Migration Partnership Facility

Common Competency Framework for Healthcare Assistants in Long-Term Care

Reference framework to support training alignment and recruitment

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About

This publication presents the Common Competency Framework for Healthcare Assistants in Long-Term Care, developed under the ***Building Competency and Recruitment Pathways for Long-Term Care in Europe*** (B-Care) project, funded by the European Union through the Migration Partnership Facility.

B-Care aimed to support five EU Member States (Austria, France, Greece, Ireland, and Malta) in addressing workforce shortages in the long-term care sector by developing a common competency reference for healthcare assistants and exploring the basis for labour mobility pathways with EU Talent Partnership countries, including Egypt, Morocco, Tunisia, Bangladesh, and Pakistan.

The CCF is a reference framework that identifies competency areas broadly relevant to healthcare assistants in long-term care and compares their presence across the training frameworks of the five EU Member States. It aims to make existing areas of convergence more visible and usable, providing a basis for training alignment and recruitment preparation. It does not create a European qualification, curriculum, recognition mechanism, or legal pathway for labour market access.

The Migration Partnership Facility (MPF) is an EU-funded initiative supporting the external dimension of EU migration policy. It aims to strengthen dialogue and cooperation on migration and mobility between EU Member States and partner countries outside the EU. The MPF is implemented by the International Centre for Migration Policy Development (ICMPD).

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Content

1. Introduction and rationale

This document presents the Common Competency Framework for Healthcare Assistants in long-term care, developed under the Building Competency and Recruitment Pathways for Long-Term Care in Europe (B-Care) project, funded by the EU through the Migration Partnership Facility (MPF).

The B-Care research project focused on five EU Member States (EU MS): Austria, France, Greece, Ireland and Malta, while exploring the relevance of the framework for labour mobility cooperation with EU Talent Partnership (TP) countries, including Egypt, Morocco, Tunisia, Bangladesh, and Pakistan.

The Common Competency Framework (CCF) identifies competencies broadly relevant to Healthcare Assistants (HCAs) in long-term care (LTC) and compares their presence across the training frameworks of the five EU MS reviewed.

The framework should be read as a reference tool. It outlines the main competencies that HCAs are expected to demonstrate in practice, and can support, for example, curriculum mapping, profile clarification, and the development of future recruitment or assessment tools. It does not establish recognition mechanisms, legal access to labour markets, or operational mobility pathways.

> *Training requirements, job titles and recognition arrangements for this occupational profile vary considerably across systems.*

The CCF is situated in a context of persistent workforce shortages across European LTC systems. These pressures are driven by demographic ageing, limited domestic supply, and difficulties attracting and retaining care workers.[1] HCAs represent an essential workforce segment in LTC, providing direct support with activities of daily living and contributing to continuity of care in residential, institutional, and home-based settings.[2] However, training requirements, job titles, and recognition arrangements for this occupational profile vary considerably across systems. These differences make it difficult to compare competencies across countries, align training content, and prepare recruitment cooperation with partner countries where training systems and occupational profiles may differ.

Compared with nurses and other regulated health professions, the role often has lower formal training requirements and can be a practical entry point for training alignment and labour mobility cooperation. Unlike nurses, who benefit from EU-wide automatic recognition, HCAs lack a common EU-level mechanism for comparing or recognising skills and qualifications acquired abroad. While many tasks performed by HCAs are broadly similar across EU MS, qualification structures, training requirements and recognition arrangements differ significantly. This leaves employers, training providers and public authorities with limited shared reference points when reviewing HCA training and experience across systems and can create practical barriers to international mobility, recruitment preparation and training alignment.

1 *Healthcare and long-term care workforce - Demographic challenges and the potential contribution of migration and digital technology*, Grubanov Boskovic, S.(editor), Publications Office, 2021, https://data.europa.eu/doi/10.2760/33427

2 There is no single, uniform EU-wide definition of HCA, although there is a consensus on core tasks that HCA are expected to perform.

This issue is increasingly relevant in the context of wider EU policy discussions on the care workforce. The 2022 European Care Strategy highlights the need to improve access to affordable, high-quality long-term care and to address workforce challenges in the care sector. The more recent 2026 Skills Portability Initiative, which aims to improve how skills and qualifications are used and accepted across EU MS through greater transparency and digitalisation, also points to the importance of making skills more visible, comparable, and transferable across borders. These developments create a supportive context for practical tools that help clarify competencies across systems, without replacing national recognition or regulatory procedures.

Existing frameworks, such as the International Standard Classification of Occupations (ISCO) and the European Skills, Competences, and Occupations (ESCO), provide useful reference points for describing occupations and related skills. They do not, however, resolve the practical question of how HCA competencies are taught, evidenced or compared across training and recruitment systems. A worker may be classified in a broadly similar occupational category, yet employers and public authorities may still lack a clear basis for understanding whether their training and experience align with the expectations of a specific care setting.

Why a competency-based approach

Because the HCA role is not regulated and has no single EU-level definition, comparability cannot rely on legal or occupational classifications alone. A functional approach is required, based on what HCAs are **observed to do in practice**, and on the competencies that appear consistently in training curricula and employer expectations.

These challenges are compounded when recruitment involves candidates from outside the EU. Employers may have limited information on how candidates were trained, which competencies were covered and where additional preparation may be needed. Training providers in partner countries may also lack a clear reference point to assess whether existing curricula align with competency expectations across EU LTC systems. A common framework is therefore relevant both for intra-EU comparability and for structuring ethical and sustainable international recruitment pathways.

Because the HCA role is not regulated and has no single EU-level definition, comparability cannot rely on legal or occupational classifications alone. A functional approach is required, based on what HCAs are observed to do in practice across different national systems and on the competencies that appear consistently in training curricula and employer expectations, regardless of how the role is titled or regulated. The comparative analysis conducted under B-Care indicates that important areas of convergence already exist across the five EU MS training frameworks reviewed, albeit defined differently or without a standardised language. What is missing is an explicit reference point that makes that convergence visible, understandable, portable and usable.

The B-Care project responds to this gap through **a common competency framework that focuses on competencies rather than qualifications**. The CCF identifies areas of knowledge, skills and behavioural standards that are broadly relevant to HCAs in LTC and compares their presence across the reviewed training frameworks. This comparison reveals substantial convergence: approximately 60% of the identified competency elements are present across all five reviewed frameworks. By documenting this convergence and presenting it in a structured, comparable format, the CCF serves as a benchmark for what HCAs may be expected to know, do and demonstrate in practice across different systems.

This approach allows the CCF to support alignment with agility without imposing uniformity. For training providers, it can help compare existing curricula against a shared competency reference and identify possible gaps. For employers and public authorities, it can help clarify the expected HCA profile across different systems. For future mobility cooperation, it can inform the design of bridging support, recruitment guidance and assessment tools, while leaving recognition, candidate selection and labour market access decisions to the competent authorities and employers.

2. Methodology: from fragmentation to structured convergence

The CCF was developed through a comparative and consultative process designed to identify areas of convergence across national systems rather than to impose harmonisation. The approach draws on three phases, ensuring that the CCF reflects both formally documented expectations and operational realities, despite differences in terminology used in each national context analysed.

