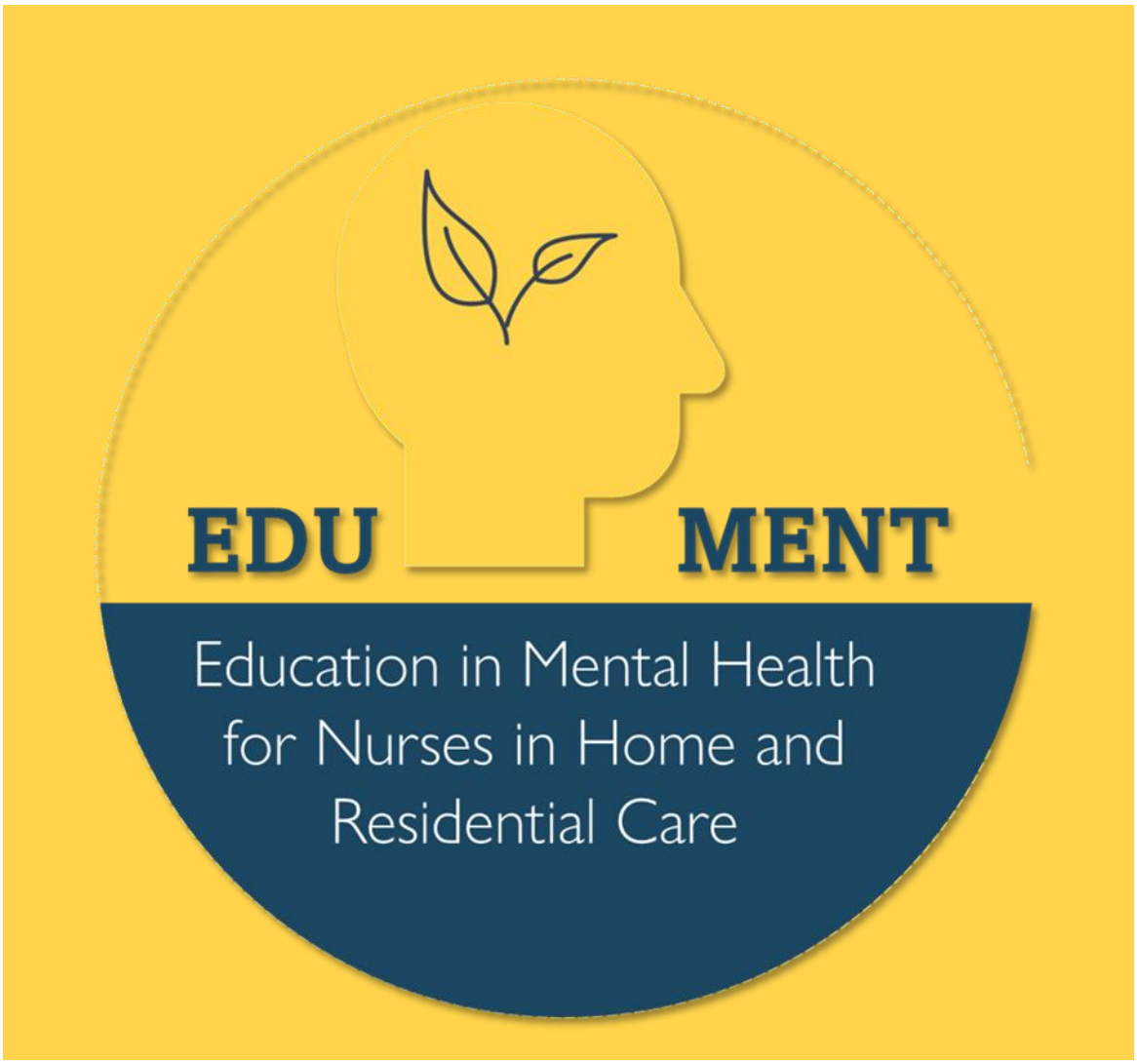


WP5 Piloting Report
Consortium findings

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Contents

Section	Page
1 Executive summary	4
2 Project purpose and WP5 mandate	6
3 How to read the pilot results	8
4 Organisational readiness and pilot support	9
5 Common documentation and templates	11
6 Cyprus implementation process	13
7 Cyprus findings and selected cases	15
8 Slovenia implementation process	17
9 Slovenia findings and practice responses	19
10 Austria national implementation and findings	21
11 Lessons across the three countries	23
12 Feasibility conditions and implementation responses	25
13 Sustainable use of the completed results	27
14 Conclusions and transfer implications	29
Abbreviations	30

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1 Executive summary

1.1 National implementation overview

EDU-MENT supported nursing observation, discussion of psychosocial concerns and care planning in community and residential settings. Practitioners used it to bring scattered observations into a structured assessment. The national records describe perceived usefulness and the training and organisational support required for use. They document implementation experience rather than clinical effectiveness.

