of home assistance, welfare, personal care services, and short-term or temporary care facilities. In addition, more emphasis is placed on the older adults' competences and their social environment, whereas professional care is seen as supportive and complementary.
- Increasingly, care policies in different European countries emphasise the importance of informal caregivers. This is part of a tendency to stimulate 'ageing in place'. Informal caregivers provide a vast amount of care, thereby forming an indispensable

¹ WHO, Health Systems in Transition (HiT) Series.



- lynchpin in community care. There are high expectations of informal care (family), volunteering and other forms of informal care. Several measures have been taken to support families in their caring process to realise these expectations.
- In all countries, age-appropriate neighbourhoods have been developed to ensure at the municipal level that the necessary infrastructure for a good life in old age is secured and that the development of social networks is initiated and supported.
- Besides, alternative forms of housing are being developed in which a combination of professional and informal care is possible (e.g., communal living, multigenerational living, assisted living, care living, service living, outpatient assisted living-care communities, et cetera).



3. Innovative trends in healthcare

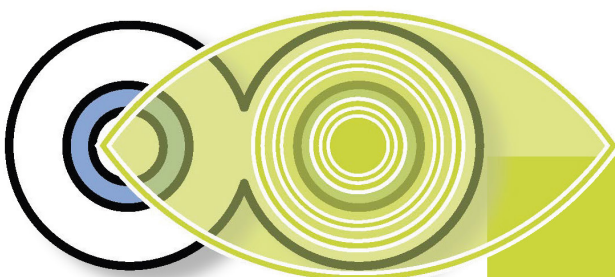
European policies regarding ageing and care for older people strongly emphasise the importance of empowerment, self-management, participation and inclusion of vulnerable older people. Part of the reason for this is budgetary; the rising healthcare costs in light of a rapidly ageing population are a point of grave concern for politicians and policymakers.

Another reason is ideological: the awareness grows that by picturing older people, particularly in the 'fourth' age, solely in terms of decline and denying their agency and individuality, their potential contribution and value to society is overlooked, with detrimental consequences for individuals, communities, and society at large (Cohen, 2000; Kruse et al., 2012). The negative and stereotypical cultural image of ageing and later life, perceived predominantly in terms of decline and deterioration, also highly affects societal views and expectations concerning institutionalised care. Many older people want to prevent moving to a residential care facility because of the stereotypical negative images that abound about these institutions (Kardol, s.a.).

Therefore, a new paradigm is needed in which the older person is central. A paradigm that looks beyond a purely task-oriented perspective on caregiving starts from a broader definition of health (e.g., Huber et al., 2013). In this view, caregiving is a comprehensive encompassing practice in which care for physical and material needs is intertwined with concern for psychological wellbeing, potentials and talents of older adults, social connectedness and meaning needs. This requires that the organisation and practice of care develop an awareness of older people's potentials, skills, and dreams, rather than just focusing on the limitations resulting from age-related decline. In this chapter, we discuss some theories about caregiving and improvement of healthcare: person-centred care, ethics of care, capabilities approach, empowerment and self-management, and competence care.

3.1 *Person-centred care*

One of the most relevant trends in healthcare improvements, based on a broader perspective on health and a holistic view of the person receiving care, is the movement towards person-centred care (Morgan & Yoder, 2011).



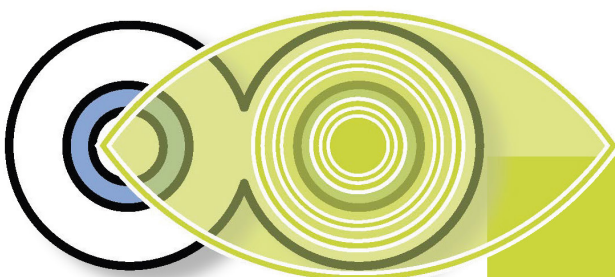
According to an expert panel of the American Geriatric Society, person-centred care is defined as follows:

"Person-centered care means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centred care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires" (American Geriatrics Society Expert Panel, 2015: 16).

This person-centred care movement pleads for a holistic approach to caregiving that acknowledges people as bio-psycho-social-spiritual beings with personal lives and needs the caregivers should adequately respond to (Papathanasiou, Sklavou & Kourkouta, 2013). Its primary concern is ethical: people should be treated as persons, not patients (Entwistle & Watt, 2013).

This personalised approach implies that people who need care are not treated along the lines of generalising protocols but that individual care plans are made with attention to the care receivers' biography, personality, preferences, needs and dreams. It aims to meet the care needs derived from people's dependency, safeguard their rights, preferences, and desires, and treat them as dignified human beings whose autonomy deserves to be respected (Martínez Rodríguez, 2011). The Basic Psychological Needs Theory (Ryan & Deci, 2017) states that for people to experience wellbeing, their needs for autonomy, relatedness and competence should be fulfilled in a well-balanced manner. This requires that caregivers give people meaningful choices in everyday life, safeguarding meaningful relationships with family, friends, and caregivers, and stimulating the use of competences even in physical or mental decline (From et al., 2013).

The person-centred approach is increasingly applied in care for older people, mostly with positive results for their quality of life and wellbeing. For example, a Spanish study using a person-centred care model in long-term care facilities for older people, including cognitively impaired people, showed a significant improvement in quality of life (Diaz-Veiga et al., 2014). A German study showed a similar effect for older people with dementia living at home when a person-centred approach was tested in an intervention trial setting (Thyrian et al., 2012). Studies in the Netherlands and Spain show that a narrative approach can be very helpful to understand the personal experience of care receivers in the context of their biography, which is provisional for realising person-centred care (Leyden Academy, 2019; Villar & Serrat, 2017).



3.2 Ethics of care

A promising philosophical framework that founds many holistic approaches to (elderly) care is provided by the ethics of care (Held, 2005; Tronto, 1993). As conceptualised by Fischer and Tronto (1990), care is seen as a fundamental way of being in the world for all human beings, not just an activity we engage in when we attend to the needs of children, people living with disabilities or older people. Rooted in feminist philosophy and critical political thinking, care ethicists depart from moral anthropology, emphasising human beings' fundamental vulnerability, interdependency, and embodied nature. This creates the understanding that caring is a reciprocal relationship rather than a one-way street.

The care- ethical definition of care reads as follows:

"[Care is] a species activity that includes everything that we do to maintain, continue and repair our "world" so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" (Fisher & Tronto, 1990: 40).

Tronto (1993) distinguishes between four elements of good care, which can be considered vital for how caregivers respond and attune to older people's potentials and their social and meaning needs (Hupkens et al., 2020).

These four elements are summarised as follows:

1) **Attentiveness:**

recognising the needs of the other, which requires suspending one's own opinions and goals and empathising with the perspective of the other.

2) **Responsibility:**

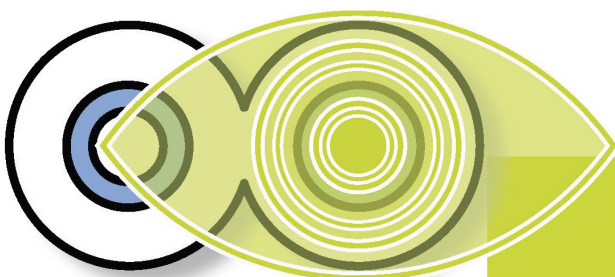
feeling responsible for meeting the recognised needs and asking oneself what can be done to fulfil them.

3) **Competence:**

performing the required acts of care is crucial for care to be qualified as 'good'.

4) **Responsiveness:**

for care to be perceived as good, it needs to be experienced and received by the care recipient. This requires that caregivers can take the perspective of the other and be aware of their expressions of (dis)satisfaction with care (Tronto, 1993).

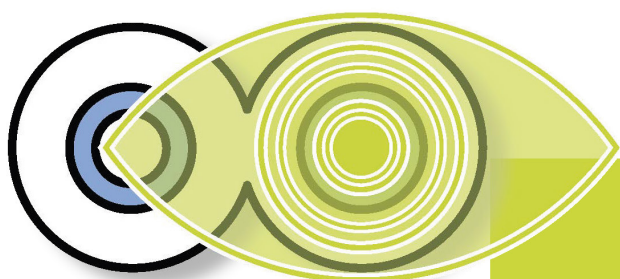


Care ethics is a practice-oriented approach in which a shared concern for realising the good life is central. An interesting example of a care-ethics inspired model from dementia studies is maieutic caregiving, developed by Van der Kooij (2018). This model requires a constant Socratic assessment of the needs of care-receivers and draws on the human intuitions and tacit knowledge of nurses and other caregivers. A critical condition for providing this type of integrated emotion-oriented care is that caregivers develop their empathic abilities. Through empathy, caregivers can imagine themselves in the people they care for, enabling them to understand what is at stake in the patients' situation and what holds meaning for them (Van Dijke et al., 2019). The underlying assumption of maieutic caregiving is that all human beings share a predicament of vulnerability and interdependence, just like in care ethics.

3.3 Capabilities approach

An important point of attention is how good care can take the diversity and heterogeneity of the older population into account so that individual people's needs are adequately recognised, even if they belong to a minority or underrepresented groups in society. This is all the more important given the insight that social constructions heavily shape how we look at different groups of older people, with sometimes detrimental consequences for their health and wellbeing (Calasanti & King, 2015). Several authors have argued that the capabilities approach developed by Sen (1985) and further elaborated by Nussbaum (Nussbaum & Sen, 1993) can provide relevant perspectives to acknowledge differences among the older population while at the same time safeguarding their dignity and fundamental needs (Anand, 2005; Gopinath, 2018; Pirhonen, 2015). The capabilities approach is developed as a normative evaluative framework for assessing individual wellbeing with social arrangements and policies that aims to safeguard the dignified and just treatment of every human being (Gopinath, 2018). It enables us to assess differences in wellbeing and quality of life despite inequalities and social disadvantages. It also opens up a space for valuing people's conceptions of what is meaningful to them, rather than subjecting them to a priori assumptions based on generalising stereotypes of older people as a group.

'Capabilities' are defined as genuine opportunities people have to achieve various valued 'functionings' (Sen, 1993). Functionings are understood as things that people value to do or be, for instance, to be nourished, to be safe, to be socially valued, to work, to exercise, et cetera. The basic idea of the capabilities approach is that people can have a good life if they have access to the capabilities they need to perform valued functionings. Subsequently, Nussbaum distinguished ten domains she considers essential to a good life that should be accessible for all people: a normal life span, bodily health, bodily integrity, senses, imagination and thought, emotions, practical reason, affiliation, other species, play and control over one's environment (Nussbaum, 2001).



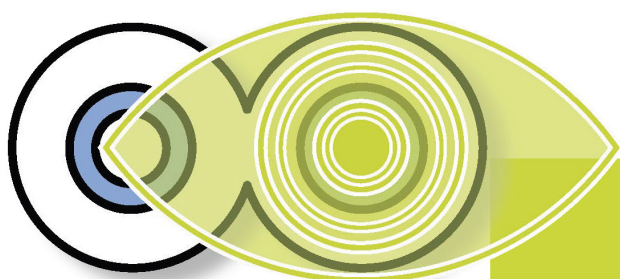
Nussbaum's domains of capabilities can be translated to the social practice of care; for example, people should be well-nourished and inhabit a safe space, their bodies should be treated with dignity and respect, they should have access to meaningful activities that stimulate their senses, imagination and thought and bring joy to their lives, be enabled to maintain in contact with people and things they are emotionally attached to, be given a choice in the daily matters of their lives, form and maintain meaningful relationships with others, et cetera (Bleck et al., 2020; Ghiglieri, 2020; Pirhonen, 2015).

Entwistle and Watt (2013) list several concerns to be considered in training caregivers to treat their patients as persons according to the capabilities approach-inspired version of person-centred care. First, care receivers must be included in the "community of ethically significant persons" (34) by treating them with compassion and respect. Second, caregivers should be responsive to the subjective experiences of care receivers, which includes becoming acquainted with their unique biographies, identities and life projects. Third, they should learn to facilitate a relational type of autonomy, that is, supporting people to develop and use their autonomy capabilities so that people's preferences are taken seriously but in a context-sensitive manner.

