NEW ZEALAND NURSES ORGANISATION

Gerontology Nursing Knowledge and Skills Framework 2014

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2.0 Introduction

This document intends to provide a framework for Gerontology Registered Nurses whose primary work is with older adults in long term care environments, i.e. specialty gerontology nursing practice.

> *Nursing specialty practice is defined as practice that focuses on a particular area of nursing. It is directed towards a defined population or a defined area of activity and is reflective of increased depth of knowledge and relevant skills. Specialty practice may occur at any point on the continuum from beginning to advanced practice*[2]

Much of gerontology nursing practice occurs in facilities with little public access until care is needed, as such it suffers from a lack of visibility both among the general public and the nursing profession. Having a nursing knowledge and skills framework supports gerontology nurses to articulate their specialty practice and allows other to see what they contribute. It is an important step in the journey towards our vision

Gerontology Nursing: Visible and Valued

2.1 Purpose

This document intends to provide a framework for Gerontology Registered Nurses whose primary work is with older adults in long term care environments (older adult specialty) to articulate their practice. It is not specifically developed for Enrolled Nurses however it is recognised that Enrolled Nurses working in long term care make a significant contribution to the care of older adults and work in partnership with Registered Nurses in all of the aspects of the care identified in this knowledge and skills framework.

It is not an exhaustive list of everything a Gerontology Registered Nurse knows and does; rather it identifies core themes that make Gerontology a speciality practice area. It promotes best practice and should be used in conjunction with national and international guidelines and standards of practice.

It is complementary to Nursing Council of New Zealand's (NCNZ) competencies for registration and aims to support Gerontology Registered Nurses to articulate their practice. It does not replace Professional Development Recognition Programmes (PDRP) but it can be used as a tool to help nurses evidence their practice. As best practice is dynamic in nature it remains the nurse's responsibility to stay up to date, regularly evaluating what is best for the older adult in his/her care.

This document is not intended for all nurses that encounter older adults (although we acknowledge selected areas may prove useful) and it is not intended for Advanced Gerontology Nurses.

It is not intended as a disciplinary or performance management tool.

3.0 Gerontology Nursing

Gerontology nursing is a distinct area of practice.

It is an evidence based specialty that focuses on the age-related physiological, psychological, developmental, economic cultural and spiritual changes of older adults and the health needs these changes generate.

It promotes autonomy, wellness, optional function, comfort and quality of life from health gain to end of life in collaboration with older adults, their family / whanau, care givers and the multidisciplinary team.

It involves leading multidisciplinary teams in a holistic person centered approach in the specialist care of older adults.

In addition to providing clinical care gerontology nurses advocate, educate, manage, consult and conduct research about the dynamic trends, issues and opportunities related to ageing and its effect on older adults[3]

3.1 **Person centred care**

Person-centred care is practice that places the person at the centre of their own care and considers the needs of the older person's care giver. Simply it is treating older adults as they want to be treated, it preserves the dignity of the older adult and all those who work with them. It is an important practice approach because older adults are heterogeneous group with different needs and expectations of care. Person centred care can make a positive difference to health outcomes and patient satisfaction and can improve health care workers' sense of professional worth[4].

The principles of person centred care are[5]

- Getting to know the older adult:
  - beyond the diagnosis building relationships with the individual and care giver family / whanau
- Sharing of power and responsibility
  - respecting preferences and treating older adults as partners in setting goals, planning care and making decisions about care, treatment or outcomes (to their maximum ability).
- Accessibility and flexibility
  - Meeting older adults individual needs by being sensitive to values, preferences and expressed needs. Giving choices by providing timely, complete and accurate information they can understand, so they can make choices about their care.
- Coordination and integration
  - Working as a team to minimise duplication. Teamwork allows service providers to maximise patient outcomes and provide positive experiences.
- Environments:
  - Physical and organisational or cultural environments are important, enabling staff to be person centred in the way they work.

4.0 Summary

The Gerontology Nurses Knowledge and Skills Framework provides nurses working with older people especially in long term care environments with a specific older adult focus, to support planning their careers and continuing professional development. It provides a structure to help support individuals to identify their own development and training goals.

The development of this framework is important for the continuing growth of an experienced and well trained gerontology nursing workforce that can support our vision Gerontology Nursing: Visible and Valued.