In Cyprus, the national report, implementation checklist and confirmations from two care services document twenty screenings and twenty Activity D forms. Delivery combined orientation, self-study, six additional facilitated sessions and independent practice.

In Slovenia, the University of Maribor, Faculty of Health Sciences (UM FHS), coordinated a university-led pilot with practical applications in participants' workplaces. The fifteen practice forms comprise fourteen learner records and one trainer record. Employers' identities remain confidential; UM FHS is the formal educational institution involved.

Austria implemented EDU-MENT in the Wohn- und Pflegeheim Fulpmes and Haus Ehrenberg Reutte. Trained colleagues introduced the tool, supported its use and facilitated team discussion. The national account reports five applications per facility. Four September screening profiles underpin the Austrian examples in the twelve-case Best Practice Brochure.

WP5 met the target of implementation in at least six care and assistance organisations, as confirmed by the WP5 lead. The audit programme covered eight institutions: the original six across Austria, Cyprus and Slovenia, plus Fulpmes and Haus Ehrenberg Reutte following a change of Austrian pilot sites. Eight audits against a target of six represent an excess of two institutions. Twelve selected practice examples and guidance for future use complete the WP5 results.

1.2 Main lessons for implementation

Guided application is an important part of the learning pathway. In Cyprus, the implementing team added six facilitated sessions after monitoring difficulties with independent study, digital navigation and abstract content. In Slovenia, participants valued practical cases and interpretation of results. The Austrian training synthesis similarly describes the importance of orientation, exchange and national examples. The lesson is to plan sufficient support for the actual

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learner group rather than assume that access to online materials produces practical competence.

Digital access and care routines need to be planned together. Navigation, devices and connectivity sometimes interrupted use or sensitive conversations. Facilitated sessions, practical assistance and feedback from partners to the development team helped users continue. The University of Cyprus (UCY) reports implementing requested changes that were feasible. Local support and protected time remained relevant to implementation.

Professional judgement remains central. Slovenian records describe both agreement between screening and nursing assessment and a case where a reassuring community score did not reflect the quality of a person's social relationships. Practitioners used contextual interpretation and discussion to examine such differences. Screening supported the assessment process, with care planning, team review and appropriate referral providing the route from a concern to a professional response.

Continuation builds on existing university teaching and partner training activities. Formal recognition through the European Credit Transfer and Accumulation System (ECTS) remains under institutional consideration. Chapter 13 sets out the partners' reported plans and support arrangements.

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2 Project purpose and WP5 mandate

2.1 Project scope and responsibilities

EDU-MENT addresses education in mental health for nurses in home and residential care. The project combines needs assessment, a digital screening tool, blended learning and organisational development. WP5, led by Hafelekar, examines how the education and tool can be introduced into real care organisations and maintained within their working conditions. Its focus extends beyond a learner's ability to complete an online task: the organisation must be able to support practical use and respond to relevant findings.

The approved project period is 1 October 2023 to 30 September 2026, under project number 2023-1-AT01-KA220-VET-000166434. The consortium consists of UMIT TIROL, Hafelekar, the University of Cyprus, AGECARE/Materia and the University of Maribor. UMIT TIROL coordinates the project; Hafelekar leads WP5 methodology and synthesis. National implementation partners support providers and nurses, while UCY contributes technical development.

The application links organisational assessment to adaptation of training, communication strategies, practical evaluation and sustainable use. It calls for continuing-education and certification guidance, quality-assurance guidance, good practices and a transfer handbook. This report contributes the implementation analysis needed for those results. The organisational findings complement the separate project outputs and the final project report.

WP4 concerns the blended curriculum and educational pilot; WP5 concerns organisational readiness, practical introduction and continuity. A practice record may inform both work packages. Reuse in different outputs does not create an additional case.

The national reporting template covers participants, delivery, learning and tool feedback, recommendations and annexes. This report follows those domains and adds the definitions needed to compare the national contributions.

2.2 WP5 targets and results

WP5 set three organisational targets: six audits, implementation in at least six care organisations and at least five online meetings. It also called for twelve selected case studies. Each target concerns a different part of the work.

The audit target was exceeded: eight institutions were audited against six planned. Implementation in at least six care and assistance organisations was confirmed. Austria contributed four audited institutions following the change of pilot sites; Cyprus and Slovenia contributed two each. The national chapters

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explain the care-provider pilots in Austria and Cyprus and the university-led learning route in Slovenia.

Table 1 WP5 reference points and documented implementation

Reference point	Evidence unit	Interpretation of the completed work
Six organisational audits	Audit records and national synthesis	Target exceeded: eight audited institutions, comprising four in AT following the site change, two in CY and two in SI; two above target.
At least six implementing care organisations	Actual providers linked to practical use	Target achieved: implementation in at least six care and assistance organisations; national evidence retains its documented institutional scope.
Twelve Activity 5.5 case studies	Twelve selected examples from existing national practice records	Final Best Practice Brochure: four AT, four CY and four SI examples
At least five WP5 online meetings	Minutes and coordinator correspondence	Five documented meetings: 23 Oct 2025; 20 Jan, 25 Feb, 22 Apr and 31 Aug 2026

WP4 had a separate completion target of at least fifteen registered nurses per country, forty-five in total. The consolidated training report records forty-eight participants. Participation does not establish completion, which depends on the responsible provider's assessment records.