In applying the capabilities approach to care for older people, further development of person-centred care can be realised. The aim of person-centred care to treat patients' as persons' takes shape by recognising and cultivating the capabilities fundamental to being a person and securing that people are given the real opportunities to realise the functionings that are valuable to them (Entwistle & Watt, 2013). In the context of care for older people, it is particularly important not to mix up having a capability with having the actual ability to function. The ability to function refers to realising one's ability, whereas capability is a multidimensional construct that combines desires, abilities, means, and access. For instance, a care home resident's capability to go outside is actualised when the resident wishes to go out, can do so, has a place to go, and may freely enter that place (Pirhonen, 2015).

3.4 Empowerment discourse

Transitions in healthcare policies and care systems also promote self-management and empowerment of older people. This tendency matches the discourse of 'active' ageing, deinstitutionalisation of care, community care, and ageing prevalent in health care policies throughout Europe (Janssen, 2013; Steverink et al., 2005). Empowerment relates to a broad paradigm concerning social inclusion and good care, which is multifaceted and encompasses other paradigms, such as relational care, demand-orientation, participation and diversity (Van Regenmortel, 2009).



The empowerment discourse has an explicit emancipation goal. The underlying value feeding into empowerment discourses is enhancing social justice (Boumans, 2012; Van Regenmortel, 2002). The assumption is that empowering people will result in social inclusion and full citizenship, particularly for marginalised groups.

With this in mind, a wide variety of empowerment interventions has been developed for different vulnerable groups (Boumans, 2012; Maertens & Desmet, 2013).

Empowerment is thereby defined as follows:

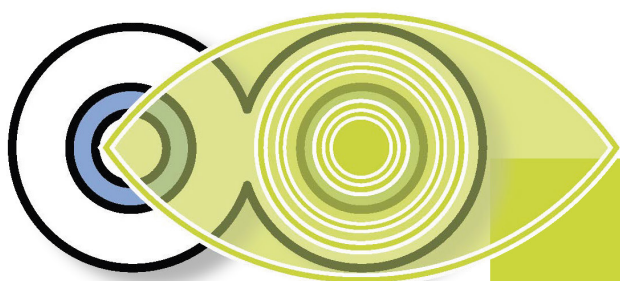
"Empowerment is a strengthening process whereby individuals, organisations and communities gain mastery over their situation and their environment through the process of gaining control, sharpening the critical awareness and stimulating participation" (Van Regenmortel, 2002: 76).

Actively managing one's ageing process is conducive to successful ageing and experiencing the quality of later life. This self-management can also improve the health status of older adults and reduce their use of healthcare (i.e., tertiary prevention) (Jonker et al., 2009; Elzen, 2006; Kempen, 2006). To achieve this, older people need to be supported to develop their self-management competences, which draw on external and internal resources. Important self-management abilities are self-efficacy beliefs, a positive frame of mind, taking the initiative, investment behaviour, multifunctionality of resources, and various resources (Soderbacka et al., 2016; Steverink, Lindenberg & Slaets, 2005).

This individual strengthening process is always related to people's connections and relations with others and from the broader communal, organisational and societal setting in which people live their lives. The empowerment discourse is empathically characterised by a multidimensional approach that looks at micro, meso and macrolevel factors and their mutual interactions (Boumans, 2012; (Janssen, 2013).

Empowerment is not always aiming for maximal independence; rather, it enables care recipients to fully discover their authenticity and identity (Van Hove, 2001). This is important in the context of vulnerable older people, for whom independence is not always a viable or even desirable goal. Empowerment focuses on enhancing the strengths of individuals and becoming aware of their potentials without neglecting the fact that they are vulnerable.

Caregivers can facilitate, support or enable the process of self-management and empowerment of vulnerable older adults. They can help them maintain a sense of mastery by acknowledging the paradoxes inherent to human life, such as the desire to remain autonomous versus the inevitable existential vulnerability. An accepting attitude towards the limitations caused by a vulnerability in later life proved beneficial for people's life quality and resilience against adversities (Janssen, 2013).



A focus towards empowerment, which implies that older people are stimulated to use their self-management skills and activate their social networks when necessary, requires other competences from caregivers. Essential competences are, for example, listening carefully to the stories of care receivers, being creative and taking initiatives to meet personal needs, using outreaching approaches and being reflective regarding one's attitudes, skills, knowledge and assumptions (Kluft, 2012).

A specific approach drawing from the literature about self-management and empowerment of older people is competence care (Kardol, s.a.). Competence care refers to "the care of older people to reside and participate in their community in a meaningful and dignified way, until the end of their lives" (ibid: 12). It is based on the notion of competences, which includes being an actively functioning agent and encompasses accepting limitations and receiving help and support where needed. It appeals to the resilience of older persons, their ability to take care of themselves and make decisions (if desired through a proxy) about their lifestyle and care provision.

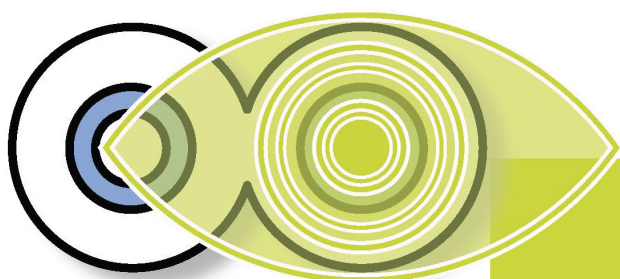
Competence care aims for the following outcomes (ibid: 13):

- Older people have control over their lives and are resilient.
- They accept diminished self-management and experiences of loss.
- They experience reciprocity and selflessness in relationships.
- They experience opportunities to develop talents, share an interest or participate in activities with others.
- They experience the joy of life, look forward to the next day and certain events.
- They have support in dealing with unfinished business and finding closure/completing. their lives.
- They experience that significant others continue to play a role in their lives.

3.5 Implications for caregivers

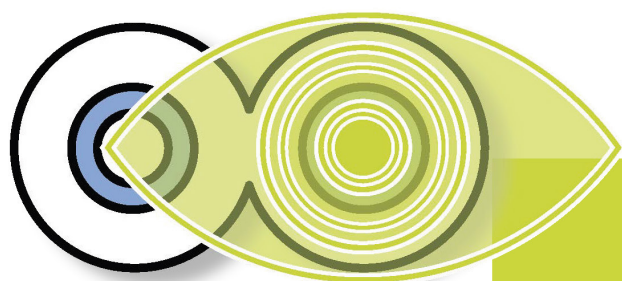
These caregiving theories aim to improve the healing of the individual as a bio-psycho-social unity. It considers the patient's biological, social, and spiritual needs (Papathanasiou, Skavlou & Kourkouta, 2013).

This holistic view of caregiving presupposes that the care recipient is seen as a person, not just a patient. In this view, adequate care requires a differentiated approach that is adequate for older people's heterogeneous needs and capacities (Remmers, 2020).² It seeks to unite the perspectives of older people, the family and professional caregivers in promoting person-centred care (Nolan, Davies & Grant, 2001).



This holistic, person-centred approach requires significant changes in the role of health care professionals and the skills and competences of caregivers. It is challenging to meet older patients' basic or fundamental needs to ensure more integrated, holistic patient care practices (Kitson, Athlin & Conroy, 2014).

² The Australian "See me, Know me" program and the "Live well, Feel better" program from the Spanish Fundación La Caixa and Matia Institute constitute good examples of interventions where person-centred care for older people is realised.



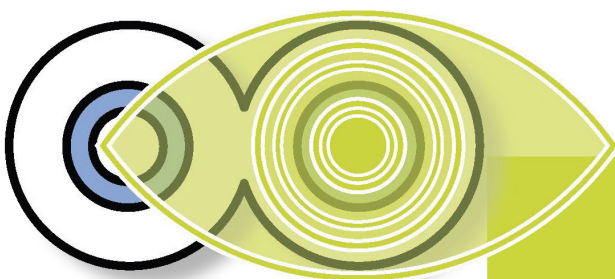
4. Professionals, volunteers, and informal caregivers

4.1 Formal and informal care

The shift to holistic, person-centred care has implications for the skills and competences of formal and informal caregivers. In the next chapters, we describe the necessary skills and competences that caregivers must have to see the potentials and talents of older adults and meet their social and meaning needs. We will focus on three types of caregivers that are important in the current care systems in European countries: professional (formal) caregivers, volunteers, and informal caregivers. These caregivers each have their position and role in caregiving to older adults. Whereas formal help refers to professionals who are paid for their services and are dependent on them for their livelihood, informal care is given by citizens who, in return, receive no financial reward to support themselves. The term 'informal' indicates that the assistance provided involves little or no formalised (and sometimes legally covered) accountability procedures in the form of protocols and registrations to legitimise the assistance, whereas formal assistance does. Informal assistance is often an extension of formal assistance; it either precedes it or complements it. As the competences needed to see the client as a person are the same for all caregivers, we will not distinguish when describing the competences. If relevant, we will make additions relating to volunteers and informal caregivers.

4.2 Professional caregivers

Professionals are formal caregivers, practising a profession and being paid for their services. They provide care for which an indicated legitimation is necessary (the threshold for granting professional care) and have to deal with accountability procedures in the form of protocols and registrations to legitimise their help. Diplomas are required for various professional positions to prove competences and expertise (as quality requirements), including specialist knowledge for specific problems. Professional caregivers are formally responsible for the quality of the assistance provided (Van Daal et al., 2005: 44-48).



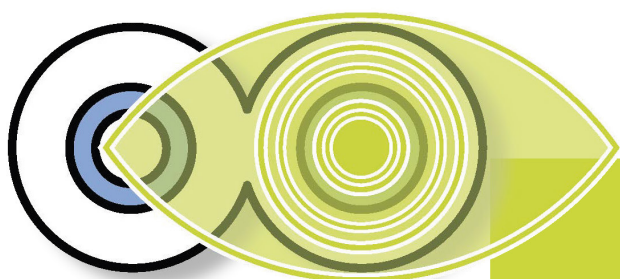
Although patients have expectations about the professionals' knowledge and ability to provide good quality technical care, their assessment of the quality of caregiving is significantly improved if nurses also exhibit interpersonal, 'human' attributes such as kindness, trust, and empathy (Calman, 2006). Besides technical competence, patients value it if they can make a real connection with professionals. They perceive a spiritual or 'life-giving' bond as highly empowering. They expect professional caregivers to create a synergy between knowledge and experience realised in good caring practices (Haugan, 2014). At the same time, they expect healthy distance between caregiver and care recipient, based on respect and compassion (Halldorsdottir, 2008, 2012). In this report, we will not address the technical competences of professional caregivers but focus on the competences needed to see the person as a person, with her/his potentials and needs.

4.3 Volunteers

Volunteers are not a homogeneous group; the types of care activities vary widely, as do their qualities and competences and the time they invest. Moreover, there are more different groups of volunteers. Examples are volunteers who use their professional expertise (in addition to a job or after retirement), young people with social apprenticeships and experience placements, specialised volunteers, citizens who make a compulsory (i.e. involuntary) unpaid contribution, and companies that undertake a social enterprise and make working hours and employees available for voluntary work (Runia & Machielse, 2012). And then there are the voluntary neighbours who run errands for a vulnerable fellow neighbourhood resident or keep an eye on things (Grootegoed et al., 2018; Van Oostwaard, Machielse & Dangermond, 2014).

The diversity in how volunteering is being interpreted and carried out today and how citizens can be called upon to start volunteering make a fixed definition impossible. For this reason, we use a broad definition. In this report, the term 'volunteers' refers to all forms of voluntary efforts that make a valuable contribution to the care for older people, whether organised or unorganised, compulsory or non-compulsory, 'paid' or unpaid. Volunteers can be very experienced and skilled. Many highly trained volunteers put their professional experience and skills to use voluntarily. An increasing number of volunteers also attend courses and training programmes to acquire specialised knowledge and skills.