Aspect of care	Level of knowledge and skill – Gerontology RN	Example
Assessment		
Comprehensive gerontology assessment (CGA) is the corner stone of best practice care for the older adult. It is a detailed and in-depth assessment that includes wellness and illness perspectives and forms the basis of care for older adults reduces mortality and morbidity and improves quality of life for older adults[6].	Able to complete / ensure completion of a CGA that includes[7]: • Medical History: from older adult, family and records (records may be incomplete) • Medication: current and historical prescriptions (when & why medication stopped / started) and medication concordance • Social/cultural: formal and informal support, care giver stress, environment, culture • Psychological: mood, cognitive function, substance abuse, behavior change • Functional: ability to perform activities of daily living (ADL and instrumental ADL) • Mobility: gait and balance and physical activity • Bladder and bowel: continence / constipation • Sensory loss: vision and hearing • Pain: acute and chronic pain and impact on function • Skin: risk of pressure injury • Nutritional and hydration status: includes dental/oral health and swallow • Sexuality and sexual function • Advance planning / directives • Perceived quality of life • Health promotion activity (immunization, cardiovascular risk, exercise, sense of self) • Economic resources: (access and ability to survive) A range of appropriate standardised evidence based assessment tools (SEBAT) are used to complete this process including but not limited to: Activities of daily living (ADL) and Instrumental ADL[8] cognitive function[9,10,11] mood[12] pain[13] pressure injury risk[14] nutrition[15,16] falls[17] interRAI[18]	

Aspect of care	Level of knowledge and skill – Gerontology RN	Example
Pathophysiology		
Age-related changes	• Can describe the common age related changes to physical, mental, social and economic health. • Can differentiate between age-related processes and reversible conditions • Can identify and respond to atypical / non-specific presentations of acute illness in older adults • Understands the risk of physical / cognitive decline and deconditioning during periods of acute illness in older adult • Promotes usual function (mobility, nutrition, hydration) during acute illness to reduce the risk of decline and deconditioning • Takes action to restore baseline function after periods of acute illness	
Recognises and responds to common geriatric syndromes "***Geriatric Syndromes*** *are multifactorial health conditions that occur when the accumulated effects of impairments in multiple systems renders a person vulnerable to situational challenges."*[19]	Falls • Uses SEBAT to determine risk of falling[20] • Identifies individual fall risk factors and develops a patient centred falls prevention and management plan (includes referral to others as required) • Responds to fall events by assessing for trauma and acute illness in the first instance referring for medical/emergency assistance as required • Completes a post fall assessment to identify all potentially contributing causes (includes assessing patterns of falling) • Reviews and updates the falls prevention and management plan.	
	Frailty • Uses SEABT to determine frailty risk factors[21] • Recognises that unreversed frailty is an end stage conditions with high mortality / morbidity • Develops a patient centred care plan (PCCP) to reduce / slow frailty progression • Refers to other members of the multidisciplinary team (MDT) as required	
	Mental health • Is able to compare and contrast delirium, depression and dementia • Recognises deviation from persons normal behaviour occurs for a variety of physiological/cognitive and social reasons/conditions • Recognises that older adults may experience an exacerbation of a long standing mental health disorder and/or a new mental health, neurological or substance abuse disorder • Seeks support to ensure accurate diagnosis of new presenting symptoms	
	Dementia • Can described the diagnostic criteria for dementia[22] • Understands that the term "dementia" is used to describe a broad range of progressive, irreversible life-limiting conditions and degrees of cognitive impairment • Adjusts discussion / assessment / care and treatment to meet individual need focusing on quality of life.	