The reporting period ends on 30 September 2026. Institutional approval, practical application and preparation of reporting records are treated as separate events.

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3 How to read the pilot results

3.1 What was reviewed

The report brings together national pilot reports, implementation checklists, practice forms, institutional confirmations and audits. The Best Practice Brochure presents twelve examples from this material. The consolidated training report and the final evaluations add the educational and project-wide perspectives.

The documents describe different aspects of implementation. Institutional confirmations record organisational approval; checklists summarise activity; practice forms describe application and interpretation; audits examine working conditions. The WP5 lead confirmed implementation in at least six organisations. This does not mean that every audited institution also implemented the tool.

The report compares how the pilots were organised, what practitioners experienced and which conditions helped them use EDU-MENT. National figures retain their original units. The small, unequal samples do not support statistical comparisons between countries or a combined estimate of clinical effectiveness.

The Slovenian partner used inductive qualitative content analysis and tabulated practice-form items. These are reproduced as partner-reported results with their original denominators. The handwritten forms and clinical records were not independently reanalysed for this report. Cyprus supplied a narrative synthesis and selected examples, so equivalent frequency counts are unavailable.

The external evaluators assess project relevance, partnership and continuation. The internal evaluation records the views of all five partner organisations.

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4 Organisational readiness and pilot support

4.1 Audit scope and national context

The organisational audits examined four areas: devices and working conditions, care processes, staff preparation and integration into everyday work. A checklist, evaluation matrix and interviews with management and nursing leads helped identify support needs before introduction.

Eight institutions were audited, two more than the target of six. The initial programme covered one community-oriented and one residential setting in each country. After the Austrian pilot sites changed, Fulpmes and Haus Ehrenberg Reutte were also audited. The original readiness scores range from 3.4 to 4.25 out of five. Table 2 retains those scores for the original sites.

Table 2 Historical organisational readiness scores

Country	Community profile reported	Residential profile reported
Austria	3.4 out of 5	3.7 out of 5
Slovenia	3.7 out of 5	4.1 out of 5
Cyprus	3.75 out of 5	4.25 out of 5

Across the audits, staff were interested in learning, while device access and documentation arrangements varied. Fulpmes and Reutte used electronic care records and drew on daily observation, conversations and dementia-related experience to recognise concerns.

The Austrian closing records identify fit with ordinary care as the main implementation issue. Staff needed clear instruction, manageable documentation and defined responsibilities. Trained colleagues supported use and brought experience into team discussion.

Austria contributed four audited institutions: mobile care and the residential home in Völs, followed by Fulpmes and Haus Ehrenberg Reutte as the practical pilot sites. The site change extended audit coverage; the original and replacement institutions remain distinct.

4.2 Readiness findings and implementation support

Structural readiness concerns workable access during care. Fulpmes reported shared computers, CareCenter documentation and an external IT contact. Reutte's checklist also records laptops and tablets alongside CareCenter. Device access alone did not establish confident use: practical assistance and an accessible contact were relevant safeguards. The Slovenian and Cypriot findings

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similarly connect digital access with guided use, suitable equipment and the conditions of the actual care encounter.

Process readiness concerns the link between screening and care. In both Austrian facilities, screening supplemented staff observations and knowledge of residents. Trained colleagues and team reflection supported interpretation. The audits recommend linking findings with care planning and clear responsibilities; they do not document a new formal referral protocol in every facility.

10

Staff brought different levels of digital experience, and previous training had focused particularly on dementia. Austrian interviewees favoured compact online sessions with practical examples, suggesting two to three hours in the late afternoon. These were preferences for future training. During the pilot, trained colleagues provided practical guidance and helped staff discuss their interpretation.

Management support and fit with existing routines shaped integration. Fulpmes involved nursing management in preparation. Both Austrian accounts identify clear responsibility, team participation and time as conditions for continued use.

The Audit Tools retain this readiness-based approach for future organisations. The Transfer Handbook describes how preparation, supported use and review can fit existing management processes.

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5 Common documentation and templates

5.1 Purpose of the documentation

Hafelekar prepared common English partner versions of the Austrian documentation in the package. These templates supported consistent description of institutional arrangements and practical use. They complemented the earlier participation, attendance, case and national report forms, connecting the established national procedures with a shared framework for documenting implementation.

The Facility Confirmation and Authorisation template records the provider, setting, implementation period, authorising body, basis of approval and responsibilities. It can document prospective authorisation or confirm an institutional basis that already existed. Cyprus used it to distinguish the original management approval dates from the later confirmation signatures, preserving an accurate account of institutional involvement.