Volunteers and professionals increasingly come across each other in collaborations and within different domains and work areas (Van Daal & Winsemius., 2005). The volunteer is sometimes additional to, sometimes preceding and sometimes extending the professional, and sometimes co-partner of the professional (Boss et al., 2011; Grootegoed et al., 2018; Oudenampsen et al., 2006; Runia & Machielse, 2012).

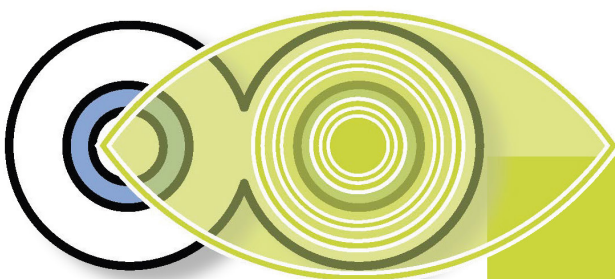


4.4 Informal caregivers

Informal caregiving is the primary source of care for older people in Europe (Barbabella et al., 2016). Informal caregivers (or 'family caregivers') have a pre-existing social relationship with the person they care for. The care recipient may be a person with whom a kinship relationship exists or a spouse, friend, neighbour, or neighbourhood member. Policymakers tend to embrace a partnership model. Professionals and family/informal caregivers are seen as equal partners to provide well-tailored care to all those in need of it (Nolan, 2001)

A primary objective of care policy is to support informal and family caregivers to enable them to continue their invaluable tasks for as long as possible. There are several reasons for this.

First, informal caregivers are often aged: for example, spouses of a person with dementia. Second, they may be overburdened with other activities. Adult children, usually daughters, often have to manage their own families and careers aside from caring for their older relatives. In addition, there is a strong emphasis on the empowerment of informal caregivers, stimulating them to use and develop their strengths and maintain an independent position alongside professionals (Nolan, 2001).



5. Competences to 'see' older adults

5.1 Competences and skills of formal and informal caregivers

To 'see' the older person behind the patient, caregivers must understand care as something more than physical and medical care. The literature clarifies that some critical competences are required to 'see' older adults' positive talents and dreams, not only their needs. This chapter describes nine necessary competences caregivers should have to 'see' the person.

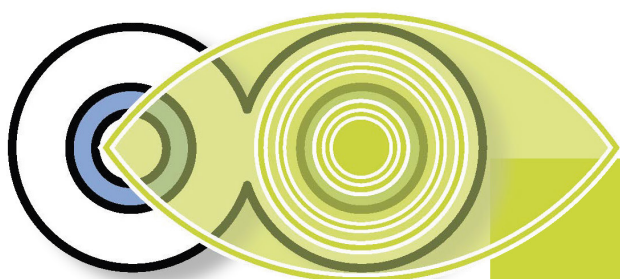
5.2 Relational competences

In person-centred care, the caregiver and the care recipient relationship is crucial. That is why caregivers should, in the first place, have relational competences. They must be able to reach out to someone, make connections, and bring reciprocity to the relationship. The willingness to engage in a long, kind and reciprocal relationship is hugely important for the experience of good, meaning-sensitive care. It makes patients feel safe and valued (Hupkens et al., 2020).

Enhancing the relational competence and the quality of relationships between caregiver and care recipient can significantly affect the overall quality of care outcomes (Church, 2016; McGilton et al., 2003). Relational competences are needed for care that considers what matters to the person and ensures that they can continue to live in a way consistent with their identity (Martinez, 2019).

A good relationship between caregiver and care recipient requires that caregivers develop a positive attitude, respect for autonomy and equal partnership. Involvement, reciprocity, attunement, equality and shared humanity are underlying principles of relational care (Van Regenmortel, 2009). Nurse-patient relationships that have the qualities mentioned can also serve as sources of meaning and purpose themselves (Haugan, 2014). High-quality nurse-patient interaction improves older adults' psychological and physical health, wellbeing, and psycho-spiritual functioning (Haugan et al., 2016).

Several studies argue that good nurse-patient interaction is fundamental in enhancing the experience of meaning in life for nursing home recipients (Haugan, 2014; Haugan, 2013a; 2013b; Hupkens et al., 2019, 2020; Halldorsdottir, 2008). The relational competences of professional caregivers seem crucial to meet their patients' meaning



needs because older people turn out to be reluctant to express their existential questions and needs towards nursing staff. They do not always expect them to be willing or able to respond to these needs (Hupkens et al., 2020). Research suggests that simply 'being there' and 'listening' are vital in responding to care recipients who struggle with existential questions (Van der Vaart et al., 2013).

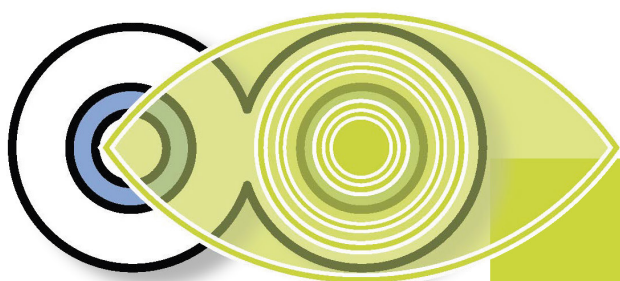
5.3 Communicative competences

The ability to enter into a real relationship with the person seeking help requires communicative competences that imply observing the client's situation and understanding its meaning from the client's perspective. These include listening well; being observant; having an eye for details, connections and contexts; seeing and understanding the value of the contact for the other, et cetera. Caregivers should be able to change perspectives, look at the situation from the client's point of view, and notice, interpret, and respond adequately to their clients.

Caring for and caring about people with dementia requires specific communication skills (Eggenberger et al., 2013; Leocadie et al., 2020). In the context of dementia, the needs of the family (who have often served as informal caregivers until the care recipient is moved to an institution) must also be taken into account. Attention to the family's suffering is also essential for good care for older people (Van de Ven, 2018). Caregivers have to pay attention to the social network of the client and include them in the decisions and practice of daily care (Traynor, Inoue & Crookes, 2011). Dealing with family members may be stressful, especially when conflicts arise. Therefore, communicative competences are crucial for communication with the patient and to consult and negotiate with the care recipients' social environment (Nathalie et al., 2016).

5.4 Empathic competences

Empathy is crucial to understand the patient's feelings, perspectives, and meanings and act upon that understanding helpfully. It can affect the quality of care and even health outcomes (Gholamzadeh et al., 2018; Mercer & Reynolds, 2002). Since empathy is a complex, multidimensional concept, the definition is not unambiguous. Still, it is rather common to distinguish between affective empathy and cognitive empathy, whereby affective empathy describes the ability to perceive and relate to another person's situation from an emotional point of view. Cognitive empathy refers to the ability to mentally reconstruct the experiential world of the other (Van Dijke et al., 2018). Both types of empathy, it is believed, help to sensitise caregivers for the needs of others and enables moral deliberation.



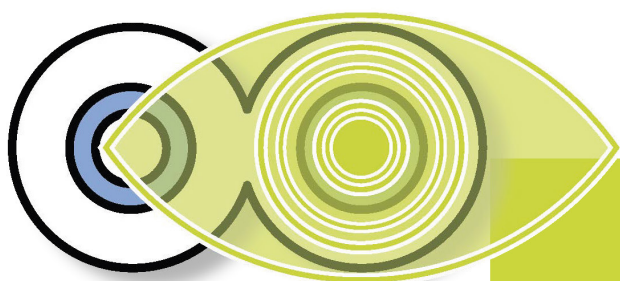
It should be noted, however, that empathy is not just an individual ability of the caregiver but a relational quality that also depends on the qualities and efforts of the care receiver, the quality of the relationship between caregiver and care recipient, and the organisational setting in which the caregiving takes place. Both caregiver and care recipient are engaged in a constant process of mutual attunement, shaping each other's feelings and understandings (Van Dijke et al., 2019). Given this relational conceptualisation of empathy, empathy is beneficial for the care recipient and plays a vital role for care providers themselves. It enhances their sense of meaning and protects against work-related emotional distress and burnout (Ekman & Halpern, 2015).

Despite its obvious merits, the concept of empathy can also give rise to some problems and dangers, which caregivers should be well aware of. It may result in the form of projection that fails to respect the otherness of the other (Van Dijke et al., 2018). First, empathy can be biased in different ways. For example, most people find it much easier to feel empathy for people who resemble themselves. This may have detrimental consequences for meeting the care needs of people very different from ourselves because empathy with their situation is less self-evident or lacking. Second, caregivers are at risk of 'over empathising' when situations of care-receivers are particularly distressing. This can lead to undesirable consequences such as so-called 'empathy fatigue' or caregiver burnout. Third, empathy can be distorted by stereotypes and prejudice against certain groups.

5.5 Moral competences

An important theme that requires special attention about caregivers' competences is the moral domain. Good care presupposes moral values in the care relationship, for example, respect for individuality, dignity, safety, a caring community, and closeness (Frilund, Eriksson & Fagerstrom, 2014). In daily practice, caregivers are often confronted with paradoxes, such as the desire to respect the autonomous choice of care recipients and a concern for their safety, or between the needs of the care recipient and the burden for informal caregivers. Another moral element of good caregiving pertains to articulating and balancing personal, social, professional and organisational values in the daily activities of caring. In some cases, there may be tension between different value sets, and specific competences are needed to navigate these situations.

Caregiving may confront caregivers also with moral issues that relate to existential questions. For example, older people struggling with life questions concerning the end of their lives (for instance, they don't want to live anymore) often generates moral dilemmas and personal life questions for caregivers (Frilund et al., 2014; Van der Vaart et al., 2013).



Moral deliberation and self-reflection skills are vital for caregivers to deal with these issues healthily. It is helpful for them to engage in periodical collective reflection with colleagues, for instance, in moral deliberation sessions, to work out the best strategy to deal with these paradoxes, which should be adapted and tailor-made for the situation at stake (Baur, 2013).

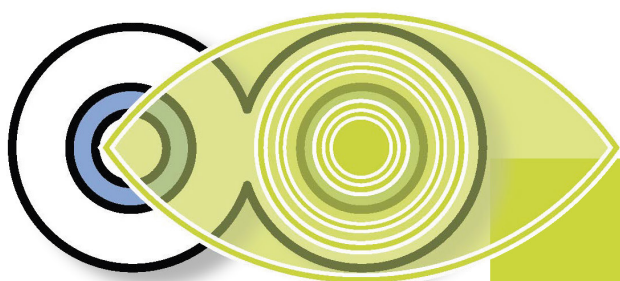
Moral competences include moral perception, judgment, and behaviour (Jormsri et al., 2005). Caregivers must develop a perspective regarding 'dignified care' and knowledge of providing dignity in care for older people (Kinneer, Williams & Victor, 2014). Furthermore, eight attributes are defined that are conducive to developing this moral competence: loving-kindness, compassion, sympathetic joy, equanimity, responsibility, discipline, honesty, and respect for human values, dignity and rights (Jormsri et al. 2005; Traynor et al., 2011). In addition, it is vital that the organisation is sensitive to moral dilemmas and provides room for ethical dialogues (Kloos, 2020).

5.6 Cultural competences

Caregivers must reflect on their own (often non-conscious and implicit) stereotypical and ageist views and how those might affect their interaction with older people, given how deeply these tend to influence people's belief in themselves and their strengths (Levy, 2009).

Therefore, interpreting and understanding clients' needs also require cultural competences and sensitivity. The cultural diversity of the older population has increased significantly in recent years, whereby caregivers provide care to people with various multi-ethnic roots. Providing practical, culture-specific healthcare can improve the health quality of these patients (Chang, Yang & Kuo, 2013).

In European countries, health care is mainly based on Western cultural values. For several decades, self-determination, liberty of choice, and freedom from others' interference have been the leading principles. Although autonomy is a core aspect of caregiving, caregivers have to be sensitive to race, class, or cultural differences. Social change and the multiple and ever-changing cultural contexts within which older people are embedded are essential factors that shape their experiences over time and impact care facilities and, for example, their ability to age in place (Perkins, Ball, Whittington & Hollingsworth, 2012).