1. The project conducted a comparative analysis of the national training-related frameworks regulating the HCA roles in the five EU MS in scope (listed in Annex 3: Comparative overview of HCAs competencies across target EU MS). These documents are of different legal and institutional natures, such as national training and qualification frameworks (Austria, France), outcome-based qualification standards (Ireland, Malta) and vocational programmes (Greece). The comparison was deliberately conducted at *competency* rather than *qualification level to ensure* that all documents could be mapped against the same grid and aligned accordingly. The review was complemented by reference to terminology used in the ESCO and ISCO classifications, as well as the 2022 European Care Strategy mentioned above.

2. A review of prior EU initiatives on HCA competencies and occupational profiles was undertaken. Building on the comparative analysis above, the CCF structure reflects already existing terminology and categorisations developed under the 2016 EU Study on Core Competences of Healthcare Assistants in Europe (CC4HCA)[3] and the Eldicare 2.0 Project.[4] CC4HCA's finding that HCA competencies converge around three competency domains provided the basis for the CCF's tripartite structure of knowledge, skills and behavioural standards, and several of its competency elements were used as benchmarks against which the CCF was cross-checked. Eldicare 2.0 confirmed the relevance of a competency-based approach. While both projects focus on intra-EU mobility (not overseas recruitment), they offered valuable insights that can lead to faster labour market entry and upskilling, while reducing costs for workers and employers. A key barrier identified by both projects is the uneven recognition of credentials across EU MS for this entry-level occupation, which is in high demand, offers career progression prospects, and requires lower training needs. These initiatives demonstrate that the feasibility of competency convergence has already been tested.

3 CC4HCA attempted to assess the feasibility of standardising competencies, with convergence on three core ones: knowledge, skills and behavioural standards

4 Eldicare2.0 aims to upskill and reskill LTC professionals in elderly care (who fall under the HCA definition), to be able to meet the growing needs of the ageing population. One of its main activities is to upgrade the existing and emerging Occupational Profiles with up-to-date, essential skills and competencies for elderly care practitioners.

3. A stakeholder consultation process allowed to refine the framework together with LTC providers and validate it through consultations with different stakeholders, including employers, training providers and public authorities from both EU MS and Talent Partnership countries. These consultations, held through several online interviews, an international in-person workshop in Malta in March 2026 and an official visit to Ireland in May 2026, ensured that the CCF reflects operational realities and is relevant for both training and recruitment contexts. Engagement with Talent Partnership country representatives focused on testing the relevance of the draft framework for sending-country training systems and sense-checking its applicability to future labour mobility cooperation.

This approach has shown that, despite differences in regulation, training duration, titles, terminology and task allocations, a consistent core of competencies emerged. This convergence suggests that alignment is not an artificial harmonisation exercise but can build on already shared practices. The value of building a CCF lies in providing common language and reference points for cross-border understanding.

3. The common competency framework explained

Structuring competence across three domains

The CCF is organised around three mutually reinforcing competency domains: knowledge, skills and behavioural standards. In this document, competency domains are understood as broad categories that group related competencies. This tripartite structure reflects existing practice and ensures that competence is not reduced to technical tasks alone but also includes applied skills and behavioural standards alongside foundational knowledge.

Within these three domains, the framework identifies 10 competencies. Competencies are understood as distinct capabilities required for effective performance in the HCA role.

These competencies are further broken down into 53 competency elements, which provide a more detailed articulation of what HCAs are expected to know, do or demonstrate in practice. The full list of competency elements is set out in Annex 3: Comparative overview of HCAs competencies across target EU MS.

Knowledge	Skills	Behavioural Standards
The theoretical and factual understanding supporting practice (e.g. infection control, public health basics, legal frameworks, ethics, ICT use). This competency domain contains:	The ability to apply knowledge in practice (e.g. observation and reporting, assistance under supervision, monitoring vital signs, supporting daily living). This competency domain includes:	Professional conduct, relational competencies, and ethical behaviour (e.g. dignity, teamwork, emotional support). This competency domain includes:
4 competencies **25 competency elements**	**3 competencies** **15 competency elements.**	3 competencies 13 competency elements.

Table 1 below presents an overview of the three competency domains and the respective competencies.

Table 1. Competency domains and competencies of the common competency framework

Knowledge	Skills	Behavioural Standards
Personal care	Observation and Reporting	Support for dignity & comfort
Infection prevention & hygiene control	Monitoring vital signs	Collaboration with nursing/ medical staff
End-of-life/Palliative Support	Preparation for procedures (under supervision)	Emotional/Psychological support
Dementia/ elderly care support		

Reading the framework: competencies, not tasks

Most HCAs perform basic care, support daily living activities, and assist healthcare teams, but roles vary widely across EU MS in titles, education, tasks, and regulations. The CCF identifies and groups competencies rather than specifying tasks. This reflects the fact that task allocations and supervision arrangements vary across healthcare systems and evolve over time. The framework, therefore, focuses on what HCAs are expected to know, do and demonstrate, rather than prescribing how tasks are performed in specific contexts.

The CCF can also be understood in relation to existing instruments such as the Common Training Frameworks (CTFs). The CTFs are formal EU tools that support the recognition of professional qualifications required to enter a regulated profession in EU MS, based on an agreed set of minimum knowledge, skills and competences. The HCA role is not regulated at the EU level, does not benefit from automatic recognition under another system and therefore falls outside the CTF mechanism.

The CCF does not create automatic recognition or harmonise national education systems. Rather, it provides an initial building block, a common position, and a reference that organises areas of knowledge, skills and behavioural standards broadly relevant to the HCA role across different systems.

Comparative overview: convergence and variation across EU Member State training Frameworks

Table 2 presents a comparative overview of how the 53 CCF competency elements are reflected in the training frameworks of the five EU MS reviewed. It illustrates which competency elements are commonly reflected across the five reviewed frameworks and which show more variations.

The columns in Table 2 indicate whether each CCF competency element is ✓ **explicitly present,** ~ **partially or implicitly covered, or** – **not found** in each country's reviewed training framework. Competency elements marked ★ **Core** are those explicitly present across all five EU MS frameworks and represent the strongest areas of observed alignment. The stacked bars make it easy to compare coverage patterns at a glance. A fuller comparison is provided in Annex 3: Comparative overview of HCAs competencies across target EU MS.

Table 2. Summary overview of competency elements coverage by EU Member State

Country / qualification	✓ Explicit	~ Partial	– Not found	Coverage breakdown (of 53 sub-items)	Explicit %
France Formation d'aide-soignante (DEAS)	39	12	2		74%
Ireland QQI Draft Award Standards (NFQ Level 5)	49	4	0		92%
Malta Award in Health and Social Care (MQF Level 3)	39	12	2		74%
Austria Pflegeassistenz (PA-PFA-AV 2016)	49	2	2		92%
Greece Voithos Nosilefti / Βοηθός Νοσηλευτή (IEK/SAEK, EQF Level 5)	37	14	2		70%

Ireland and Austria show the highest level of explicit coverage at 92%, although their profiles differ. Austria has almost no partially covered competency elements, with 2 compared to Ireland's 4, but both systems share 2 competency elements that are not found in either framework: "show entrepreneurship" and "social activities for specific age groups". France, Malta and Greece show around 70–74% explicit coverage, with differences in where gaps occur. In France, gaps are more concentrated in theoretical knowledge areas. In Malta, they relate to gerontology theory and ICT, while in Greece, they are more evenly spread across knowledge and partially covered competency elements.