The Client or Resident Information and Consent template explains purpose, participation, information use and contacts in accessible language. It requires competent local adaptation. Institutional approval and individual participation information have separate roles; neither substitutes for the other.

The Partner Pilot Implementation Checklist connects preparation, trained use, reflection, supporting material and aggregate figures. It links the organisation, participation figures, practical forms and national account within the same implementation. The approved application defines the contractual indicators; optional planning benchmarks and suggested case allocations in the template serve as implementation guidance.

The Practice in Usage of the Tool form records the initial situation, introduction and conduct of screening, interpretation and actions, client feedback and practitioner evaluation. These elements allow the report to explain practical use rather than simply list scores. The national report then synthesises the delivery process and experience. Identifiable attendance and consent records remain in the responsible restricted record, not in the general case narrative.

5.2 Documentation of implementation and practical use

The documentation links the organisation and its approval basis with staff preparation, application and reflection. The instruments answer different questions, as summarised in Table 3.

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Table 3 Roles of the pilot documentation instruments

Instrument	Main question answered	Boundary of the evidence
Facility confirmation	Where and on what institutional basis was use supported	Does not itself prove routine continuation
Participation and attendance	Who joined the relevant learning activity	Not a competence or client outcome measure
Practice form and Activity D	How was the tool applied and interpreted	Self-reported practice and educational evidence
National report	How was delivery adapted and experienced	Synthesis depends on its underlying sources
Implementation checklist	Do scope, counts and files reconcile	Aggregate confirmation requires source linkage

The final Best Practice Brochure contains twelve selected examples, four per country, drawn from existing applications. It illustrates implementation and professional reasoning rather than a representative clinical sample. The anonymised summaries omit unnecessary identifying details.

The Slovenian annex demonstrates the value of structured practice forms for describing feasibility, duration, planned actions and barriers across fifteen records. Its setting and respondent categories are retained in the national summary. The Cypriot case workbook adds detailed delivery context and examples of professional responses. The analysis uses each source for the information it actually contains.

Equivalent national records can fulfil the same documentary purposes. The templates provide a common framework for future implementation without requiring the pilots to be repeated.

12

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6 Cyprus implementation process

6.1 Recruitment and delivery

Materia Group recruited participants through direct contact and telephone communication within its professional network. Sixteen individuals were initially recruited and six joined later, bringing enrolment to twenty-two. Two withdrew by the end of April because of work and family commitments, leaving twenty continuing participants. Reported professional experience ranged from one to forty-five years. Participants required different levels of support with independent study and digital navigation.

The implementation checklist and facility confirmations give the period as 1 April to 15 July 2026. MM Care Services provides home or community care, and Thalpori Stegi Ilikiomenon Ltd provides residential care. The national report states that the nurses were working in mobile care when they joined the programme, although their professional backgrounds included several settings. Employment profiles and the settings of the participating providers are therefore reported separately.

Delivery began with orientation in April, covering objectives, programme structure, online access, progression and assessment responsibilities. Self-study in April and May involved online learning segments and quizzes. The implementing team monitored difficulties rather than assuming that the initial orientation was sufficient.

When problems with digital navigation, independent study and conceptual understanding became evident, the team added six facilitated sessions between May and June. These included classroom instruction, discussion and applied exercises. Renovation at the organisation's premises prevented delivery at the originally intended site, so another care unit and an accessible central venue were used. This was a practical adaptation of delivery, not evidence of an additional implementing care organisation.

The third phase involved independent practical application through Activity D, linking the learning content to a concrete care situation. Delivery thus became more supported and blended as the pilot progressed.

6.2 Participants, practical use and organisations

The Cyprus checklist reports twenty participating nurses, twenty screenings, twenty Activity D forms and two selected examples. The final brochure draws four examples from the existing workbook. The checklist also records three

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trainers or multipliers, whereas the WP4 synthesis identifies a lead-trainer role. These role categories are retained as reported.

The consolidated training report refers to eighteen practical case forms and twenty Activity D reflections, fifteen of which contain substantive reflective content. These are document-subset and content counts. The twenty-screening total is retained as the partner's checklist account, while the case narratives support qualitative analysis.

Table 4 Cyprus implementation figures

Evidence item	Cyprus account	Reporting use
Recruitment	22 enrolled and 2 withdrawals	Participation context
Continuing participants	20	Reported continuing cohort
Practical use	20 screenings and 20 Activity D forms	Checklist aggregate figures
Selected cases	4 in final brochure; 2 in original checklist subset	Selected from the existing Cypriot case workbook; no additional screenings
Care organisations	MM Care Services and Thalpori	Two separately confirmed care services

The facility confirmations record original management approval dates of 19 February and 1 March 2026 and confirmation signatures in September. They document the institutional basis and implementation period while keeping approval and confirmation as separate events.

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7 Cyprus findings and selected cases

7.1 Learning and tool feedback

Participants in Cyprus valued the structured materials and flexibility of blended learning, but many struggled to sustain independent progress. Facilitated sessions allowed them to ask questions, discuss practical situations and clarify connections between care domains.