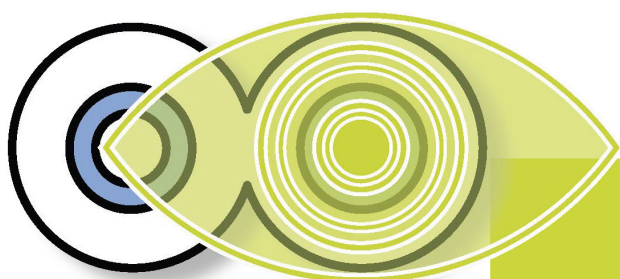
Cultural competences are also needed to match the growing needs of lesbian, gay, bisexual, and transgender (LGBT) older adults. Several studies into the experiences of LGBT older adults show that they face prejudice and discrimination from health care professionals (Foglia & Fredriksen-Goldsen, 2014; Lindroth, 2016; Molinari & Sweeney-Feld, 2017; Putney et al., 2018). Cultural competences are needed to address these older adults' needs and prevent their estrangement experiences (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emler & Hooyman, 2014; Rinaldi et al., 2005). However, sexual orientation and gender identity are not commonly addressed in health care or education programs for care professionals.

5.7 Hermeneutic competences

To acquire a holistic image of who the patient is and how the provided care can accommodate the patient's flourishing requires looking beyond the purely medical and physical elements of health and learning to interpret the emotions and experiences of the care recipient (see, e.g. the maieutic model, Van der Kooij, 2018). For example, it requires recognising the meaning needs of the spiritual needs of the older clients. Hermeneutic attunement is necessary to check whether the needs and wishes of care-receivers are adequately interpreted and addressed. This is something that requires training and practice, whereby caregivers learn to formulate and reflect on their intuitions and engage in dialogue about the proper interpretation of care receivers needs and the sensitive attunement to them. Forms of hermeneutic dialogue and moral deliberation can also help improve the active participation of (groups of) care recipients in the organisation of care in institutions, where conflicts between the life-world perspective of older people and the systemic perspective often internalised by professionals can be expressed, and mutual frustrations and misunderstandings can be shared (Baur, 2013).

Hermeneutic competences are also essential for recognising and assisting older people when they have difficulties fulfilling spiritual tasks (MacKinlay, 2006; MacKinlay & Trevit, 2010; Narayanasamy, 1993).³ They can, for example, facilitate relationships with other people;

³ MacKinlay divides the spiritual tasks relevant to later life in different categories: to find a sense of ultimate meaning; to move from self-centeredness to self-transcendence; to develop an adequate spiritual response to ultimate meaning; to acquire intimacy with God and/or others; to make meaning by transforming provisional life meanings to final meanings; to maintain hopeful.



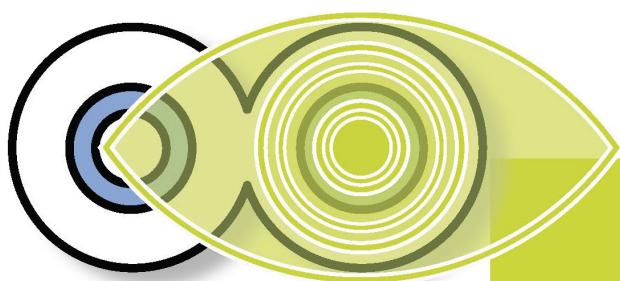
facilitate reconciliation with family members or friends, and reconciliation with God, if needed; help people express and deal with feelings of guilt, regret, anger or grief; accept and adapt to age-related frailty and physical and mental decline; acquire self-acceptance and ego-integrity; facilitate reminiscence and life-review; pray with residents and/or encourage their participation in religious practices such as church visit; develop and maintain a loving, caring and respectful relationship with the patient; affirming people in their search for hope; assist them in the process of dying, et cetera.

Finally, hermeneutic competences are crucial in interpreting behavioural symptoms of people with severe dementia. For example, to consider the possibility of that person experiencing involuntary care. Increased awareness and understanding of the meaning and consequences of the behavioural expressions is indispensable for improving dementia care by avoiding restraints and involuntary care to its maximum (De Boer et al., 2019; Vellone, Sansoni & Cohen, 2002).

In person-centred care, caregivers have an important role in identifying the potentials and social and meaning needs in older people. By accommodating these needs, they contribute to better health, wellbeing, and quality of life in their patients (Hupkens et al., 2018). Therefore, they should be trained to become aware of the following fields of attention: personal values and meaning orientations of their patients, cultural and socio-economic context; individual coping styles related to adverse events, virtues or character strengths of patients, the life story of the patient and how he/she reflects on that, daily meaning in ordinary things, preservation of meaningful roles and activities for older people, preservation of health to maintain meaningful activities, and connectedness to others and/or to something that transcends the self.

5.8 Narrative competences

Seeing someone as a person also includes taking people's life history and social situation into account when accommodating their needs. Person-centred care that fits someone's life situation and history presupposes narrative competences in the attention of older people (Villar & Serrat, year). Biographical work is required to identify older adults' social and meaning needs, where both generativity and ego-integrity play a role. Looking back on one's life helps people give a meaningful ordering to life events and thus create a sense of narrative coherence and closure. It enables people to come to terms with what may be unfinished, regret, anger, sadness, and guilt.



Competences of caregivers that enhance exploring these issues in older age can help people reframe some of these events and come to a new understanding of the meaning and purpose of their lives (Jonsen et al., 2015; MacKinlay & Trevit, 2010). In this respect, narrative interventions have been developed, for example, life reviews, logotherapy, or spiritual reminiscence emphasising meaning in life (Bohlmeijer et al., 2008; Butler, 1963; De Medeiros, 2014; MacKinlay & Trevit, 2010; Morgan, 2012).

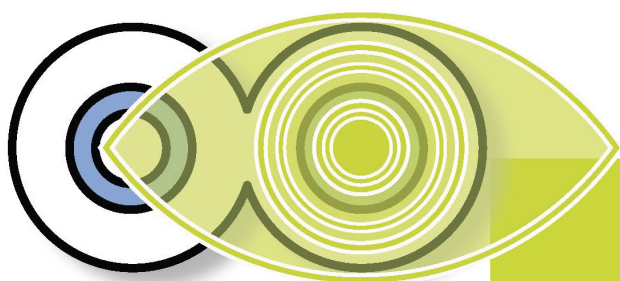
5.9 Empowerment competences

Caregivers can assist older people in recognising their strengths and helping them put their strengths into use. Rather than a paternalistic role, where the caregiver is the expert deciding what is suitable for the care recipient, the caregiver needs to adopt a coaching and supporting role to stimulate self-management skills in older people (Alpay & Jansen, 2010; Boumans, 2012). To guide and encourage the client, caregivers need the ability to think of a creative solution or to arrange things. They must have realistic expectations about clients possibilities and do not start tackling issues a client is not ready for. This requires that caregivers gain insight into a client's wishes, desires, and priorities, involving unprejudiced listening. Next, clients need to be facilitated to express their self-prioritised goals. A plan can be made for how the caregivers can facilitate the client in putting their goals into action (De Vriendt et al., 2019).

Although caregivers can support self-management and empowerment, it should be realised that empowerment has to come from within people and cannot be forced upon them from the outside by caregivers. They can only facilitate, support or enable the process. This is known as the 'empowerment paradox' (Jansen, 2013; Van Regenmortel, 2009). Also, it is essential to be sensitive not to overstep personal boundaries of both caregivers and care recipients in the care relationship characteristic of the empowerment paradigm. The goals and practices of caregiving should flow from a dialogical exchange between all stakeholders and be regularly evaluated.

5.10 Intervention competences

Professional caregivers have the task of noticing if a client has a problem, interpreting the problem, and selecting an appropriate intervention, for example, by seeking meaningful activities and social roles for people to participate in. To analyse and intervene effectively and adequately, they need to consider what intervention is appropriate in a particular case for a specific client. A 'one size fits all' approach to offering activities does not improve people's quality of life, so a tailor-made approach is required (Drageset, Haugan & Tranvåg, 2017).



Intervention competences need professionals to be context-sensitive and flexible in promoting, restoring, sustaining, and/or enhancing positive functioning and a sense of wellbeing in clients (Barber et al., 2007; Nolan et al., 2004).

Engaging in worthwhile activities is quintessential in maintaining a sense of meaning for older people (Steptoe & Fancourt 2019). Many activities are considered valuable and contribute to meaning, such as harmonious family relations and contacts, fulfilling hobbies, religious and spiritual practice, (volunteer) work, nature, travelling, and other stimulating activities. For people living in long-term care facilities, activities are vital to maintain their identity and autonomy and confirm their values (e.g. De Vriendt et al., 2019). To be experienced as valuable, activities need to meet some conditions: be useful; stimulate social interaction; help patients to connect with their home environment and make a connection to their past; provide structure in time during the day; be self-chosen, and finally enable them to remain active. Thus, autonomy/free choice, social connection and connection with the past were considered to be critical elements of activities capable of stimulating a sense of meaning.

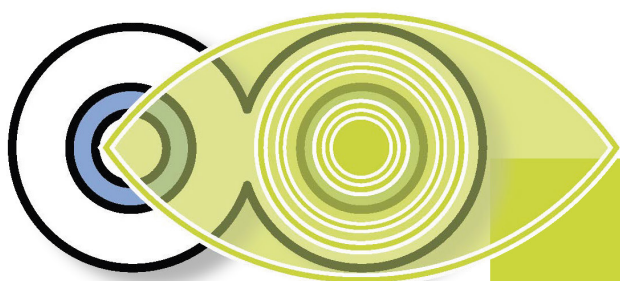
Assumptions of staff and family caregivers may stand in the way of a good provision of meaningful activities. Moreover, there may be differences in how older people evaluate activities as meaningful to them, compared to staff and family carers. In a study on older people living with dementia, it turned out that staff, and family carers found activities maintaining older people's physical abilities to be meaningful, whereas, in contrast, the older adults preferred activities that addressed their psychological and social needs more highly (Harmera & Orrell, 2008). The quality of the experience and the social interaction during the experience mattered more to residents than the type of activity. However, even the oldest old can find meaning in activities despite the sometimes severe losses they experience (Harmera & Orrell, 2008).

5.11 Self-care competences

Improving the relational competences of caregivers requires enhancing skills towards the patient and enhancing self-care skills. Caregivers need to be able and willing to enter into a personal relationship with clients, i.e., to get involved with a specific client as a person.

However, personal involvement requires that caregivers can guard their limits to prevent that it will negatively affect them (European Charter of rights, 2010). Attention for their self-knowledge, self-reflection, and self-development reduces their burnout risk (Halldorsdottir, 2012). Valuable self-care competences are expressing positive feelings, controlling aggressiveness, and discussing problems (Nathalie et al., 2016).

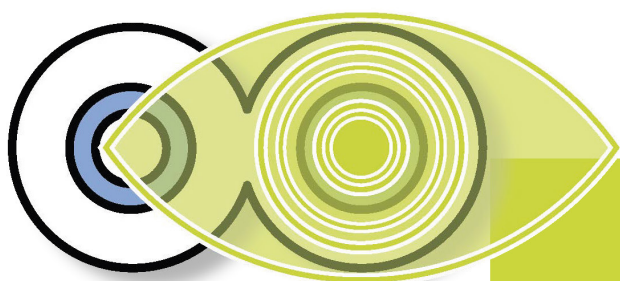
Self-care is also relevant for informal caregivers and family caregivers (Barbabella et al., 2016). Caring for a dear one can be stressful, decreasing the caregiver's quality of life. It may involve conflicts or difficulties reconciling differences of opinion or financial issues.



Studies into caregiver burden and mental health underscore the importance of the positive aspects of caregiving, such as finding meaning as potential buffers of the burden of caregiving (Che, Yeh & Wu, 2006; Given, Sherwood & Given, 2008; McLennon et al., 2011; McLennona, Habermanna and Rice, 2021). Interventions have been developed to relieve or support informal caregivers or improve informal caregivers' competences (De Cola et al., 2017; Graffigna et al., 2020; Guida et al., 2019; Nolan, 2001).