Across a total of 53 competency elements, 32 are marked as ★ Core, meaning that they are explicitly present across all five EU MS training frameworks reviewed. **These 32 core competency elements should be understood as the strongest observed area of convergence, at around 60%, within the broader framework, and can provide a potential reference base for curriculum alignment**. The partial and not-found cells are equally informative, as they show where coverage is less consistent and where further review or targeted adaptation may be needed. These patterns matter because they show that the CCF is not built around an abstract occupational profile. It reflects competency areas that are already visible to varying degrees, across the reviewed training frameworks. At the same time, the variation across countries shows why a common reference can be useful: it helps make similarities and differences easier to identify without presenting them as evidence of stronger or weaker national systems.

4. Application of the common competency framework

Because the CCF is a benchmark rather than a qualification, its value lies in providing a competency reference that actors can use to support training alignment, recruitment preparation and the development of assessment or bridging tools, while leaving national procedures and individual candidate decisions to the relevant authorities and employers.

How the common competency framework can be used

The CCF offers a range of ways through which it can benefit international mobility between EU MS and Talent Partnership countries. It can work as a:

- **Reference for curriculum mapping and training alignment.** Training providers in EU MS or partner countries can compare existing curricula against the CCF to identify areas of correspondence, partial coverage or possible gaps. In doing so, the 32 core competency elements can serve as the main practical starting point for alignment, while the remaining elements can help identify where additional adaptation, bridging or contextual review may be needed. The CCF therefore provides a basis for alignment, while allowing curricula to remain adapted to national requirements and local training contexts.

- **Tool for profile clarification.** Employers, recruiters, and public authorities can use the CCF to describe the expected HCA competency profile more clearly across different systems. This can support recruitment preparation, making expectations more transparent before individual candidate screening.

- **Compass for reviewing training, credentials and prior learning.** The CCF can help actors compare documented training or experience against expected competency areas. It does not verify credentials, establish equivalence or replace recognition procedures. This can support more consistent discussions on how previous learning or work experience relates to the HCA profile.

- **Benchmark for labour mobility cooperation.** Particularly in multi-country rather than bilateral mobility initiatives[5], the CCF can help align expectations between employers, training providers and public authorities. It can support discussions on training content, recruitment preparation and bridging needs as well as ensure greater portability of competency information across different contexts.

- **Basis for future bridging or assessment tools.** The CCF can inform the development of practical tools, such as bridging modules, interview guidance, assessment checklists or onboarding support. These tools would need to be developed separately and adapted to the relevant country context.

The way the CCF is used will depend on national regulatory and institutional contexts, as well as on uptake by national authorities, training providers and employers. In EU MS with more regulated systems, such as Austria or France, the CCF may help clarify how incoming HCA profiles compare with expected competency areas, without lowering standards. In systems where the HCA profile is less formalised, the CCF may support clearer training design, profile definition and recruitment preparation. The degree of alignment may also vary across domains:

- Knowledge is generally the most straightforward domain to align, as it is usually reflected in curricula and occupational classifications.

- Skills may show broad practical convergence, but their formal recognition depends on national rules on supervision, scope of practice and task allocations.

- Behavioural standards are often less formalised than knowledge or technical skills; they remain critical for care quality, safety, and retention.

The CCF can therefore support both intra-EU comparability and future labour mobility cooperation with partner countries by providing a common reference for comparing competencies across systems. Its role is to clarify expectations and support alignment.

Potential gains and system-level considerations

Stakeholder consultations indicated that the CCF could add value by making competency expectations more transparent across training and recruitment systems. Its practical effects will depend on how it is used by employers, training providers, public authorities and mobility scheme partners. Areas identified as bringing potential value include:

5 Bilateral corridors can often clarify competency expectations directly between the two systems involved, whereas multi-country initiatives require a shared reference to support comparison across multiple training and recruitment contexts.

- Employers often face uncertainty when job titles vary, but underlying competencies may be similar. By linking competencies to performance rather than job titles, the CCF can support more transparent approaches to skills assessments and reduce bureaucratic friction, without requiring qualification harmonisation, which is often complex and politically sensitive.

- Training providers and public authorities struggle with workforce planning when competency expectations are unclear. Clear competency benchmarks can support better forecasting of training needs, and workforce gaps over time.

- Quality and patient safety concerns, particularly around relational care, patient trust, and accountability, were repeatedly reported as weak points by LTC providers. Embedding behavioural standards directly into the framework addresses these gaps.

- Because the CCF is not tied to a specific diploma, it can evolve alongside technological change, digitalisation, and new care needs (e.g., dementia specialisation), and can support approaches to documenting and validating skills acquired through experience. This is particularly important for migrant workers.

Challenges and risks

Despite the identified convergence, the use of the CCF may face several challenges linked to regulatory sensitivity, assessment capacities and adoption capacity. These challenges include:

- Some EU MS may perceive the CCF as encroaching on national competence frameworks. Clear communication that it is a benchmark, not a qualification, is critical to addressing this concern. Related to this is the challenge of aligning expectations around autonomy and delegation without imposing uniform task allocation, which requires careful calibration across different regulatory cultures.

- Relational competencies are difficult to standardise and objectively evaluate, yet they are central to care quality and safety. Developing credible assessment tools for behavioural standards is essential but not straightforward.

- EU MS and/or partner countries with limited training infrastructure may struggle to meet expanded knowledge domains without additional investment.

- Without strong engagement from professional bodies, regulators, and employers, use of the CCF may become inconsistent.

- The CCF would require ongoing maintenance to reflect labour market changes, new care models, skills need and technology shifts (e.g. AI in care). Without a clear mechanism for this, the CCF may lose relevance over time.

5. Conclusive remarks

The B-Care CCF provides a practical reference point for addressing fragmentation in LTC workforce frameworks. It makes visible areas of competency convergence that already exist across the reviewed EU MS training frameworks and translates them into a shared benchmark for comparing HCA-related competencies.

> *Its value lies in shifting the focus from formal qualification harmonisation to competency-based alignment.*

This can support more consistent dialogue between employers, training providers, public authorities and partner-country institutions on training content, recruitment preparation and bridging needs.

Stakeholders consulted under B-Care, including private sector representatives from EU MS and officials from TP countries, indicated that identifying a shared set of competency elements could support the development of aligned training curricula in partner countries. This may help establish a satisfactory level of approximation between training provision and destination-country expectations, while informing future efforts to manage time and cost pressures in international recruitment.

Eventually, a coordinated use of the CCF may contribute to more consistent training approaches and support efforts to address workforce needs in the LTC sector, including through higher cross-border portability.