The content challenge was often the move from an abstract holistic framework to everyday nursing situations. Participants asked for more real-life examples, especially for psychosocial needs and the connections between domains. Different prior educational and digital backgrounds affected the support required. The relevant implementation lesson is to retain a common curriculum while adjusting explanation, examples and access support to the actual group.

Feedback on the digital tool describes a useful multidomain overview and interest in continued use. Some participants shared the approach with colleagues who subsequently requested access. This reported interest provides a basis for further uptake through the partner's training and capacity-building activities. It is evidence of interest, rather than established routine adoption by those colleagues.

During piloting, users reported difficulties with registration, login, progress indicators, completion status, report access and mobile navigation. Loading and back-button behaviour reduced confidence in using the tool. Guided sessions and practical assistance helped users continue. Feedback reached the development team, and UCY reports implementing the requested changes that were feasible. During the pilot, residual usability difficulties were managed through guided use and local assistance.

Language inconsistencies were managed through local explanation, adapted learning support and feedback to resource developers. Future organisations can use the completed resources together with available partner guidance.

7.2 Cyprus cases and organisational implications

Four examples from the Cypriot case workbook were selected for the Best Practice Brochure. They cover home and residential care and distinguish care-plan additions, requested reviews and arranged support.

One example concerns an older woman living alone after bereavement, with disturbed sleep and reduced social contact. The practitioner reported a moderate screening result and added emotional support, sleep advice and regular telephone contact to the care plan. The case shows how related

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concerns could be translated into a concrete plan. The recorded result is the care-plan addition, not a measured subsequent change in symptoms.

A second example concerns a resident with low mood and reduced participation in residential care. Screening brought together observations about physical health, mobility and social withdrawal. Staff increased emotional monitoring, encouraged participation and requested a physiotherapy review. The documented follow-up was the referral request, not a verified clinical outcome.

Another example concerns a resident after two falls and a loss of confidence. The source reports a high health-domain result and requests for falls and medication review and environmental changes. This illustrates prioritisation for coordinated professional review. It does not attribute a subsequent reduction in falls to screening; the practical contribution was the organisation and communication of concerns.

A further example concerns an older woman living alone in a rural area with little social contact. Screening made social and health concerns easier to consider together. The partner reports that community contact, transport support and regular follow-up were arranged. The example connects a recognised need with access to local support, rather than relying only on general advice about social activity.

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8 Slovenia implementation process

8.1 Educational setting and delivery

The University of Maribor, Faculty of Health Sciences, integrated EDU-MENT into advanced nursing education and integrated care for people with chronic conditions. Its national account describes a master's programme context and a short training programme. The university coordinated learning, while participants applied the tool in their own care settings.

Slovenian piloting took place in April and May 2026. Within the university-led route, practical application and reflection connected the online resources with participants' nursing work. The national account and consolidated training synthesis describe this learning period and the way the educational assignments supported professional interpretation.

The national narrative describes fifteen participants and one national trainer. The checklist lists four trainers or multipliers; the consolidated synthesis distinguishes three lead trainers and one national trainer.

The practical assignments asked learners to use screening, relate the output to a care situation and reflect on their professional judgement. Activity D provides the bridge between conceptual learning and practice: it records what was understood, whether the tool added insight and how its results might inform action. The practice forms contribute information about setting, duration, feasibility and responses to identified concerns.

The Slovenian package combines a national delivery narrative with aggregated evaluation of practical assignments. Structured reflection linked the online resources to workplace experience and professional interpretation.

8.2 Participants, practical use and organisations

The checklist reports fifteen screenings, fifteen Activity D forms and two selected examples. The detailed annex contains fifteen practice forms, including fourteen learner records and one trainer record. Four records were selected for the final brochure. The checklist subset and editorial selection describe different uses of the existing material.

Nine practice forms concern home or community care, four institutional care and two have no recorded setting. Participants used the tool in their own workplaces. Employers' identities are confidential, and the employers were not formal pilot facilities.

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Table 5 Slovenia institutional and practice evidence

Evidence item	What it supports	What remains distinct
UM FHS confirmation	Educational institution's involvement	Sole formal SI pilot/authorising institution; not a care-provider target entry
15 practice forms	15 practice forms: 14 learners plus 1 trainer	Not a verified unique-client or learner-completion total
9 home/community; 4 institutional	Range of practice contexts	Two records lack a setting
Four final brochure examples	Selection from the 15-record practice annex	Three learner examples and one identified trainer example; earlier checklist subset: two

UM FHS coordinated and authorised the Slovenian pilot. The report attributes the educational implementation to the university and describes workplace applications separately.

This university-led route complements the supported pilots in Austrian and Cypriot care organisations. Its particular contribution is the integration of practical application and reflection into nursing education, continued through UM FHS's Master of Science (MSc) teaching.