	• Supports family / whanau as they adjust to the consequences of their loved one living with dementia. • Uses dementia specific SEBAT to assess the needs of the older adult with dementia[23,24,25] • Recognises behavioural and psychological symptoms of dementia (BPSD) • Carefully considers whether BPSD is harmful (to self or others) and intervenes only for harmful behaviour • Works with family / whanau, MDT and older adult to identify the underlying cause of BPSD and develops a PCCP that maximises the use of non-pharmacological strategies • Recognises end stage symptoms of dementia and plans end of life care with family / whanau, MDT based on the older adults previously expressed preferences for care	
	Delirium • Uses a SEBAT[26] to identify and rapidly respond to this life threatening medical emergency • Uses behavioural, communication, and environmental-modification strategies to maintain safety for people experiencing delirium. • Reassesses cognitive function after delirium to determine degree of recovery • Manages risk factors, pain, infection, poor nutrition & hydration, lack of sensory aids on a daily basis to reduce the risk of delirium in particularly in cognitively impaired, frail older adults.	
	Depression • Uses SEBAT to help identified depression • Recognises and is sensitive to the impact of age-related life events on mood (moving into residential care, loss of professional / social role, bereavement) • Knows depression in older adults more commonly presents as physiological symptoms and is more likely to lead to suicide than in younger people[27]	
Managing multiple chronic conditions	• Takes a balanced approach to working with older adults with multiple chronic conditions considering the individuals primary concern, goals, prognosis and ability and/or willingness to participate in treatment/management • Recognises the potential for harm in conflicting treatment plans for each chronic condition[28]. • Recognises the impact of multiple chronic conditions on health related quality of life[29] • Supports self-management (to the degree possible) to minimise the impact on function and quality of life	
Common conditions of ageing	• Understands the pathophysiology, treatment and management options of the common conditions of ageing (Heart Failure, Chronic Obstructive Pulmonary Disease, Cancer, Osteoporosis, Type 2 Diabetes Mellitus, Stroke and Parkinsons disease) • Identifies advanced disease and works with the older adult and / or family / whanau on a palliative approach to care	

Aspect of care	Level of knowledge and skill – Gerontology RN	Example
Interventions		
Managing fundamental care (ADL) to maximise health and quality of life	• Supports the older adult with ADL deficits (directly or indirectly via a PCCP) to avoid complications leading to a deterioration in health such as infection, delirium, constipation, weight loss, dehydration, immobility, pressure ulcers,	
	Constipation • Assesses constipation using a combination of medical and patient definition • Identifies potential causes of constipation and develops a PCCP using both pharmacological and non- pharmacological interventions	
	Urinary incontinence • Assesses the degree, type and significance of urinary incontinence to the older adult and develops a PCCP to manage the issue.	
	Pain • Uses SEBAT to help identify type and significance of pain and develops a PCCP to manage the issue. • Uses non-pharmacological and prescribed pharmacological interventions to achieve optimum pain management • Refers to other members of MDT or specialist services for intractable or sudden onset pain	
	Intimacy • Acknowledges that older adults are sexual beings and the desire to express sexuality remains into old age • Understands and supports appropriate intimate and sexual relationships between consenting older adults in / outside residential care. • Acknowledges the potential for loneliness, unsatisfied sexual desire and grief caused by separating older couples on entry to residential care • Understands the full range of human sexuality is experienced by older adults (lesbian, bisexual, gay, transgender [LGBT] and heterosexual) • Is sensitive to the risk of homophobic attitudes impacting on the care and socialisation of older adults revealing their LGBT sexuality	
Communication	• Communicates in a respectful and patient manner using non-derogatory language • Recognises that the older adult's ability to communicate verbally and non-verbally may be impacted by age-related conditions, medication, sensory loss and culture. • Uses effective communication techniques such as 'journeying' through a life story, active listening, rephrasing, minimising environmental noise' and interruptions, using sensory aids and prioritising the collection of information. • Modifies communication to match individual needs of older adults who are demonstrating distressed behavior or who have complex communication needs. • Asks open questions to check the older adults understanding of health information and treatment recommendations	

Supporting health decision making	• Assists older adults and family / whanau to make health decisions by explaining potential risks and benefits of treatment and care. • Manages expectations of treatment and care by clearly explaining current and likely future health status / disease progression • Advocates for older adults to receive evidence based screening and health maintenance interventions that match their health needs and goals. • Advocates for treatment to be based on health status rather than chronological age • Promotes the independence of cognitively impaired older adults by frequently involving them in decisions about their care (no matter how small). • Uses the older adults previously expressed views, advance care plans, family / whanau and / or attorney and clinical knowledge to assist with decisions that must be made on behalf of the older adults who lack the capability to make or express decisions.	
A palliative approach and end of life care.	• Understands that dying is an inevitable and normal part of gerontology practice • Works with older adults and family / whanau to develop realistic expectations of their health care and plan for predictable symptoms and end of life • Focuses of activities than enhance quality of life (as defined by older adults) • Use standardised assessment tools/pathway to manage end of life symptoms[30,31]	
Working with family / whanau and care givers	• Where there is a positive benefit for the older adult includes family / whanau and care givers in developing and implementing a PCCP. • Is aware that undisclosed family dynamics may impact on establishing health partnerships • Works with family / whanau and care givers to understand the breath and limitations of their involvement in PCCP development • Understands the impact of care giving on the carer (includes loss of role in relationship). • Assists caregivers to identify, access, and utilise specialised products, professional services, and support groups that reduce caregiver burden. • Understands that functional and cognitive losses of parents impact on adult children	
Working with the multidisciplinary team (MDT).	• Understands that a MDT approach is fundamental to effective care of the older adults. • Forms relationships and works effectively with the MDT (includes health professionals across primary, secondary and tertiary services) • Understands how, when and why to refer to specific members of the MDT such as occupational therapist, physiotherapist, dietician, speech and language therapist. • Coordinates care and initiates appropriate and timely referrals to maintain and promote health	
Managing care transitions	• Recognises that care transitions (between services) are high risk activities for older adults and uses and evidence based hand over process between services • Ensures continuity of care by sharing relevant/appropriate patient centred information that is accurate, concise, timely, complete, and relevant, including but not limited to diagnosis medication and care plan	