Annex 1: Definitions

Behavioural Standard	Standard of behaviour expected of HCAs arising from personal interactions and communication with other practitioners, employees, third-party providers of services, patients, their family members and others.
Competency	The specific set of knowledge, skills and behavioural standards needed in a particular area of work. Often described in terms of responsibility and autonomy, which reflects the ability to apply knowledge and skills independently and responsibly.
Competency Domain	A broad category grouping related competencies. The CCF comprises three competency domains: knowledge, skills and behavioural standards.
Competency Element	A granular articulation of what an HCA is expected to know or be able to do in practice within a given competency. The CCF comprises 53 competency elements, which form the unit of analysis for cross-country comparison.
Competency Framework	A structure that sets out the competencies employees need to complete their tasks well. It can be used to set an objective minimum acceptable benchmark for performance.
Common Competency Framework	A benchmark that can support alignment across training and recruitment systems. In this document, the CCF is neither a European Curriculum nor a diploma nor a qualification.
Core competency elements	The 32 competency elements marked as ★ Core in the CCF comparative overview. These elements are explicitly present across all five reviewed EU MS training frameworks and represent the strongest observed area of convergence within the broader CCF.
European Skills, Competences, Qualifications and Occupations (ESCO) 3412.4.12	In residential homes, older adult care workers counsel and support the elderly with physical or mental disabilities. They monitor their progress and provide them with care in a positive living environment. They liaise with clients' families to arrange their visits.
Healthcare Assistant (HCA)	In this document, HCA refers to an institution-based or home-based direct care worker who supports people with daily living activities and basic care needs, usually under the supervision or coordination of health or care professionals. There is no single, uniform EU-wide definition of a healthcare assistant (HCA), although there is consensus on the core tasks HCAs are expected to perform.

International Standard Classification of Occupations (ISCO) 08: 5321	Refers to HCAs who are institution-based personal care workers providing direct assistance to patients and residents with daily living activities in health care settings, working under the supervision of health professionals. These roles involve assisting with care plans and are found in hospitals, clinics, and residential nursing facilities.
International Standard Classification of Occupations (ISCO) 08: 5322	Home-based personal care workers provide routine personal care and assistance with activities of daily living to persons in need of such care due to ageing, illness, injury, or other physical or mental conditions, in private homes and other independent residential settings.
Knowledge	Theoretical and/or factual information that supports the understanding of a specific subject or area.
Long-Term Care (LTC)	A range of services and assistance for people who, due to mental/physical frailty or disability over an extended period, require help with daily activities (like eating, dressing, or bathing) and/or permanent nursing care
Skills	The ability to apply knowledge and use know-how to complete tasks and solve problems

Annex 2: competency domains explained

Knowledge

The breadth of knowledge areas included in the CCF reflects the complexity of the HCA role in LTC. Beyond basic care, HCAs are increasingly expected to have knowledge in areas such as dementia, infection control, communication, and digital tools. These are areas relevant to the quality of care and patient safety, but their coverage varies across training systems.

Some systems emphasise geriatric care and clinical knowledge, while others remain task-based. These differences can make it harder to compare training content and to assess whether knowledge acquired in one system aligns with expectations in another. From a policy perspective, knowledge may be the most straightforward domain to align, as it is often documented in curricula, training standards and occupational classifications.

Uneven training durations and variation in content depth can still make it difficult to assess equivalence. By identifying a shared minimum knowledge base, the CCF offers instead a reference point for reviewing gaps and supporting curriculum alignment without requiring uniformity across national systems.

Skills

The B-Care comparison shows that many practical skills expected of HCAs are broadly similar across the five EU MS frameworks, although they are not always recognised, documented or supervised in the same way.

This is also the area where variation across EU MS becomes most visible, particularly in terms of autonomy and delegation. The CCF can help make practical skills more explicit and comparable by linking them to observable performance areas rather than relying on job titles. Based on stakeholders' feedback, a CCF can add value to the extent to which skills are widely practised but not uniformly recognised or assessed.

Across EU MS, the main challenge is documenting and assessing these skills in a standardised, credible way. The comparison highlights inconsistencies in autonomy, supervision, and task delegation. These differences often reflect regulatory caution rather than actual worker capability. This is critical for mobility, as employers need confidence that a worker trained elsewhere can perform safely from day one.

Behavioural standards

LTC quality is not only technical but relational. Deficits in behavioural standards, rather than technical skills, are a major source of quality and safety concerns, according to stakeholders consulted for the project. Yet, such competences are the least formalised but the most critical dimension of competence.

Embedding these standards into a CCF can strengthen professional identity and trust across borders as they can support quality of care, patient trust, and workplace safety. Values such as dignity, accountability, teamwork, and ethical conduct are central to patient outcomes and workforce retention. The challenge lies in consistently and objectively assessing behavioural competencies.

The comparison suggests that behavioural standards are broadly reflected across the reviewed frameworks, although they are not always documented in the same way. For example, EU MS with clearer standards tend to have stronger supervision and accountability structures. The CCF can help clarify these expectations for employers and workers alike, aligning with professional ethics, and reducing misunderstandings around professional conduct or communication, which can hamper integration and retention.

Annex 3: Comparative overview of HCAs competencies across target EU Member States

The table below is structured around the CCF's competency domains, competencies and competency elements as defined in Table 1. Competency domains and competencies of the Common Competency Framework (CCF). The CCF is compared against the following training frameworks:

- Formation d'aide-soignante (DEAS) (France),
- QQI Draft Award Standards (Ireland, NFQ Level 5),
- Award in Health and Social Care (Malta, MQF Level 3),
- Pflegeassistenz (Austria, PA-PFA-AV 2016), and
- Voithos Nosilefti / Βοηθός Νοσηλευτή (Greece, IEK/SAEK, EQF Level 5).

Each column shows whether the competency element is documented in each country's reviewed training framework:

✓ explicitly present
~ partially or implicitly covered
– not found

Competency elements marked ★ **Core** are explicitly present across all five country sources and represent the strongest foundation for a CCF. No additional competencies have been imported from the country sources.

The comparative overview below shows that most competency elements are widely present across the five reviewed EU MS, particularly in areas such as personal care, collaboration with medical staff, and emotional support. Ireland (QQI) and Austria (*Pflegeassistenz*) have the highest levels of explicit coverage across the CCF competency elements. Austria's qualification profile is legally structured around 57 competency elements and covers anatomy, pharmacology, care process and medical diagnostics in considerable depth.

Greece (IEK/SAEK) shows strong explicit coverage of core nursing skills, infection control, anatomy/physiology, vital signs, and ethics, while elderly- or dementia-specific theory, social activities, and ICT are less consistently reflected in the reviewed framework. France DEAS and Malta MQF Level 3 show broadly comparable levels of explicit coverage overall, with France stronger on gerontological theory and Malta stronger on direct care skills and behavioural standards.

Some areas of more limited or uneven coverage also appear in the comparison. For example, end-of-life or palliative support is less explicitly reflected in the Greek framework reviewed, while Ireland and Malta display some limitations in preparation for procedures. The competency element 'show entrepreneurship' (Cat.8) remains the weakest point of cross-country alignment, as it is absent or only partially implied in all five reviewed frameworks.