18

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9 Slovenia findings and practice responses

9.1 Assessment findings and planned responses

The Slovenian coding identifies loneliness or reduced social inclusion in ten of fifteen practice forms, sleep concerns in eight, chronic disease or polypharmacy in seven, mobility or fall-related concerns in seven, cognitive concerns in six, and emotional or depressive concerns in six. Categories overlap and were counted once per relevant form. They describe the records, not prevalence among clients.

The pattern suggests that psychosocial and physical concerns often occur within the same care situation. A practitioner may already know about chronic illness while being less aware of the person's social isolation, sleep or emotional experience. The source describes the tool as a prompt to consider these aspects together, rather than as a replacement for professional assessment.

Eleven forms contain concrete planned actions or referrals; four contain a plan without a specified action. Responses include social activation in seven records, monitoring or follow-up in six, sleep-related support in four, and medication support, physician referral or fall prevention in three records each. Categories overlap. The counts concern documented proposals, not independently verified delivery.

The records also show why follow-up must fit available local support. The trainer identified limited rural resources as a practical constraint. The transferable response is to relate each proposed action to services and responsibilities that are actually available, use team discussion where options are limited, and retain the concern in the normal care-review process. This provides a realistic route beyond identifying a need.

The practice descriptions show how a structured overview informed professional reasoning and care planning. Clinical effectiveness was not measured.

9.2 Slovenia usability, feasibility and learning

Recorded screening durations range from 15 to 60 minutes, with a median of 20 minutes in the annex's Table 1. The national trainer distinguishes a 15-minute screening from a 45-minute whole visit. These estimates may cover different combinations of conversation, data entry, interpretation and follow-up.

Feasibility in everyday practice was rated 'yes' in eleven forms and 'partly' in three. One form had no response, and none recorded 'no'. Time, equipment, connectivity and willingness to discuss sensitive topics affected use.

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Navigation difficulties appear in six practice forms, sensitive questions in four, time demands in three and equipment or connectivity concerns in three. Less frequent observations concern general recommendations, revising answers, understanding questions, translation, staff resistance and fit with the setting. These findings inform the readiness and communication guidance for future use.

In the practice forms, all fifteen responses to 'Did the tool support your professional judgement?' and 'Did the tool enable new insights?' were affirmative. Fourteen forms describe positive or neutral-positive client reactions, while one records no opinion. Three also note sensitivity or reserve when discussing loneliness, grief or distress. A generally positive encounter can therefore include discomfort when discussing a particular topic. These are practitioners' accounts, not a direct client survey.

The annex distinguishes fifteen substantive entries in its methods description from thirteen reflections in the Activity D content analysis. Eleven of those thirteen explicitly report agreement between the screening result and clinical judgement. This narrative judgement is separate from the two yes/no items in the fifteen practice forms; the denominators are not combined. The brochure includes four Slovenian examples, one identified as the national trainer's case.

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10 Austria national implementation and findings

10.1 Delivery and professional experience

Following the site change, Austria piloted EDU-MENT in Fulpmes and Haus Ehrenberg Reutte, both residential long-term-care facilities. UMIT TIROL reports ten applications, five per facility; these are distinct from staff and interview counts. Complete attendance and role records were unavailable, so staff participation is described qualitatively from the closing audits. Closing audits describe organisational conditions, and four September profiles support the Austrian brochure examples.

The closing audits describe electronic care documentation and experienced staff whose prior training focused particularly on dementia. Fulpmes used shared computers with external IT support; Reutte also recorded laptops and tablets. Colleagues who had completed the EDU-MENT course introduced the tool locally. An introduction of approximately one hour was followed by practical support and closing discussion.

Fulpmes practitioners valued systematic attention to psychosocial concerns, clearer written documentation and discussion within the care team or with other professions. For residents already well known to staff, screening sometimes confirmed existing assessments. Its contribution was making that reasoning explicit. Direct participation was not always accepted: some residents stopped answering or found personal questions uncomfortable. Observation, biography and previous knowledge were sometimes used to continue the record.

The Reutte account similarly distinguishes direct questioning from observation-based completion when communication was limited. Reported application time in both settings ranged from roughly ten to thirty minutes. Staff learning, sensitive explanation, leadership support and time within normal workflows were important conditions. The accounts distinguish observation-based records from resident self-report. Observation-based use was described as practice experience, not validation of an alternative administration method.

The overview supported team discussion in Fulpmes. Reutte's reports included automatic action prompts, which remained distinct from individual care decisions. Both closing audits linked longer-term use with clear responsibilities, time and care planning. Continuation on selected wards was intended; long-term adoption was not assessed.

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10.2 Practical use and selected profiles

Four Reutte profiles underpin the Austrian brochure examples. Their twenty-four domain results comprise thirteen low, ten moderate and one high result in the tool's categories. The profiles illustrate a health-related priority, sleep and social concerns, predominantly low indicators and a cognitive/emotional assessment focus.