The involvement of volunteers in care settings needs special attention in this respect. Often volunteers are highly motivated to help older adults but willing to offer unlimited help (Machielse & Runia, 2014). To reduce the risk of burnout, organisations should develop a clear vision of volunteering that clarifies the role of volunteers. Voluntary work with highly complex and vulnerable clients demands professional supervision. This requires professionals who have the competences and the time to follow and supervise the volunteers. Fundamental issues in this respect are sharing experiences on the care trajectory and monitoring the boundaries of the volunteer. There are also limits to the work of volunteers. Clients with serious, 'heavy' existential questions, for example, in case of a death wish, can make the volunteer feel uncomfortable (Leocadie et al., 2020).

Professional (spiritual) caregivers are quintessential to meet the meaning needs of people in situations where simple attention of informal caregivers and nurses is not enough (Van der Vaart et al., 2013, 2015). Volunteers need to recognise when it is better to bring in a professional and learn to deal with their feelings of powerlessness, as problems cannot be solved (Van der Vaart et al., 2013).



6. Competences of caregivers according to SeeMe participants

6.1 Introduction

This chapter focuses on the skills and competences caregivers need to 'see' older adults and how to improve these skills and competences, as found in the qualitative interviews with caregivers. From the literature review and the SeeMe problem statement (see chapters 1-3) main themes were derived from exploring the competences and skills of informal, volunteer and professional caregivers.

This resulted in an interview guide⁴ that centred around four main topics:

1.1) **Assistance/help/care:**

what kind of help was given, to whom, how; does the contact with clients meet the caregivers' expectations;

1.2) **Attuning to clients' needs:**

were clients' social and meaning needs recognised and met; what kind of barriers were experienced and how to deal with that;

1.3) **Competences and skills:**

what competences and skills are needed to help the clients, like understanding client, practical skills et cetera.;

1.4) **Quality of caregiving:**

prerequisites to provide care, like professional competences, needed experiences, personal characteristics and training.

Interviews were conducted with seventeen respondents – six professional, six volunteer, and five informal caregivers - involved in a local care project⁵ chosen by each country (i.e., two from the Netherlands). All interviews were part of the entire SeeMe project, which also covered interviews with older adults (see Machielse, Van der Vaart, Laceulle, & Klaassens, 2022). The current chapter focuses on interviews with caregivers only (see [Table 1](#)).

⁴ The full interviewguide can be found on the website <https://see-me-project.eu/> or requested from the authors. ⁵ Further information about the six SeeMe partners and their selected local care project can be found on the website www.seemeproject.eu and in Report 3 – Case studies (also available on the website).

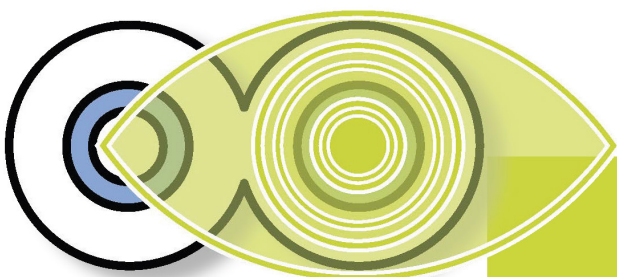


Table 1- SeeMe interviews: overview for this report

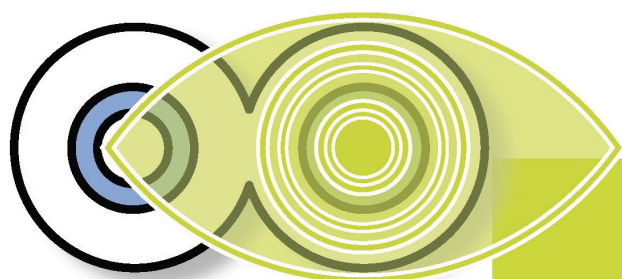
Country	Professional	Volunteer	Informal caregiver	Extra mural	Intra mural
Belgium		2*	1	X	
Germany	1	1		X	X
Italy	1	1	1		X
Netherlands (UHS)	2	1	1	X	
Netherlands (AA)	1	1	1		X
Spain	1	1	1	X	
Total	N=6	N=7	N=4	10**	7**

*) One Belgian volunteer also had a professional function, but the interview focused on the volunteer role.

**) The German professionals were active both extra and intra mural; they are assigned to one category here.

All interviews were summarised, coded and analysed in ATLAS.ti using a coding scheme with sixteen entries (see Appendix II), organised into six main categories:

- 1.4.1. Tasks (which): what kind of assistance/help/care tasks do they perform?
- 1.4.2. Attuning to needs (how): how do they tailor care to clients' needs?
- 1.4.3. Competences and skills needed (which): what assets are needed for good care?
 - 1.4.3.1. Relational (incl. responsiveness, connecting, attunement)
 - 1.4.3.2. Communicative (incl., dialogical, observation)
 - 1.4.3.3. Empathic (perspective taking, cognitive and affective, compassion)
 - 1.4.3.4. Moral (recognising moral, balancing values, moral deliberation)
 - 1.4.3.5. Cultural competences (reflecting on stereotypical views)
 - 1.4.3.6. Hermeneutic (sensitivity for meaning issues)
 - 1.4.3.7. Narrative (sensitivity for stories, co-narrator, intake)
 - 1.4.3.8. Empowering (recognising strengths and helping put them into use)
 - 1.4.3.9. Intervention (problem-solving; finding tailored solutions for problems)
 - 1.4.3.10. Selfcare (self-reflection, self-knowledge, personal limitations)
 - 1.4.3.11. Role (inductive; distinguishing between professional roles)
- 1.4.4. Improving competences and skills (how): in what manner can they be enhanced?
- 1.4.5. Management and organisational quality (what): what is required to enhance the quality of caregiving?
- 1.4.6. Specifics national or cultural issues (which): what affects the quality of caregiving?



The outcomes of the data analysis as presented below follow these main categories. Many topics were discussed, but the analysis focuses on the most salient, surprising and inspiring findings that add insight into social and meaning needs and how to accommodate them in care settings.

6.2 Data analysis

6.2.1 Overall remarks

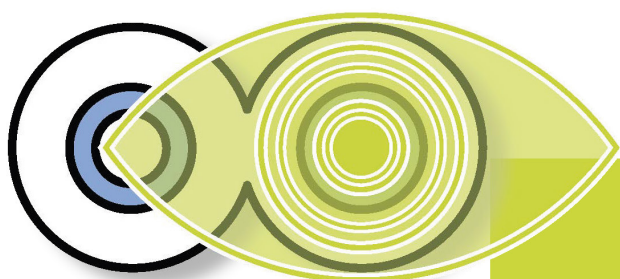
There are no substantial differences between the five countries, though situations and programs are different and locally defined. The data encompass a limited number of respondents, but all presented experiences and impressions fit well and could have come from any country. Thus the phenomena studied here seem to concern rather generic care issues for older persons. This also applies to the differences between informal, volunteer and professional caregivers. Differences between the three categories of caregivers, of course, were found. Still, they are very much role-related and seem somewhat independent from the country, whether concerning intra- or extra mural care, client characteristics, et cetera. Below the main findings are depicted for each of the main themes.⁶

6.2.2 Asks performed by caregivers

Informal caregivers and volunteers in each country describe their everyday tasks mostly in terms of practical care and daily help, from transportation to administration. With those tasks, they also seem to bring an important social role. In particular informal caregivers usually take a comprehensive role. This ranges from social and emotional to practical issues like cleaning, cooking, shopping, and being intermediary towards health care staff (for example, translating or organising health visits). Also, some volunteers demonstrate such a broad role in exercising their tasks. Meaning tasks are not mentioned as social roles, especially in the volunteers.

However, informal caregivers stress that they are important in this respect and should be able to recognise meaning needs (IT5). This meaning role also has a moral component for informal caregivers who – particularly when they are relatives - feel that they are needed to give their family members depth in life. But also volunteers express that they feel the moral need that it is important to help the people who need it (BE1).

⁶ Legend for respondent roles in the text: Volunteers: BE1, BE3, D2, NL4 (UHS), #NL6 (AA), SP3; Informal carers: BE5, IT5, NL5 (UHS), #NL3 (AA), SP4; Professionals: D1, IT4, NL6 (UHS), #NL2, #NL4 (AA), SP5.



The professional caregivers describe similar practical, social and meaning tasks and add to this their organisational work, topics that will be dealt with below. One noticeable issue is that they see it as their task - and the task of their organisation - to offer a life perspective to older people: reinstating people's dreams, working with their dreams, and acknowledging future perspectives of older clients. SP5 "[Mentions] a pilot project called 'dreams manufacture' that seeks to identify and meet unmet dreams. Its basic value is that dreams are still there, that older people can still dream, and have the right to have and start life projects."

6.2.3 Attuning to the clients' needs

All respondents acknowledge the importance of tailoring care to the individual client, seeking to recognise and meet their needs. Some specific aspects arise from the interviews as being not self-evident but of particular importance for the quality of care.

Recognising social and meaning needs

First, the issue arises what's needed to recognise social and meaning needs. Some informal caregivers and volunteers say that they "sense what people need" and that not everyone has this ability (BE1). They listen to the needs of the people they help but state that they don't know how they do this and just might have learned it by long practising their job. Also, they indicate they are not sure whether they can recognise and respond to meaning needs when the client has a reserved personality and barely shares any of these needs (SP3).

Connecting to clients' biography

Informal caregivers that help their relatives state that it is essential to know the person and their life experiences for seeing meaning needs.

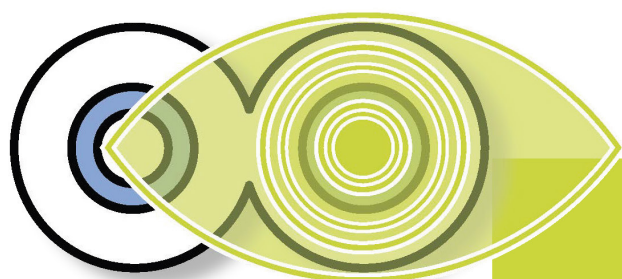
"Often, it is not the company or what you tell them, but what (they) need to tell you. Often it is what they need to tell you and of course, without knowing their life story, as you say, or their values, it is very difficult to make contact, to connect, because they don't know how to express those needs". (SP4)

This informal caregiver suggests almost excluding all possibilities for non-family members to make real contact with the client and their life histories. (SP4)

It's salient how caregivers regularly seek to connect to clients' biography to offer them a perspective in life. Volunteer BE1 states that people have been able to do things all their lives and still want to feel like they can. She talks about their wishes and dreams and follows the older people's desires and thoughts even though they're often unrealistic.

"If people want to dream, you have to let them dream.

Sometimes there are people who ask for weird or unfeasible things, but I say, no, let them do what they want." (BE1)



Much of such a biographical approach in attuning to specific needs is also acquired by professionals: as well as for attuning to the client (starting with mapping one's biography and then using it as much as possible in care), as for making a good match between client and professionals, for each task or activity (D1, #NL2).

Different caregivers

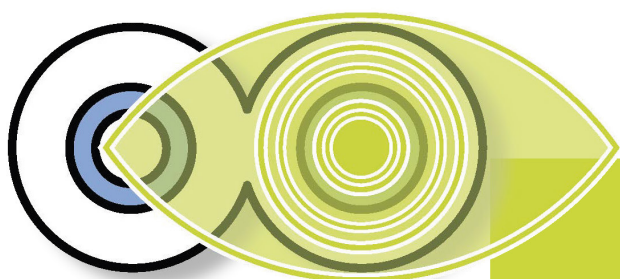
One possibility to respond to the needs of the residents is by offering different attachment figures (#NL4, D1). As a professional caregiver states: ".. the chemistry always has to be right. Because some residents might be better with another colleague than with me" (D1). Moreover, in this case, volunteers are matched with specific tasks and with clients to fit the volunteers' profile, capabilities, and needs (just like tailoring for clients). Regarding relatives as informal caregivers, such an approach leads to roles that fit their (closer) relationship with the older adult (D1). These diverse opportunities offer volunteers the chance to get involved in different ways. Instead of assigning them a task or even imposing it upon them, each volunteer can contribute with his/her capabilities. Thus, one approach of attuning seems to match clients' needs to different caregivers and match caregiving tasks with caregivers' needs.