These variations suggest that while there is broad alignment in many HCA competency elements, some specialised or technical areas are documented less consistently across national frameworks. This reinforces the value of the CCF as a reference for identifying both shared expectations and areas where further review may be needed.

Table 3. Comparative Overview of the CCF competency elements across the reviewed EU Member States

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 1. Personal care	**Cooperation in a multi-professional team** ★ Core	✓	✓	✓	✓	✓	**FR:** Block 5: organisation of work and cooperation within the multi-professional team to ensure quality and continuity of care. **IE:** Fundamentals of Healthcare Learning Outcome (LO) context; Principles of Nursing LO7. **MT:** Module 1 explicitly requires harmonious teamwork; Module 2 covers staff communication.
	Legislation regulating professional activities of HCAs ★ Core	✓	✓	✓	✓	✓	**FR:** Mainly Block 5: knowledge and compliance with the legal framework governing HCA practice, scope and limits of practice, as part of quality and risk management. **IE:** Safe Care Practice; Fundamentals LO9 — professional obligations and scope. **MT:** Module 1 explicitly covers National Occupational Standards and professional obligations.
	Ethical principles in healthcare and awareness of these principles ★ Core	✓	✓	✓	✓	✓	**FR:** Embedded in Block 1, 3 and 5 : knowledge and application of ethical principles with regard to respect for the person, care relationship, user rights and quality of care. **IE:** PPD LO2; Fundamentals LO9; Palliative Care LO7. **MT:** Module 1 explicitly covers equitable care, dignity, consent and professional accountability.
	First aid in emergency situations	✓	✓	~	✓	✓	**FR:** In Block 2 (recognition of emergency situations, vital sign assessment, basic first aid and alerting) and Block 4 (safety, risk prevention and implementation of emergency protocols. **IE:** mandatory sector requirement (CPR/AED) across all defined awards. **MT:** emergency response covered (M3 — breathing difficulties, oxygen set-up) but CPR/AED not listed as a standalone named requirement.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 1. Personal care	**Principles of (manual and mechanical) positioning, lifting and transportation of patients** ★ Core	✓	✓	✓	✓	✓	**FR:** Blocks 1, 2 and 4: assessment of mobility and risk, implementation of safe manual and mechanical positioning, lifting and transfer techniques, and prevention of risks (MSDs, falls, patient safety. **IE:** mandatory Assisted Mobility Training (Safe People Moving) in all awards. **MT:** Module 3 and M7 explicitly cover positioning, mobilisation, assistive aids and fall prevention.
	Rights and duties of HCAs ★ Core	✓	✓	✓	✓	✓	**FR:** Mainly in Block 5 (professional responsibility, confidentiality, quality/risk management) and in Blocks 1 and 3 through respect for users' rights and dignity. **IE:** Safe Care Practice; Fundamentals LO9. **MT:** Module 1 explicitly covers rights/duties, accountable practice and seeking support when not competent.
	Supporting patients/clients in activities of daily living (basic and instrumental) ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered in Block 1 (support with basic and instrumental activities of daily and social living, with graded assistance to preserve autonomy), supported by Block 2 (identifying loss of autonomy and risks) and Block 5 (coordination with the care team and other providers). **IE:** Fundamentals LO4; Pre-nursing Care Skills LO1. **MT:** Modules 2, 3, 4, 5 all explicitly address ADL support across dependency levels.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 1. Personal care	Cultural, gender and other personal factors impacting patient care	~	✓	✓	✓	~	**FR:** not explicitly named; but implicitly present throughout Blocks 1, 3 and 5 (respect for the person, care relationship, non-discrimination, adaptation of care). **IE:** EDI explicitly required across Broad Standards and multiple defined awards. **MT:** Module 1 directly requires equitable care irrespective of race, religion, ethnicity, sexual orientation and culture. **AT:** Austrian curriculum (Topic III) explicitly covers sociocultural influences on activities of daily living, conceptions of gender, and cultural sensitivity in care contexts. **GR:** implicit through ethics and professional conduct content; not named as a distinct competency.
	Communication and interaction with patients and co-workers ★ Core	✓	✓	✓	✓	✓	**FR:** Covered in Block 3 (communication and therapeutic relationship with patients and relatives, adapted to diverse publics) and in Block 5 (handover and communication within the multi-professional team to ensure continuity and safety of care). **IE:** Fundamentals LO3; Principles of Nursing LO6. **MT:** Module 2 is a dedicated 12-hour communication module covering verbal/non-verbal, active listening, family communication and conflict management.
	Patient rights ★ Core	✓	✓	✓	✓	✓	**FR:** Addressed transversally: patient rights defined by law (information, consent, non-discrimination, dignity, privacy, confidentiality, access to records, pain management, palliative care, complaints) embedded in Blocks 1, 3 and 5 (respect for the person, care relationship, quality and safety of care). **IE:** Fundamentals LO1 and LO9; Broad Award Standards (human rights-based approach). **MT:** Module 1 explicitly names human rights in Health and Social Care as a learning outcome.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 1. Personal care	ICT use and use of technological applications	~	✓	~	✓	~	**FR:** Partially covered in a transversal way: use of digital tools for documentation and communication, and connected monitoring devices, mainly in Block 5 (handovers, quality/safety) and Block 2 (clinical data collection), with no explicit standalone ICT competency. **IE:** explicitly required across PPD and multiple defined awards as a transversal skill. **MT:** record-keeping and parameter charting present (M1) but no named digital competence or e-health tools content. **AT:** ELGA (electronic health records system) explicitly covered in Topic I.1 (professional law/data exchange); computer-assisted data exchange and data processing in the nursing professions named in the curriculum. **GR:** record-keeping covered but dedicated ICT/digital health competency not explicitly named.
	Clerical, administrative and care planning issues	~	✓	✓	✓	✓	**FR:** Partially covered: HCA contribute to organising their work and to practical care planning (Block 5 – handovers, continuity and prioritisation of care), whereas clerical and medico-administrative tasks are mainly carried out by medical administrative assistants in the French system. **IE:** Fundamentals LO3; Safe Care Practice LO7. **MT:** Module 1 explicitly covers recording parameters, checking supply documentation and body-turning charts.
	The national health system and social insurance system	✓	✓	~	✓	~	**FR:** Partially covered: basic understanding of the health and social insurance system used in Blocks 1, 3 and especially 5 (user information/orientation, networking, care pathway coordination), but not defined as a standalone competency. **IE:** Principles of Nursing LO2 (structure of Irish healthcare system). **MT:** references National Occupational Standards and MDT structures but no dedicated module on the Maltese national health or social insurance system.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 1. Personal care	Basic knowledge of public health	~	✓	~	~	~	**FR:** Partially and transversally covered: basic public health concepts (prevention, health promotion, determinants of health, organisation of the health system) embedded in Blocks 1 and 3 (everyday prevention and health education) and especially in Blocks 4 and 5 (risk prevention, quality and safety of care, user rights and health policies). **IE:** Broad Award Standards include health promotion; Fundamentals addresses wellbeing across the lifespan. **MT:** not explicitly addressed as a topic; public health dimensions implicit in infection control (M6).