Table 6 Austria implementation and selected profiles

Evidence item	What it supports	What remains distinct
Two closing audit records	Organisational conditions in Fulpmes and Reutte	Historical audits retain their own attribution and scores
10 reported applications	Five applications in each residential pilot facility	Applications are not a verified unique-client or learner-completion total
Four screening profiles	24 domain results from existing Reutte records	
Four final brochure examples	Selected profiles with supporting practice summaries	Selection from existing applications.

The profiles provide assessment priorities to review alongside staff knowledge of residents. The organisational accounts explain preparation and team use. Potential care implications are kept separate from documented interventions.

Fulpmes staff sometimes completed records from observation, biography and prior nursing knowledge when direct participation was limited. The information source must therefore be explicit, and residents' decisions about participation respected. This was practice experience, not validation of an alternative self-report method.

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11 Lessons across the three countries

11.1 Shared findings and institutional routes

Across the national accounts, practitioners valued EDU-MENT for structuring attention and discussion. Cyprus described a multidomain overview; Slovenian records identified psychosocial concerns and possible responses; Austria documented team use in residential care. The shared finding concerns professional reasoning and care organisation.

Training support recurred across countries. Cyprus added facilitated sessions; Slovenia embedded application and reflection in teaching; Austria used trained colleagues and team discussion. In each route, learners needed opportunities to connect the material with a care situation.

The institutional routes differed. Cyprus involved two named providers; Austria involved Fulpmes and Reutte. UM FHS coordinated the Slovenian educational pilot, with individual workplace applications outside formal employer participation. Table 7 compares these routes.

Digital use required both workable access and confidence in the tool's sequence. Users could be familiar with a device yet need help with navigation or report access. Guided sessions, practical assistance and feedback to technical development addressed these different needs. UCY reports implementing feasible requested changes, while local facilitation supported participants during application.

11.2 Implementation at a glance

Table 7 compares the national routes, practice material and transfer lessons.

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Table 7 National implementation routes

Dimension	Cyprus	Slovenia	Austria
Delivery	Provider-linked supported learning	University-led workplace practice	Introduction by trained colleagues in two residential facilities
Practice material	20 reported screenings; four brochure examples	15 forms, including one trainer record; four examples	10 reported applications; four selected profiles
Institutional basis	Two named care providers	UM FHS as formal pilot facility	Fulpmes and Haus Ehrenberg Reutte
Transfer lesson	Guided learning and usable access	Link reflection with feasible action	Team support and fit with residential care

24

Austria reported ten applications, Slovenia supplied fifteen practice forms including one trainer record, and Cyprus reported twenty screenings. These are different measures of activity and cannot be added together as a common clinical sample. Four existing examples per country were selected for the brochure.

Feedback is reported for the group that answered each questionnaire. Cyprus had different numbers of pre- and post-training responses, and the Slovenian material included a trainer record. The results therefore describe participants' views without calculating a combined improvement score.

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12 Feasibility conditions and implementation responses

12.1 Conditions for practical use

Feasibility depends on the whole care encounter. A short period of data entry is only one component. Preparing access, introducing sensitive topics, listening, interpreting the report, documenting a decision and arranging follow-up can take longer than completing the visible screening sequence. The Slovenian variation in recorded duration and the Austrian staffing concerns make this distinction especially important.

Suitable devices, connectivity and a private setting are practical conditions for use. During pilots, digital and navigation difficulties were addressed through assisted access, facilitated learning and feedback to technical development. Local readiness review, suitable devices and accessible support provide practical safeguards for continued use. Offline operation and integration with local record systems were not assessed in the national accounts.

Sensitive conversations require clear explanation and attention to the person's circumstances. Contextual interpretation helps relate questions to residential care, community care or situations in which communication is limited. Safeguards include voluntary participation, respect for a decision to stop, clear identification of information sources and retention of the standardised scoring method.

Follow-up capacity connects an identified concern with a realistic professional response. Nurses used care planning, team discussion and existing referral routes; where local services were difficult to access, the response was to discuss feasible support within available responsibilities. The records describe professional reasoning and proposed actions, not verified completion of every referral. A named next step and normal care-review route are the transferable safeguards.

The records describe feasible application where preparation, professional competence, access and follow-up were supported. The Audit Tools and Transfer Handbook translate these conditions into guidance for receiving organisations.

12.2 What the pilot results can tell us

The pilots show how EDU-MENT was used, what practitioners found helpful and what support they needed. They were not controlled clinical studies. They

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cannot establish diagnostic accuracy or show whether clients' health improved because of the tool.

Selection is shaped by the pilot context. Participants were recruited through partner networks and educational or provider settings. Those who supplied reflections may differ from those who withdrew or did not complete a form. In Cyprus, different pre- and post-response numbers make a simple paired improvement interpretation inappropriate. In Slovenia, the inclusion of a trainer record affects the meaning of a participant-only denominator.

26

Attendance, screening forms, Activity D and institutional confirmations answer different questions about participation, use, reflection and organisational involvement. Their respective roles are defined in Chapters 3 and 5.

