Knowledge Profile of Professional Health Carer

In the Continuity of Care

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Lifelong Learning Programme

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Introduction

The knowledge profile identifies the skills that professionals health carers should have in order to provide assistance to their patients taking into consideration all aspects that affect their conditions.

The knowledge profile has been developed on the basis of the research activity conducted by each Heppy project partner in the European countries involved. The research activity focused on: analysis of publications available at national level on the topic; analysis of case studies of health assistance; identification of best practices among the case studies.

All information have been presented in National Reports and then analysed in a comparative way in a Transnational Report presenting common tendencies and main differences among the partner countries.

The methodology used to create the knowledge profile is based on the "knowledge management" approach adopted by Gradenigo Hospital in a previous European project (to see www.fadgradenigo.hippocrates.it)

The main **Steps that have been developed for the elaboration of this profile are:**

- Description of the profile process according to Knowledge management methodology
- Internal validation by experts panel of HEPPY Project. The experts who have been involved are: Riziero Zucchi, Parental Pedagogy Expert (IT); Augusta Moletto, Parental Pedagogy Expert (IT), Lorenza Garrino, Researcher Nusing Science, University of Turin (IT); Marisa Toso, Nursing Coordinator of Continuity of Care Service, Gradenigo Hospital (IT); Carla Bena, Director of Home care Service, ASLTO4 (IT); Claudia Rizzati and Annamaria Cornero, Nursing Coordinators of Homecare Service, ASLTO4 (IT);
- External validation by all partners of Heppy Project: Jacek Kabziński, Academy of Humanities and Economics in Lodz (PL); Flor Gutierrez, CECE (ES); Marián De Villanueva, CECE (ES); Adina Pescarovici, CECMA (RO); Simona Musteata, CECMA (RO); Tania Re, CIPES Piemonte (IT); Sabrina Grigolo, Gradenigo Hospital (IT); Aldona Droseikiene, LMSU (LT); Laurynas Drosika, LMSU (LT); Lorenzo Martellini, Pixel (IT); Omar Zein, Projectize (UK); Stefania Hrivnakova, TRANSFER Slovensko, s.r.o (SK).

The phases of knowledge management methodology are:

- To analyse the references related to knowledge profile and job description
- To list knowledge and skills
- To check and validate the list of knowledge by the experts and, then, by the project team
- To classify the validated knowledge and skills list
- To create and validate the knowledge and skills profile

For more information about the methodology of knowledge management, you can see the website of Hippocrates Project http://www.hippocrates.fadgradenigo.it/

The knowledge profile of professional health carer in the continuity of care is the main reference for the development of the training package for health professionals willing to develop an holistic approach with patients and to apply the principles of Narrative Medicine, Parents Pedagogy and ICF.

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Transversal skills

- Being able to explain the concepts of Health and Illness in different cultures.
- Being able to describe the history of both social welfare and health care system.
- Being able to describe the health needs of the population
- Being able to describe the environmental context and the cultural and socioeconomic status of patients and families
- Being able to define the relational circumstances among patients, families and professional workers
- Being able to act according to the laws, rules and regulations that affect the professional, criminal and civil responsibility which is applied to the role of the case manager.
- Being able to describe the ethical and deontological aspects.
- Being able to advice families and patients about the land services and hospital services in the healthcare field, in the social and educational field.
- Being able to acquire knowledge and skills of the family and relatives with relation to the ICF personal factors information: the patient's life story, aspect of life, relationships, habits, activity and participation in the normal life.

Planning and realization of the Care Programme

- Being able to identify the assistance needs.
- Being able to estimate the patient's aspect of life and the practicability.
- Being able to identify the caregiver for supporting and sharing the planning assistance.
- Being able to make plans and paths which are personalized flexible and adjustable as time goes by
- Being able to plan interventions.
- Being able to estimate the effectiveness of interventions.
- Being able to identify the skills for improving and developing the existing family resources.
- Being able to respect the family in the therapeutic education programme.
- Being able to reach the family culture in a respectfully way (habits by learning from it)
- Being able to apply methods and tools of the system quality management within the Welfare Continuity in hospital and territory.

Planning of Health and social care services and link with territorial resources

- Being able to set up the procedures for the Local services or for the areas that take care of the "underprivileged people" from 0 to 65 years old or older than 65 (minors at risk, disabled persons, drug-addicted, heavy drinkers, people with AIDS or cancer, people with psychiatric troubles, the chronically sick etc…)
- Being able to describe the hospital fact, the Social services and the relation with the territory.
- Being able to apply security management methods and tools at home.
- Being able to establish an equal level relationship with the family to stimulate the resources within the health education programme

Professional development

- Being able to manage the skills (*knowledge management)* that aim to improve the health system.
- Being able to apply methods and tools in order to look for the best evidences of effectiveness.
- Being able to estimate the interventions on the basis of process and results indicators.

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- Being able to apply methods and tools in order to update activities following the scientific knowledge and the new technologies.
- Being able to manage a proper and equal relationship with the family.

Communication and helping relationship

- Being able to use techniques of help relationship as counselling, therapeutic education, the awareness of the meaning of coping, adherence and in general the way to support and reassure the weak person.
- Being able to listen, mediate and communicate in an effective manner with the patient and his family.
- Being able to orient the person in the field of the territorial resources
- Being able to identify and contain emotionally stressful situations.
- Being able to apply methods and tools to support and train the caregivers how to handle people at home.
- Being able to make a therapeutic education programme starting from the patient's story, according to the Methodology of parents' pedagogy.

Team work

- Being able to apply tools to coordinate the health and social team
- Being able to apply tools for the supervising and the check of the performed activity
- Being able to work in group or as a team
- Being able to put themselves into question
- Being able to take their own responsibilities and understand their own limitations.
- Being able to apply tools for the collaborative e cooperative learning
- Being able to learn with the group and from the group
- Being able to include the family and the relatives improving their knowledge and skills.

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