	Psychological support ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: basic psychological support mainly embedded in Block 3 (helping relationship, listening, support in situations of distress, end of life, challenging situations) and Block 1 (considering the psychological dimension in daily care), within an ethical framework supported by Block 5. **IE:** Fundamentals LO10; Mental Health Care Skills LO7. **MT:** Module 2 covers empathy and emotional support; Module 4 includes monitoring and guiding anxiety.
Knowledge 2. Infection prevention & hygiene control	Pharmacology, administration of medicines and non-pharmacological treatments	~	✓	~	✓	✓	**FR:** Partially covered: basic pharmacology and treatment monitoring embedded in Blocks 2 and 4 (detecting adverse effects, medication safety), a tightly regulated role in assisting with non-injectable medicines under RN supervision, and extensive use of non-pharmacological interventions (comfort, stimulation, non-drug therapies) in Blocks 1 and 3. **IE:** Principles of Nursing LO8 most explicit — medication safety principles, accuracy and legal aspects. **MT:** Module 3 covers storage/administration procedures and Module 4 references medication documentation, but treatment is brief.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 2. Infection prevention & hygiene control	**Health and safety in the workplace and quality management systems** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered in Blocks 4 and 5: implementation of occupational health and safety rules (prevention of MSDs and accidents, use of PPE, safe environments and devices) and participation in quality and patient safety management systems (protocols, risk management, documentation, improvement actions). **IE:** Safe Care Practice; Fundamentals LO9. **MT:** Module 1 covers National Occupational Standards compliance; Modules 3 and 6 cover fall prevention and safety procedures throughout.
	Hygiene and infection rules and procedures in patient care ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered, mainly in Block 4 (application of standard and transmission-based precautions, hand hygiene, PPE, cleaning/disinfection, linen and waste management to prevent healthcare-associated infections), linked to Block 2 (integrating these rules into all care) and Block 5 (quality and risk management). **IE:** Safe Care Practice minor award (App.4) — dedicated module. **MT:** Module 6 (dedicated 12 hrs) covers cleaning, disinfecting, PPE, hand hygiene, sterilisation and waste protocols.
	Manually and mechanically cleaning equipment ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered, mainly in Block 4: performing pre-disinfection, manual or mechanical cleaning/disinfection and drying/storage of care equipment and assistive devices according to hygiene and risk-prevention protocols (with appropriate PPE), linked to Block 2 for safe use of equipment during care. **IE:** Safe Care Practice LO5 (cleaning, disinfection and sterilisation procedures). **MT:** Module 6 explicitly requires cleaning/disinfecting clinical equipment per manufacturer instructions, bed pans, urinals and bed areas.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 2. Infection prevention & hygiene control	Human anatomy, physiology and pathology	✓	✓	~	✓	✓	**FR:** Fully integrated in the training framework as core knowledge, mainly underpinning Block 2 (clinical assessment and understanding the impact of diseases and treatments) and supporting Block 1 (adapting daily care to somatic impairments). **IE:** Anatomy, Physiology, Human Growth, Development & Biology — explicit minor award (App.7). **MT:** implicit through vital signs, breathing and mobilisation content (M1, M3) but no dedicated anatomy module.
	Storage and transportation of equipment and materials	✓	~	✓	✓	~	**FR:** Fully covered, mainly in Block 4: internal storage and transport of equipment and health products in accordance with hygiene, safety and conservation rules (appropriate storage areas, layout of stocks/trolleys, clean/dirty circuits), with Block 5 contributing to work organisation and traceability. **IE:** implied in Safe Care Practice (waste/materials management) but not an explicit learning outcome. **MT:** Module 6 explicitly covers linen trolley upkeep, consumable storage and documentation of supplies from stores.
Knowledge 3. Dementia / elderly care support	Specific patient groups, e.g. elderly	✓	✓	~	✓	~	**FR:** Fully covered: care for elderly people and other specific patient groups is central to Blocks 1, 2 and 3 (adapting care and support to age-related needs, dependency, comorbidities and life context). **IE:** Holistic Care and Wellbeing of Older Adults (App.11) — dedicated elective minor. **MT:** elderly care home included in placement (M7) but no theoretical gerontology module; age-related content implicit in ADL and skin/continence care.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 3. Dementia / elderly care support	Chronic disease management	~	✓	~	✓	~	**FR:** Partially covered: HCAs support people living with chronic diseases in daily care (clinical monitoring, basic care, prevention of complications, first-line educational support – Blocks 1, 2 and 3). Structured chronic disease management (therapeutic adjustment, care pathway coordination) responsibility of nurses/advanced practice nurses and physicians. **IE:** Fundamentals LO5; Pre-nursing Care Skills LO2 — awareness of chronic conditions and their functional impact. **MT:** awareness implicit through observation/monitoring tasks (M1, M4) and stoma/catheter care but no dedicated module.
	Specialist areas of care, e.g. diabetes care, at basic level	–	✓	~	✓	~	**FR:** Not disease-specific competency element (e.g. diabetes, COPD), but HCAs apply generic competencies from Blocks 1, 2 and 3 (monitoring, basic care, prevention and first-line educational support) to these areas; more specialised skills (e.g. diabetes care) are mainly developed through continuing education and on-the-job experience. **IE:** Fundamentals LO5 addresses range of medical conditions; QQI electives (Mental Health, Palliative, ID Care) provide specialist depth. **MT:** specialist care implicit in placement (disability and elderly care homes) but not addressed as named theoretical content. **AT:** Austrian curriculum explicitly covers dementia (Pain and Dementia module, Topic IV) and specialist care for elderly, disabled persons and people with cognitive impairments across Topic IV. **GR:** specialist conditions implicit through nursing science modules but not explicitly named as distinct topics.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Knowledge 4. End-of-life / palliative support	Palliative care and pain management and post-mortem care provision	~	✓	✓	✓	~	**FR:** Partially and transversally covered: pain assessment and relief and palliative care embedded in Blocks 1, 2 and 3 (comfort care, pain observation and adjustment of care at the end of life); post-mortem care and support to relatives embedded in Blocks 3 and 5 (dignity, respect for cultural and religious practices, legal procedures and quality/safety of care). **IE:** Palliative Care Skills dedicated minor award (App.15) — most explicit treatment across all sources. **MT:** Modules 4 and 7 explicitly address last offices, spiritual arrangements and family support at end of life. **AT:** Austrian curriculum (Topic IV) explicitly names palliative care in multiple sub-modules including pain management, end-of-life care, and post-mortem care provision. **GR:** referenced in nursing science content but no dedicated palliative module in the IEK/SAEK specification.
Skills 5. Observation & reporting	**Attend to sanitary needs of clients/ patients** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered, mainly in Block 1 (meeting hygiene, elimination and comfort needs in daily life), with links to Block 2 (clinical observation during hygiene care) and Block 4 (implementation of hygiene and infection-prevention procedures). **IE:** Pre-nursing Care Skills LO1; Fundamentals LO4. **MT:** Modules 4 and 5 explicitly address toileting, continence, commode/bedpan use and personal hygiene.
	Apply body hygiene procedures in patient care ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: mainly in Block 1 (implementation of body hygiene care in daily life), with strong links to Block 4 (application of hygiene and infection-prevention procedures) and Block 2 (clinical observation during hygiene care). **IE:** Fundamentals LO4; Pre-nursing Care Skills LO1. **MT:** Module 5 dedicated (bathing, bed bath, oral/eye/ear care, dressing, skin integrity).