Supporting meaningful activity	• Enables the older adult to maintain their personal identity • Identifies and support others to identify and implement physical, social and leisure activities specific to the wants and needs of the older adult • Identifies loneliness, helplessness and boredom in the older adult and works collaboratively to address these issues[32] • Enables older adults to contribute in a way that is meaningful to him/her (no matter how small) • Considers spiritual, intellectual, occupational, emotional and environmental needs of the older adult and where possible prioritises these over medical needs	

Aspect of care	Level of knowledge and skill – Gerontology RN	Example
Medication		
Older adults are at high risk of inappropriate polypharmacy and adverse drug effects.	• Participate in medication reconciliation processes[33] • Use SEBAT to help identify high risk medication / medication combinations[34,35] • Supports older adults to access safe medication delivery / administration systems • Assesses for adverse drug events at each medication regime change • Understands his/her obligations under Nursing Council New Zealand Guidelines for Direction and Delegation[36] (NCNZ D&D) in environments where medication administration is done by unregulated health care workers and/or enrolled nurses	

Aspect of care	Level of knowledge and skill – Gerontology RN	Example
Context of care		
Works within a legal and ethical framework (NCNZ 1.1, 1.3)	• Understands the need to work with the older adults correctly identified and activated Enduring Power of Attorney (EPoA) personal care and welfare[37] to support the intent of the legislation including how this act relates to treatment, resuscitation orders and advance directives. • Understands the role and legal position of advance care planning (ACP) in New Zealand. • Able to open ACP conversations, provide information and refer / work with the MDT to support the completion of an ACP (ie level 1 competencies[38]) • Supports and and assist older adults to make choices and take risks until it is evident that are no longer competent to do so, or to do so would cause harm to others • Demonstrates an awareness of elder abuse and works with the team to appropriately support those at risk (identify, support & empower, assess risk, plan safety, document, refer[39]). • Understands the implications of informed consent when older adults have altered cognition and considers consent issues in every day activity • Has a clear understanding of own obligations under NCNZ D&D in a setting with large unregulated health care worker /enrolled nurse to RN ratio	
Social and cultural position of the older adult	• Recognises the older adult as a cultural group at risk of age-based discrimination • Recognises and responds to the potential for age-based discrimination within own practice and practice of others • Recognises that culturally and linguistically diverse (CALD) [40] populations are at risk of isolation in a residential care setting and plans care/activities to minimise this risk. • Ability to work with the older adult's cultural norms and values to develop a PCCP that minimises institutionalisation and/or depersonalisation • Recognises and supports Kaumātua in their unique role in Maori culture and practices with regard for and knowledge of Te Tiriti o Waitangi	
Leadership	• Role models and sets expectation of health care team regarding best practice and care of older adults • Recognises knowledge gaps in best practice and care of older adults and provides or accesses education/support for members of the health care team to address identified gaps	

Abbreviations
ADL: activities of daily living
BPSD: behavioural and psychological symptoms of dementia
CALD culturally and linguistically diverse
CGA: comprehensive geriatric assessment
D&D; direction and delegation
EPoA; Enduring power of attorney
LBGT: lesbian, gay, bi-sexual and transgender
interRAI: International residential assessment instrument
MDT: Multidisciplinary team
NCNZ: Nursing Council New Zealand
PDRP: professional development and recognition programme
PCCP: Patient centred care plan
SEBAT: Standardised evidence based assessment tools

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