Creating an everyday surrounding

Another method of attuning to clients' needs is to create a kind of 'every day', 'natural' surrounding of help for clients in which they feel comfortable and safe (#NL2, NL6). This is demonstrated by professionals eager to have more 'all round' volunteers who can help with daily issues, like minor repairs, groceries, writing a letter. Often such tasks are too limited when the program doesn't accept requests for just practical help, but care receivers do make such requests. Professionals suspect that there might be some more significant issues behind such practical demands of clients, making it worthwhile to respond to them (NL6).

Personal involvement

Additionally, volunteer and informal caregivers (BE3, BE5) view help as something natural, as what one does if others are in need. They provide more help than formally needed and/or get involved more personally, like giving some money for food (which is not allowed). Illustrative is how a volunteer involved her sister in calls with a client, at first accidentally, and noticed how the client enjoyed this (SP3). These approaches seem to create a kind of everyday life for clients, having 'daily' contacts with people in their surroundings like one had more frequently before with family, neighbours or acquaintances.



6.2.4 Competences and skills needed

Concerning the competences and skills that caregivers need to help clients properly, ten of the eleven distinguished dimensions (see code list in 6.1) were well represented in the data. Only the dimension of 'cultural competence' was not recognised in the data. While respondents did talk extensively about really seeing the client and addressing their needs, this was not worded in terms of cultural differences or other (stereotypical) group differences. To summarise the relative importance of the remaining nine competences, we might say that six of them were most valued by respondents (roughly in this order): relational, empathic, hermeneutic (sensitivity), self-care, intervention, empowering, and communicative competences. Less often recognised are aspects of moral, narrative and role competence. It's important, though, to realise that the ten competences inevitably overlap and that aspects of specific dimensions may also be attributed to other dimensions.

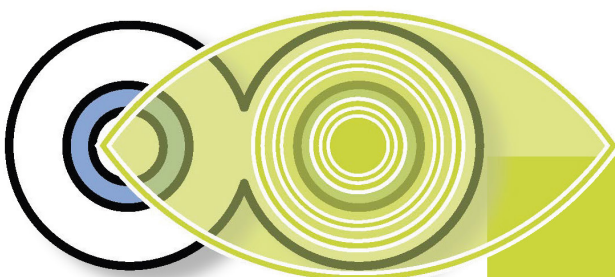
The competences and skills don't show distinctions between caregivers from different countries, but – given their roles - differentiation can be found between volunteer, informal and professional caregivers.

Volunteer caregivers

The principal competences and skills that volunteer caregivers mention are: being empathic (seeing what client feels, understanding), relational (being social, showing respect, listening well, being patient and adept to the client), hermeneutic (feeling it, sensing what is going on, connecting to client) and self-care (in particular putting limits to the demands). Volunteers are often very much involved in the care relationships and expect this involvement from other caregivers.

They assume it to be the right attitude or disposal required for giving care:

"... an attitude, a will to help and to want to get involved" (BE2); "... the willingness to provide affective accompaniment" (SP3). One volunteer articulates the importance of paying respect in this relationship (BE1): "you have to take care of people like they are royalty" [...] "you have to take the baggage that a person already has in life into account".



Informal caregivers

Informal caregivers largely mention the same competences and skills but stress certain aspects. Some emphasise the relational part of adapting oneself to the level of the client: while respecting their limits, not thinking or acting for them. "Because, even if they're limited to a high degree, some activities they are able to, might be very important to them" (SP4).

Moreover, informal caregivers seem to emphasise being able to make (affective social and) meaning connections: providing a feeling of trust and connection, meeting wishes of clients (NL5, SP4, IT5).

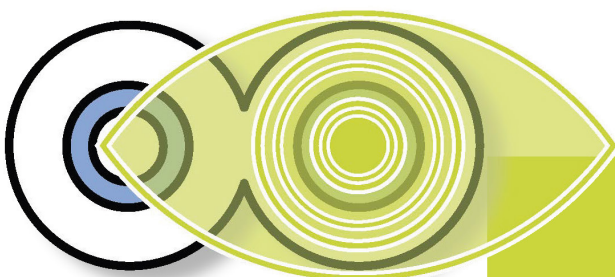
Since it is hard to judge the clients' real needs and to connect really with a person, informal caregivers stress the vital role of relatives:

"Sometimes only family members share memories and life history with a client - and know, for example, other persons in the family pictures - and can help. Also, close family relationships aren't replaceable on many issues, particularly since older clients have a bigger need for an intimate circle." (SP4)

Regarding self-care, informal caregivers mention the importance of being able to tell their own story to someone and to request/get help from professionals/others (BE5). Also, moral competency is mentioned more often, like keeping up the spirit, being positive, balancing the client's wishes and what's needed (e.g., insisting on going out for a walk or not, SP4).

Professional caregivers

The data on professional caregivers results in similar main themes as mentioned above, but also lead to two additional competences and skills: they stress the importance of role competence (i.e., being flexible, having some expertise in activities that are organised, planning skills, organisational skills, having contacts with other disciplines and institutions) as well as intervention, and empowering competences (finding creative solutions for individual problems) (D1, IT4, #NL4, NL6). Regarding the other competences and skills, professionals often add some own distinguishable characteristics. Next to empathic skills, they mention in particular relational (i.e., being responsive, calm, showing acceptance, creating feelings of closeness, finding the right tone), hermeneutic (i.e., being attentive, remarking, reflecting on clients life history), and communicative (i.e., listening, observation skills, moderation skills to include people) aspects (D1, IT4, SP5, #NL2, NL6).



According to one professional, the essential attitude can be summarised as:

"You have to love people, which means a bundle of competences: empathy, attentiveness, observational skills, composure, acceptance, the ability to establish closeness and at the same time maintain a good balance of proximity and distance." (D1)

6.2.5 Improving competences and skills

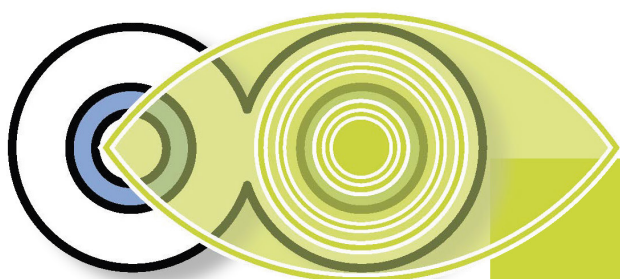
Most volunteers mention that their organisation provides some education, workshop, or short talks that address relevant topics and skills they like and do attend (NL4; SP3). There is interest in learning the organisation, preparing for house visits, dealing with clients' reactions, grief or emotional management (SP3). For instance, a volunteer states that she does not know of any place to follow training on dealing with older persons. Still, she thinks it would benefit her and other volunteers if the organisation offers it to them (BE1). Volunteer BE3 is interested in psychology training or how to react to other people. At the same time, an informal caregiver (SP4) would like more knowledge to understand ageing and age-related pathologies and distinguish between minor illness, mood problems, and potentially important problems.

A volunteer states that it is important to pay attention to the dreams of older adults, which might be addressed in training for volunteers (BE1). Being able to listen is important to volunteers. Talking for an hour is easy, but listening until the person has said everything they want without interrupting them can be challenging.

"Volunteers sometimes need to ask questions to get the people to talk, but just listen when the other person is talking. They do not need questions or discussions. They need to be able to empty their thoughts." (BE1)

Recurrently, informal and volunteer caregivers stated that being sensitive, feeling what others need, and being human can't be learned; it's a natural attitude that people have or don't have (BE1, BE5, D2 IT5). According to volunteer BE1 the critical components of giving care and knowing what people need can be taught, but seeing and feeling what others need is something that cannot. Similarly, a professional (D1) wonders - just like a volunteer/informal carer - whether empathy can be learned.

Many volunteers say to learn mainly by doing (and reflecting); they find continuous support by a coordinator very helpful (SP3) as well as having intervision with peers (BE5). An informal caregiver (NI5) states that, as a form of self-care, she'd value having the opportunity to tell her story to other (professional) caregivers, suggesting a form of colleague-intervision. In the same vein, a professional states that volunteers need continuous, cross-sectional training in emotional management (SP5). According to this professional, a more continuous pedagogic effort to challenge the ageism of volunteers is required, which is a rare reference to enhancing the cultural dimension of caregiving competences (SP5).



6.2.6 Quality of caregiving: organizational and cultural prerequisites

A limited number of times respondents referred to organizational or management issues. No further accounts were given on the more general level of national or cultural issues that might affect the quality of caregiving, except one on 'ageism'. Overall three main organizational issues came to the fore: setting limits to the tasks and responsibilities of volunteers and informal caregivers, providing professional autonomy, and the role of care organizations in their care network.

Limiting tasks and responsibilities of non-professional caregivers Respondents mentioned that older clients regularly draw a rather heavy appeal on volunteers and informal caregivers. While this may give a high workload and emotional stress, they find such an appeal hard to resist and expressed that the care organization might help them to deal with this better. An informal caregiver mentions that her mother wants more help every time she's visiting her and wants her to stay longer. This makes her feel bad because of the continuous feeling that it is not enough (SP4). Both informal and volunteer caregivers sometimes need others – that is to say the care organization - to set limits to the demands of their relatives/clients (BE3, BE5, SP4). As another informal caregiver states: "An external authority can also help the mom to accept that decisions are being made for her. She does not always listen to her children." (BE5)

Providing professional autonomy to caregivers

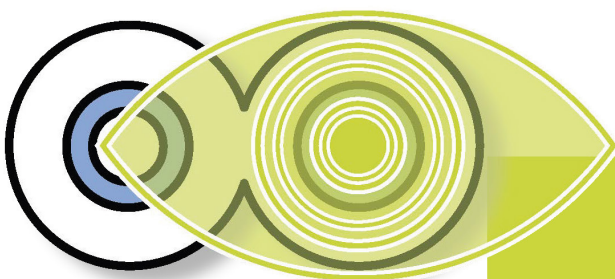
While on the one hand caregivers might need help to limit their tasks, on the other hand, they sometimes need more space. As a volunteer expresses: "It's also important to have the authorisation to help people" (BE3). She explains that she always has to listen to her coordinator and that this is sometimes restricting her to help people.

One care organization explicitly tried to promote the engagement and autonomy of volunteers and facilitated – and supported - new proposals from volunteers and the community (SP5).

Also on professional level initiatives exist, like to let staff work from their expertise. As an involved professional states:

"This also means that new staff can contribute with their own strengths and skills, instead of having to take on the activity that is currently in short supply." (D1)

In this case, there is hardly a fixed program to which staff has to fit in, so staff is always qualified for the activities that they are doing and need hardly training for such activities.



On a more general level trust is mentioned as a prerequisite for good care. While for informal caregivers “having confidence in the care staff is important” (#NL3), it is evenly important for professional caregivers to be supported by their management and their colleagues (#NL4) in doing their daily work well.

The role of care organizations in their care network

Also, care organizations may be hampered by responsibilities they have to adhere to. While for example the issue of ‘ageism’ is largely out of control for a care organization, being a societal problem, it does affect daily care conditions.

A professional caregiver states that the negative image of older people that exists in society, and also affects caregivers, makes older clients behave accordingly:

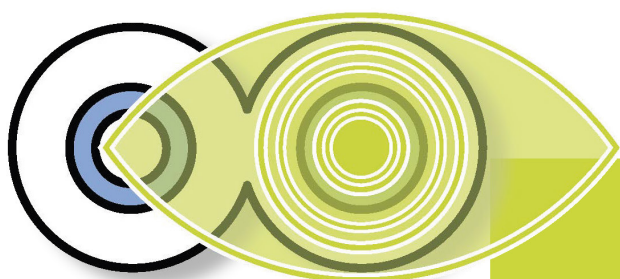
“That’s the way they are because that’s the way we look at them, so change the way we look at them and many things will change.” (SP5)

Changing the view that care organisations have on older people – for example through community-based interventions (SP5) - also may change the concrete conditions of older clients.