Frequencies describe the records reviewed. Categories can overlap, and small samples are not treated as estimates for the wider population. Country totals remain separate where the measures or respondent groups differ.

Within this descriptive scope, the national accounts explain the role of guided learning, digital support and professional follow-up. They inform the implementation guidance in the Transfer Handbook.

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13 Sustainable use of the completed results

13.1 Partner continuation plans

In the final internal evaluation, all five partner organisations rated the Transfer Handbook 'Very useful'. This is a partnership assessment of the resource, rather than independent evidence of care outcomes or long-term adoption. Table 8 summarises the reported continuation pathways.

UM FHS reports continued use in existing MSc teaching. UM and UMIT are considering ECTS recognition and curricular integration. Formal credit recognition remains subject to institutional procedures.

Table 8 Reported partner continuation pathways

Partner	Continued-use pathway	Practical basis
UM FHS	Existing MSc teaching; ECTS and curriculum-integration consideration	Course, lecturers, learning materials and practical reflection
UMIT TIROL	Teaching/continuing education; ECTS and curriculum-integration consideration	Austrian training experience, curriculum and facility contacts
Materia / AGECARE	Training and capacity building	Adapted resources, staff and organisational infrastructure
Hafelekar	Train-the-Trainer courses and online training	Audit Tools, implementation guidance, templates and Transfer Handbook
University of Cyprus	Technical support for continued partner platform use	Technical expertise; application-specific access and support arrangements

13.2 Practical safeguards for continued use

Future organisations need local management support, trained staff, suitable devices, time for interpretation and an agreed process for discussing findings and follow-up. The national examples offer different ways to arrange that

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support: guided learning, university assignments and facilitation by trained colleagues.

Staff changes are addressed through induction, shared learning materials and handover of local facilitation. A new colleague should understand when EDU-MENT is useful, which information sources are being considered and how a concern reaches an appropriate professional. Existing team meetings or supervision can retain the practical reasoning developed during use.

UCY offers technical support to partners continuing platform use. Educators and providers remain responsible for their own teaching, care and documentation arrangements. Access, responsibilities and available support need to be agreed for each application.

The Audit Tools provide an entry point for future organisations. Readiness assessment is followed by learning support, practical application, interpretation and review within existing processes. This pathway addresses staffing, digital confidence, sensitive communication and follow-up conditions encountered during the pilots, using the resources already delivered.

Recognition may develop through university curricula, institutional completion certificates or options for continuing professional development. The learning and assessment documentation can support institutional review; it does not itself confer recognition.

The Transfer Handbook identifies the resource collection and relevant partner contacts for materials, training and technical support. Continued use builds on these arrangements and the resources developed during the project.

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14 Conclusions and transfer implications

14.1 Conclusions

The pilots document how practitioners used EDU-MENT to organise psychosocial and physical observations and discuss care responses. Its perceived contribution was a structured overview within professional assessment. The national records do not establish diagnostic accuracy or independently measured health effects.

Delivery required adaptation: Cyprus added guided sessions and changed venues; Slovenia linked application with teaching and reflection; Austria used trained colleagues and team discussion. Feedback informed technical development, while closing audits identified responsibilities and resources needed for local use.

WP5 achieved implementation in at least six care and assistance organisations, confirmed by the WP5 lead, and exceeded the audit target with eight institutions against six planned. The Austrian site change extended the audit coverage to four institutions while practical piloting took place in Fulpmes and Reutte. The twelve selected brochure cases illustrate applications from the three countries.

For future use, the principal recommendations are to assess readiness, prepare staff, explain sensitive questions, interpret results in context and agree feasible follow-up responsibilities. The Transfer Handbook sets out this process. Chapter 13 distinguishes reported continuation plans from recognition decisions still under institutional consideration.

14.2 Resources for practical implementation

The Transfer Handbook guides organisations through preparation, staff learning, practical application and review. Its resource catalogue explains the purpose of the materials and identifies the relevant partner contacts.

Use the Audit Tools to assess local readiness. The Training Framework and E-Training Manual help plan learning; the Screening Tool User Manual explains practical use and reports. Activities A-D and the blank practice form support casework, communication and reflection.

The Best Practice Brochure provides twelve examples for team discussion. The education and service-quality guidelines support clear responsibilities and continued use. Documents and access information are available through the project website: https://edu-ment.eu/public-deliverables/.

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Abbreviations

Abbreviation	Meaning
AT	Austria
CY	Cyprus
SI	Slovenia
EDU-MENT	Education in Mental Health for Nurses in Home and Residential Care
ECTS	European Credit Transfer and Accumulation System
MSc	Master of Science
QM	Quality management
UCY	University of Cyprus
UM	University of Maribor
UM FHS	University of Maribor, Faculty of Health Sciences
UMIT TIROL	UMIT TIROL, project coordinator
WP	Work package
Activity D	Practice-based application and reflection assignment in the EDU-MENT learning programme

30

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