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Skills 5. Observation & reporting	**Apply quality and safety procedures in patient care** ★ Core	✓	✓	✓	✓	✓	**FR:** Mainly covered in Block 4 (implementation of hygiene, risk-prevention and safety procedures), with additional coverage in Block 5 (quality approach and risk management. **IE:** Safe Care Practice; Fundamentals LO9. **MT:** Module 1 (National Occupational Standards) and Module 6 (infection control and safety procedures).
	Communicate clearly with clients/patients and family ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered, mainly in Block 3 (clear, adapted and compassionate communication with the person and their relatives), with links to Block 1 for daily support and Block 5 for consistent information within the team. **IE:** Fundamentals LO3; Principles of Nursing LO6. **MT:** Module 2 dedicated 12-hour communication module including family communication, active listening and empathy.
	Prepare and serve food and drinks to clients/patients ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered, mainly in Block 1: preparing and serving food and drinks in line with prescribed diets, textures, safety requirements and personal habits, while monitoring intake and reporting any difficulties (linked to Block 2 for detecting undernutrition/dehydration. **IE:** Fundamentals LO11 (nutrition across lifespan). **MT:** Module 4 covers feeding, food storage, protective clothing, appropriate food consistency and reporting changes in feeding patterns.
	Support patients in activities of daily living, including hygiene, comfort, mobility and feeding needs ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: core competency in Block 1 (support in activities of daily living: hygiene, comfort, mobility, feeding, elimination, sleep and social life), linked to Block 2 for clinical observation and Block 3 for the relational component. **IE:** Fundamentals LO4; Pre-nursing Care Skills LO1. **MT:** Modules 2, 3, 4 and 5 all explicitly address ADL support across dependency levels, promoting independence throughout.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Skills 5. Observation & reporting	Apply first aid in emergency situations	✓	✓	~	✓	✓	**FR:** Fully covered: Block 2 (recognition of emergency situations, delivery of basic first aid within the HCA scope of practice and immediate alerting of the medical team), linked to Block 4 for safety and implementation of emergency protocols. **IE:** CPR and AED use listed as mandatory sector-specific requirement in all defined awards. **MT:** emergency response referenced in Module 3 (breathing difficulties, equipment set-up) but CPR/AED not explicitly named as a standalone requirement in the specification.
	Conduct basic care activities ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: core of Block 1 (delivery of basic care / essential daily life care: hygiene, comfort, nutrition, elimination, sleep, social activities), with an acute-care and monitoring dimension integrated into Block 2 in collaboration with the RN. **IE:** Fundamentals of Healthcare SPA — core of the award. **MT:** Modules 4, 5, 6 and M7 placement all involve basic care activities across clinical settings.
	Support patients' / clients' relatives in patient care related activities	~	✓	✓	✓	~	**FR:** Partly explicit: mainly in Block 3 (support and communication with relatives, helping them understand and, when appropriate, participate in daily care activities), linked to Block 1 for demonstrating comfort/ADL care and Block 5 for team handovers and respect of scope of practice. **IE:** Fundamentals LO addresses working with families; Pre-nursing Care Skills LO6 (emotional needs of patients and families). **MT:** Modules 2 and 4 include supporting families, end-of-life family support (M7) and last offices in presence of relatives.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Skills 5. Observation & reporting	Carry out social activities for specific age groups	~	~	–	–	–	**FR:** Partly covered: the HCA contributes to maintaining social life (Block 1) and supports people during group activities, but the design and formal delivery of age-specific social or therapeutic activities generally falls to other professionals (activity coordinators, OT, etc.) or additional training. **IE:** Holistic Care of Older Adults LO6 addresses leisure and social activities for older adults; not a universal requirement. **MT:** not identified as a learning outcome in any module of the Maltese specification.
	Supply and distribute medicines	~	~	~	~	~	**FR:** Partially and strictly regulated: participation in assisting with and, in some settings, distributing non-injectable medicines under RN responsibility and according to protocols (Blocks 2, 4 and 5 – medication safety, risk prevention and respect of scope of practice).
Skills 6. Monitoring vital signs	**Monitor and measure vital parameters and overall patient condition** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered, core competency in Block 2 (measuring and monitoring vital signs and overall condition, detecting warning signs and reporting to the team), linked to Block 1 for observation during daily activities and Block 5 for handovers and risk management. **IE:** Fundamentals of Healthcare LO8 (vital signs observation — explicit). **MT:** Module 1 covers temperature taking and recording, urine testing, breathing pattern observation and parameter recording; Module 3 covers respiratory monitoring in detail.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Skills 7. Preparation for procedures (under supervision)	**Assist other healthcare professionals and have the required competence to do so** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: assistance to other healthcare professionals is embedded in Blocks 1 and 2 (delivery of daily and delegated care in collaboration with the RN and the multi-professional team) and formalised in Block 5 (organisation of work, team cooperation and working within one's scope of competence). **IE:** Fundamentals of Healthcare; Principles of Nursing LO7 (interdisciplinary collaboration). **MT:** Modules 4 and 6 explicitly require assisting nursing staff with stoma care, catheter management, oxygen therapy and cleaning clinical equipment — always under supervision.
	Move and transfer patients ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered in Blocks 1, 2 and 4: carrying out patient moves and transfers (bed/chair, standing, walking) using appropriate manual handling techniques and assistive devices, assessing abilities and risks, and preventing MSDs and falls. **IE:** mandatory Assisted Mobility Training (Safe People Moving and Positioning) across all defined awards. **MT:** Modules 3 and 7 explicitly cover positioning, mobilisation, use of assistive aids per mobility assessment reports.
	Conduct (delegated) activities related to ADT (admission, discharge, transfer) and documentation of care	~	✓	~	✓	~	**FR:** Partially covered, mainly in Block 5 (organisation of work, continuity and documentation of care through records and handovers) and in Blocks 1 and 2 for admission, transfer and discharge support and basic clinical assessment, as delegated activities under RN responsibility. **IE:** Fundamentals LO3 and Safe Care Practice LO7 include documentation; ADT activities referenced in Pre-nursing Care Skills. **MT:** Module 1 covers documentation and parameter recording; ADT-specific procedures not explicitly named in the Maltese specification.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Behaviour 8. Collaboration with nursing/medical staff	**Be accountable — able to answer for your actions or omissions** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: professional responsibility mainly in Block 5 (organising one's work, complying with protocols, reporting incidents, reflecting on practice, working within the legal framework) and transversally in Blocks 1 and 3 towards the person cared for (quality of care, respect for rights, prevention of abuse). **IE:** PPD LO2; Fundamentals LO9; Palliative Care LO7. **MT:** Module 1 explicitly requires accountable practice and reporting personal difficulties that might affect safe practice.
	Work in collaboration with colleagues to ensure high quality, safe and compassionate healthcare ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: core competency in Block 5 (collaboration within the multi-professional team to deliver high-quality, safe and compassionate care), with collaborative practice embedded across all care blocks (sharing information, coordinating and supporting one another). **IE:** Principles of Nursing LO7; Broad Award Standards (team-based practice). **MT:** Modules 1 and 2 require harmonious teamwork environment and keeping conflict away from clients.
	Work under supervision of other healthcare professionals to assist in care provision ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: this is the core framework of HCA practice, working under the supervision and responsibility of the RN and in collaboration with other healthcare professionals to assist in care provision, mainly in Blocks 2 and 5 (collaborative care, work organisation, working within scope of practice). **IE:** defined throughout award standards — "under supervision" is explicit in Pre-nursing Care Skills, Fundamentals and all clinical awards. **MT:** central requirement across Modules 4, 6 and M7 placement — assisting nursing staff throughout.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Behaviour 8. Collaboration with nursing/medical staff	**Take responsibility for actions and justify them professionally and ethically** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: mainly in Block 5 (professional responsibility, reflective practice, compliance with legal and procedural requirements, contribution to quality and risk management) and transversally in Blocks 1 and 3 (ethical justification of actions towards the person cared for: respect for rights, dignity and confidentiality. **IE:** PPD LO2; Fundamentals LO9. **MT:** Module 1 explicitly covers accountable practice, professional attitude and seeking support when not competent.
	Assess basic patient vital signs and care needs without supervision and report to others ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: core competency in Block 2 (independent assessment of vital signs and basic care needs, identification of abnormalities and escalation), linked to Block 1 for observation during daily activities and Block 5 for reporting and continuity of care. **IE:** Fundamentals LO8 (vital signs) and LO7 (identifying deterioration and escalating). **MT:** Modules 1 and 3 require recognising and reporting changes in parameters, breathing and condition to appropriate authority.
	Assess the need for basic healthcare assignments without supervision ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: mainly in Block 1 (assessment of autonomy and basic care needs using the 14 fundamental needs and prioritisation of support) and Block 2 (consideration of clinical status to prioritise care), with organisation and reporting in Block 5. **IE:** Fundamentals LO7 (identifying signs of deterioration and situational risk). **MT:** Module 1 requires evaluating normal attitudes/behaviour and recognising early signs of physical or emotional disturbance without waiting for direction.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Behaviour 8. Collaboration with nursing/medical staff	Show entrepreneurship	–	~	–	–	–	**FR:** No specific entrepreneurship competency; only a general expectation to reflect on practice and suggest improvements (Block 5). **IE:** PPD LO1 references employability skills and personal effectiveness, which may encompass entrepreneurial initiative, but the term is not used. **MT:** not addressed in any module.
	Carry out care assignments according to a care plan without supervision ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: autonomous delivery, within the HCA scope of practice, of the care tasks set out in the care plan (Block 1 for basic care, Block 2 for clinical adaptation), with work organisation and reporting in Block 5. **IE:** Fundamentals LO2 (care planning tools) and Know-How & Skill Selectivity in major award. **MT:** Module 4 requires following care protocols and mobility assessment reports; Module 5 covers carrying out personal care assignments per care plan.
Behaviour 9. Support for dignity & comfort	**Promote and uphold privacy, dignity, rights, health and wellbeing of people who use services and their carers at all times** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered transversally: mainly in Block 1 (respect for dignity, privacy and safety), Block 3 (information, consent, compassionate support for the person and their carers) and Block 5 (user rights, professional confidentiality, quality and safety of care). **IE:** Fundamentals LO1; PPD LO2; Broad Award Standards (person-centred care). **MT:** Module 1 (treating clients with respect and dignity) and Module 5 (assisting clients while respecting privacy and dignity) — explicitly stated as primary obligations.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Behaviour 9. Support for dignity & comfort	**Respect a person's right to confidentiality** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: respect for professional secrecy and confidentiality of information about the person, particularly in Blocks 1 and 3 (privacy, intimacy, information and consent) and in Block 5 (user rights, handovers and data protection. **IE:** Fundamentals LO3 and multiple defined awards address confidentiality explicitly as a legal and professional requirement. **MT:** Module 1 explicitly requires managing client privacy and confidentiality; Module 2 names confidentiality as a distinct communication obligation.
	Strive to improve quality of healthcare through continuing professional development	✓	✓	✓	✓	~	**FR:** Covered in Block 5: participation in quality and risk-management activities, reflective practice and identification of training needs, in line with the requirement for continuing professional development to maintain and improve quality of care. **IE:** PPD LO4 and LO5; CPD requirement stated across all defined awards. **MT:** Module 7 requires 5 reflective journal entries linking placement observations to theory — reflective CPD embedded in the assessment design.
	Uphold and promote equality, diversity and inclusion	~	✓	✓	✓	~	**FR:** Transversal principle not explicitly named: addressed through non-discrimination and equal access to care (user rights and safeguarding) and covered in Blocks 1, 3 and 5 (respect for each person's uniqueness, adapted communication and support, inclusive team culture). **IE:** EDI explicitly required and named across Broad Award Standards and multiple defined awards — the strongest treatment across all sources. **MT:** Module 1 directly requires equitable care irrespective of race, religion, ethnicity, sexual orientation and culture; spiritual and cultural sensitivity referenced across M3 and M4.