Sometimes society also may have an inappropriate appeal to care organisations. One professional (NL6) states that their project sometimes is used by other organizations to refer older people with heavy social problems like psychiatric issues. She finds it hard to refuse the psychiatric clients but isn’t able to address their problems. This is too much for volunteers who are trained to address loneliness by listening and being there for a client. The needs of older adults are often different than the referring organization thinks, and sometimes also hard to detect in an intake interview. In such cases working in a care network is crucial to refer clients properly to other forms of care, also if care organizations are frequently confronted with care issues that are not within their competences (NL6, SP5).

6.3 Summary

The outcomes on competences and skills of informal, volunteer and professional caregivers showed no substantial differences between the five countries. The issues studied thus appeared to be somewhat generic in care for older persons. Four main themes came to the fore in the data.

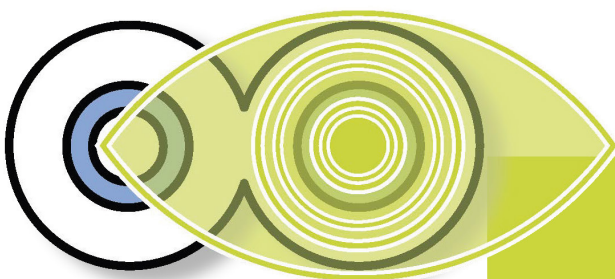


First, the task performed by caregivers generally can be characterised as very broad, ranging from health care tasks to transportation and administration. This is particularly striking for informal caregivers, partly because they are very much involved in a 'meaning role' with their relatives. In general, a 'social role' is more prevalent in caregivers, also as a role that inevitably comes along with more practical forms of caregiving. Volunteers have a significant contribution here. Professionals add to this their organisational position and generally stress the importance of 'offering a perspective on life' to older adults.

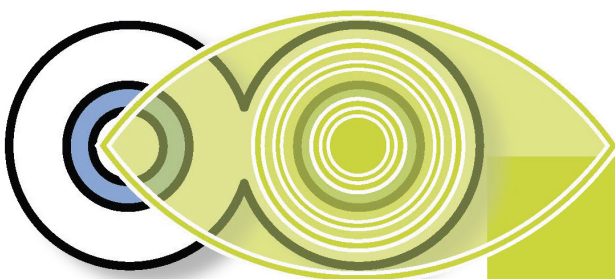
Second, regarding attuning to the clients' needs, caregivers aim to tailor care to the individual. Many states that a caregiver needs a skill to "sense" what people need, which may be hard to train. Informal caregivers stress the importance of knowing the older person and his/her life history. Also, professionals seek to connect to the clients' biography to offer perspective in life. Acknowledging wishes and dreams is important, and respecting and creating 'the natural' feeling surrounding informal help every day. A salient and recurring finding was the importance of matching both clients' and caregivers' capabilities and needs as a prerequisite for good care.

Third, while this chapter distinguished eleven dimensions of competences and skills (one inductively derived from the data), the caregivers in our study seem to stress seven of them: relational, empathic, hermeneutic (sensitivity), self-care, intervention, empowering, and communicative competences. Less often recognised are aspects of moral, narrative and role competence. Cultural competences were not mentioned, meaning they were not specified in terms of cultural or group differences. It is important to consider that the different competences overlap and that aspects of specific dimensions may be present in the outcome of other dimensions. Overall, it was found that volunteers generally emphasise being empathic, relational, and hermeneutic (sensing what is going on) and self-care (putting limits to demands). Informal caregivers showed a similar pattern, stressing certain aspects like adapting oneself to the older adult and creating a trustful meaning connection. Professionals emphasise communicative aspects, intervention/empowering competences, and role competence (organisational skills, flexibility, networking).

Fourth, concerning improving competences and skills, caregivers seemed to doubt whether empathy and "really seeing and feeling what others need" can be learned. On the other side, they demonstrated a clear interest in education. They attached importance to learn more about organisational issues, fundamental health issues, and (particularly, volunteers) psychological and relational competences (like really listening and paying attention to 'dreams'), having supervision, utilising colleague-intervision meetings, and learning from colleagues in practice.



Finally, the main organizational and cultural prerequisites for care quality that caregivers reported, related in different ways to (putting) 'limitations' to care. On the one hand, volunteer and informal caregivers tend to be overcharged by their older clients and need formal limitations set by the care organization to withstand this (emotional) pressure. On the other hand (all) caregivers sometimes need more autonomy in doing and organizing their job to provide adequate care. This requires trust among caregivers and trust provided to them by their management. In addition, also care organizations sometimes are overcharged by other organizations or limited in providing care because of their formal competences. Quality of care at this level seems to require a care network in which clients can be properly referred to other organisations.



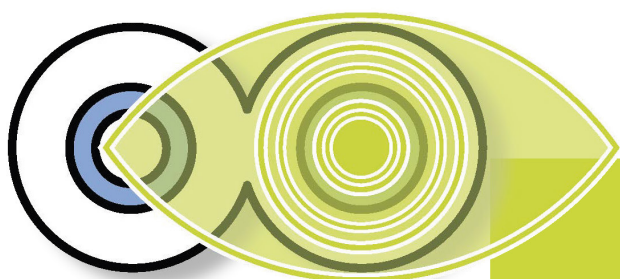
7. Conclusions

7.1 *Conditions for person-centred care*

Vulnerable older people need help and support from formal and informal caregivers. This support needs to take a holistic look at the person and respect their uniqueness (Åberg et al., 2020). Older adults' needs are adequately served if they are seen as people with potentials, talents, and social and meaning needs. To attune to their patients' needs, caregivers must dispose of communicative skills to get beyond the superficial conversation. They also need sensitivity to changes in older adults' potentials, talents, and social and meaning needs due to generativity, ego-integrity and gerotranscendence (Tornstam & Tornqvist, 2000).

The empirical findings of this study illustrate that actually 'seeing' the older clients is the main issue of which professional caregivers and volunteer and informal caregivers are very much aware. All the seventeen interviewed caregivers, connected to care projects from each of the five different countries, portray a care practice in which they take an extensive role on a practical level and a social and meaning level. These roles appear to be highly interconnected, due to which also practical tasks of a volunteer entail important social consequences for clients. Informal caregivers, often relatives of the older adults, may have an essential role in recognising and addressing meaning needs due to their relationship. But it applies as well to professional caregivers that knowing the person and his/her life experiences is crucial to attuning care to specific, individual needs. A central theme running through all caregivers' accounts is that matching the needs and capabilities of both clients and caregivers (and caregiving tasks) is a requirement for sensitive and well-tailored care.

Person-centred care also makes demands on the conditions in which caregivers work. The level of autonomy and competence that caregivers have affects the quality of care. The life quality of older people who need care benefits from structures that acknowledge dependencies and vulnerabilities and help people navigate their lives with them in a meaningful way (Bødker et al., 2019). Caregivers and relatives stepping in to take over feel like deprivation of the opportunity to manage one's own life and make choices, which impedes one's sense of dignity and self-worth.



Competence development and sufficient autonomy can contribute significantly to a better quality of care (From et al., 2013). In contrast, several factors form an obstacle against developing the required attitudes and competences for person-centred care, for instance, work pressure or a lack of opportunities for professional development (Chang et al., 2020; Van Stenis, Van Wingerden & Kolkhuis, 2017). Meeting the patients' needs requires several conditions, such as a manageable workload, satisfying contacts with colleagues, sufficient autonomy to organise their work, room for self-development, shared values, and personal and team development (From et al., 2013). Professional pride comes from a high level of satisfaction with work and recognition. It relates to knowledge and ability, self-confidence, commitment, moral courage, meaningfulness, and independence (Zegelin, 2021).

7.2 Summary of required competences for caregivers

The interviews with caregivers in this study confirm the importance of distinguishing subtle dimensions of care competences and skills. An additional dimension - 'role competence' – was inductively derived from the data and accomplished the ten dimensions derived from the literature review. Professional caregivers particularly mentioned role competence in terms of organisational skills, expertise, and networking abilities. However, similar competences could be 'translated' to the realm of volunteers and informal caregivers. Furthermore, each type of caregiver seems to have its accents and focal points within this multidimensional space of competences.

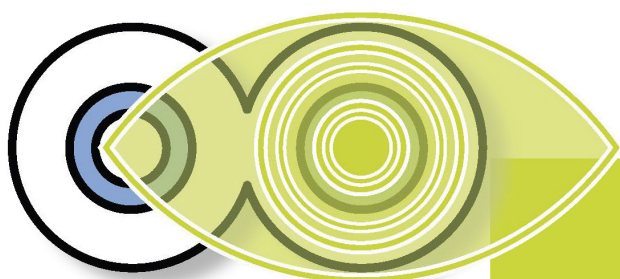
Below, the competences and skills (formal and informal) caregivers need to 'see' older adults' potentials, and their social and meaning needs are summarised.

2.1) Relational competences

refer to traits that allow caregivers to interact with their clients effectively. Relational competences include responsiveness, connecting, and attunement. Relational competences are overarching and encompass many of the other competences.

2.2) Communicative competences

refer to the ability to communicate in a given communicative setting. Communicative competences include dialogical competences, observational skills, skills to convey and interpret messages and negotiate meanings in a specific context, and social knowledge required for social interaction.



2.3) Empathic competences

refer to the ability to perceive and relate to another person's situation from an emotional point of view or mentally construct the experiential world of the other. Empathic competences include perspective-taking (both cognitive and affective) and compassion.

2.4) Moral competences

refer to recognising moral dilemmas, conflicting values and perspectives, balancing values, and moral deliberation. Moral competences include recognising the moral dimension of situations, moral deliberation skills, awareness of values, personal integrity, and wisdom.

2.5) Cultural competences

refer to the ability of a person to effectively interact, work, and develop meaningful relationships with people of various cultural backgrounds and awareness of stereotypical views. Cultural competences include sensitivity to the beliefs, customs, and behaviours of people from different groups (e.g. race, class, gender, sexuality).

2.6) Hermeneutic competences

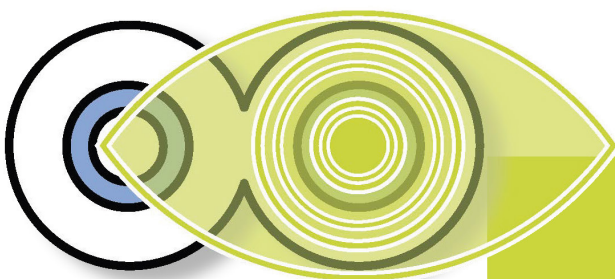
refer to interpreting situations and responding to them by giving meaning to the situations. Hermeneutic competences include sensitivity for meaning issues, recognising layers of meaning in patient's stories, listening to the 'question behind the question'.

2.7) Narrative competences

refer to the ability to identify, listen to, understand, be touched by and act on the stories that one is exposed to. Narrative competences include sensitivity for (life)stories, skills to take in and understand these stories, being co-narrator if required, preventing narrative foreclosure.

2.8) Empowering competences

refer to the ability to facilitate and support people to use their skills and talents to benefit their wellbeing. Empowering competences involve recognising other people's strengths and helping them put these strengths to use.



2.9) Intervention competences

refer to the ability to notice and interpret a problem and select an appropriate intervention. Intervention competences include finding creative and tailored solutions for specific problems.

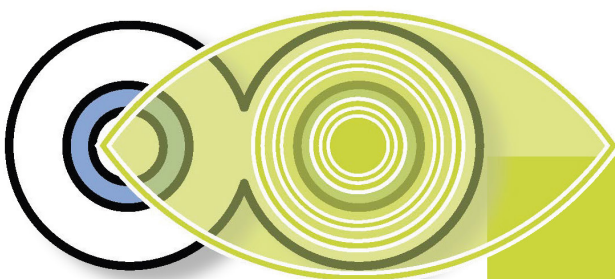
2.10) Self-care competences

refer to the ability to take responsibility for their health and wellbeing. Self-care competences include keeping both the body and mind fit and healthy, self-reflection, self-knowledge, awareness of personal boundaries and limitations.

2.11) Role competences

refer to the ability to take on a specific role, to know how to act appropriately in this role, and to decide whether to accept this role. Role competences include guarding boundaries and one's health, social, emotional, and practical needs.

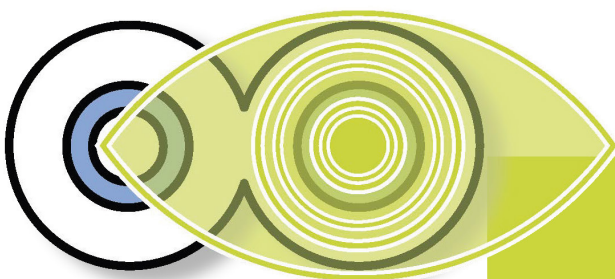
By definition, all the different dimensions show overlap, but the data did indicate relatively unique patterns of competences for each caregiver. Learning more about such patterns of competences is of great importance for creating optimal matches between the needs and capabilities of the caregiver and the care receiver. As shown in this study, such an optimal matching appears to be the primary condition for providing person-centred care that is well-tailored to the clients' social and meaning needs.



Appendix I - Several roles of professionals

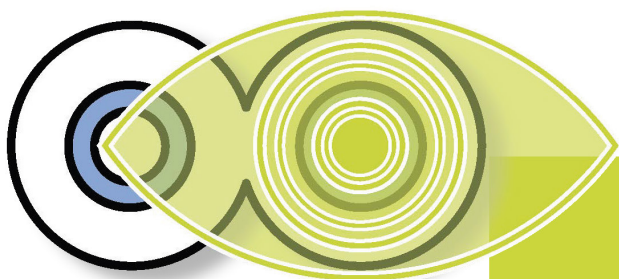
To improve the quality of living and dwelling in residential care, Demaerschalk and Switsers (2017) developed a practical guide in which they distinguish between several roles that the professional can fulfil: being a mentor, monitoring living, guiding activities, including the neighbourhood, being a cultural coach and a reference person. These roles can help caregivers get to know people and facilitate their wishes and needs: their purposes and preferences, how they want to spend their time, and how they want to maintain relationships with others. Where possible, the older person remains in charge, and the caregiver has a facilitating and supporting role. There is a strong focus on participation and citizenship in the context of the care residence.

- Competences that caregivers need to fulfil the mentor role are empathy skills, trust-building skills, relational skills, autonomy-supporting skills, listening skills for distilling important points from people's stories, social and networking skills.
- Competences that caregivers need to fulfil the role of monitoring living are: supporting a positive self-image of residents, stimulation skills to improve participation and wellbeing, sensitivity and abilities for enhancing a pleasant atmosphere in the facility, observation skills, creativity skills to find solutions and improve the shared living.
- In their role of guiding activities, caregivers need creative skills to create a tailor-made program of activities, organisational skills, and collaborative skills to work together with other caregivers, volunteers and family.
- Competences that caregivers need in their role of including the neighbourhood are networking skills, building bridges between the neighbourhood and the residential facility, inspirational skills, seeing opportunities, engaged in presenting a positive and attractive image of the facility to the outside world.
- In their role of cultural coach, caregivers need networking skills, creativity skills, collaborative skills, project-based working, using arts-based interventions as a source of personal growth and social connectedness.
- Competences that caregivers need in their role of reference person are: sensitising staff members to the needs of older people and the importance of quality of care, quality management skills, dialogical skills, intercultural skills to facilitate open dialogue between staff members with different (cultural) values, stimulating innovation and change processes. (Demaerschalk & Switsers, 2017).



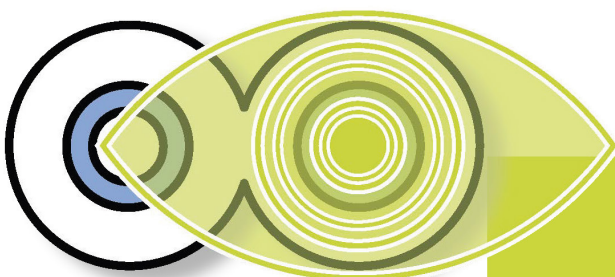
Appendix II - Topics of the coding scheme

- 1.) Tasks (which): what kind of assistance/help/care tasks do they perform?
 - **Practical, social, meaning, moral aspects**
 - **Task limitations (inductive)**
- 2.) Attuning to needs (how): how do they tailor care to clients needs?
 - **Social and meaning needs**
- 3.) Competences and skills needed (which): what assets are needed for good care?
 - **Relational (incl. responsiveness, connecting, attunement)**
 - **Communicative (incl., dialogical, observation)**
 - **Empathic (perspective taking, cognitive and affective, compassion)**
 - **Moral (recognising moral, balancing values, moral deliberation)**
 - **Cultural competences (reflecting on stereotypical views)**
 - **Hermeneutic (sensitivity for meaning issues)**
 - **Narrative (sensitivity for stories, co-narrator, intake)**
 - **Empowering (recognising strengths and helping put them into use)**
 - **Intervention (problem-solving; finding tailored solutions for problems)**
 - **Selfcare (self-reflection, self-knowledge, personal limitations)**
 - **Role (planning skills, organisational skills)**
- 4.) Improving competences and skills (how): in what manner can they be enhanced?
 - **Social and meaning competences**
- 5.) Management and organisational quality (what): what is required to enhance the quality of caregiving?
 - **Policy, facilities, recruitment, training, supervision, support staff capabilities (inductive)**
- 6.) Specifics national or cultural issues (which): what affects the quality of caregiving?
 - **national policy/cultural setting**
 - **related (cultural) competences**



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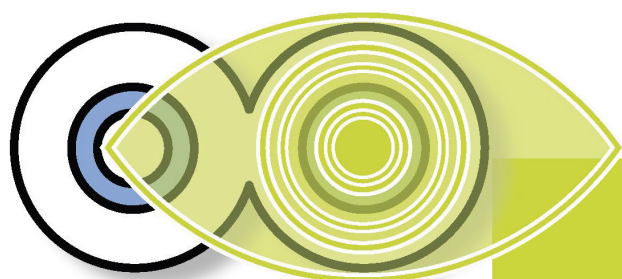
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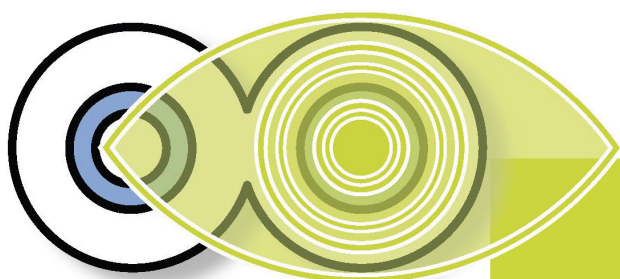
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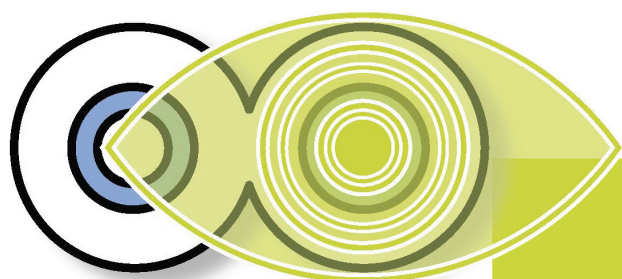
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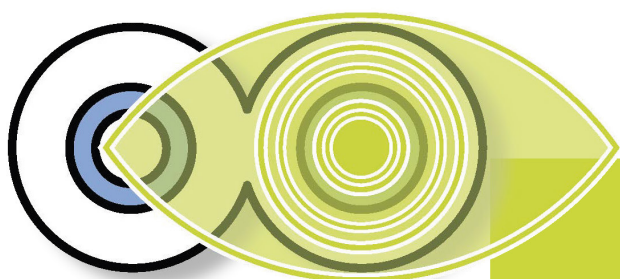
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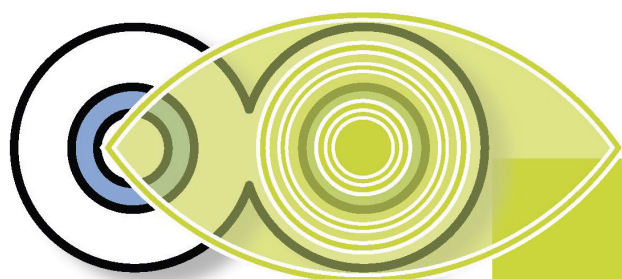
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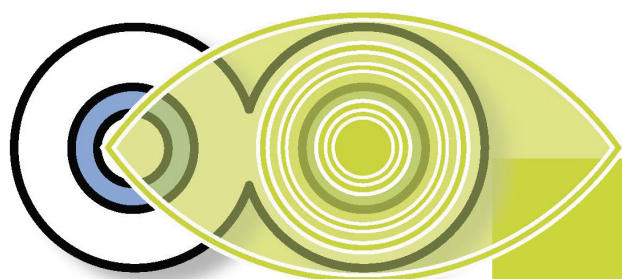
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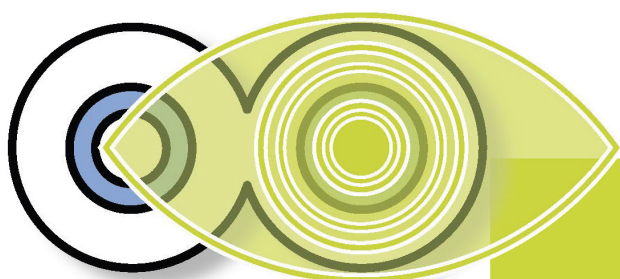
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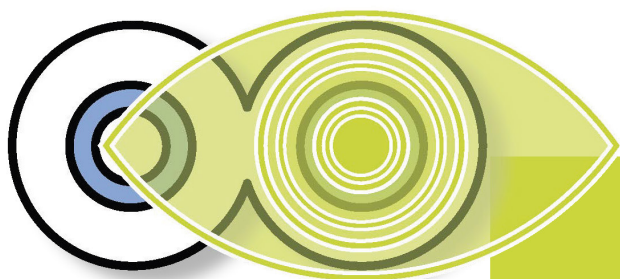
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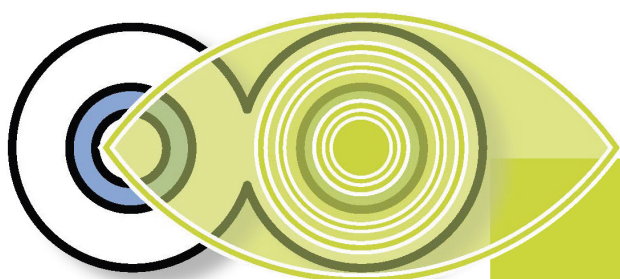
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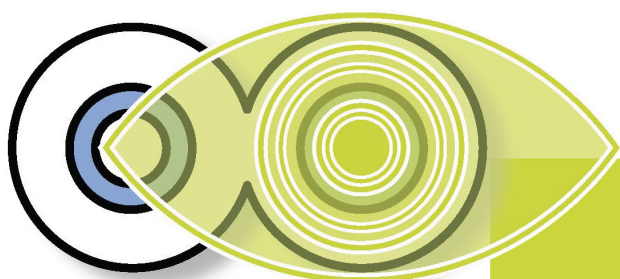
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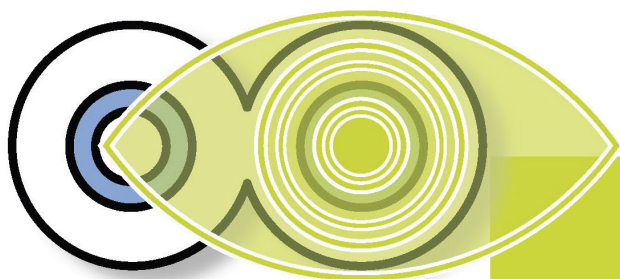
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