Competency domain	CCF competencies & competency elements	FR	IE	MT	AT	GR	Notes
Behaviour 10. Emotional / psycho-social support	**Communicate in an open and effective way to promote health, safety and wellbeing of people who use services and their carers** ★ Core	✓	✓	✓	✓	✓	**FR:** Fully covered: mainly in Block 3 (open, clear and adapted communication to promote the health, safety and wellbeing of the person and their carers), with links to Block 1 (everyday support) and Block 5 (consistent information and quality/safety of care). **IE:** Fundamentals LO10; Broad Award Standards (empathy, compassionate communication, trust-building). **MT:** Module 2 explicitly covers emotional support, sensitivity, empathy and keeping the client calm; Module 4 includes monitoring anxiety and facilitating spiritual/family needs.

Sources: (1) Common Competency Framework for Healthcare Assistants in Long-Term Care: Reference framework to support training alignment and recruitment, Annexes 1–3 (2025). (2) Formation d'aide-soignante (DEAS). (3) QQI, Consultation on Draft Award Standards in Healthcare at NFQ Level 5 (October 2025). (4) MFHEA, Award in Health and Social Care, MQF Level 3 (284 hrs). (5) GÖG/ Gesundheit Österreich, Qualifikationsprofil Pflegeassistenz (PA-PFA-AV BGBl. II Nr. 2016). (6) Greek Ministry of Education / DYPA, Οδηγός Κατάρτισης Βοηθός Νοσηλευτικής Γενικής Νοσηλείας, IEK/ SAEK (EQF Level 5, 2023).

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