Project Proposal from the School of Nursing: Gerontological Nursing (GersNurs) Competencies: Online resource

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Within the School of Nursing, the Ageing and Dementia Health Education and Research (ADHERe) (www.adhere.org.au) is a centre of interdisciplinary researchers working together to generate evidence in gerontological studies. The purpose of ADHERe is to create evidence based resources which practitioners can use to transform the lives of older people and family carers. ADHERe use their website to host a range of educational and research resources which are made freely available to practitioners. These resources include filmed vignettes of best practice clinical scenarios, interactive workbooks and online interactive educational modules. ADHERe undertakes work which is important globally as the ageing population increases and the workforce needs grow in response to the need to meet the needs of this population group. ADHERe provides crucial resources to enable practitioners working with older people and their family carers to develop the specialist skills they need to provide evidence based care to their client groups. Gerontological practice is a relatively new discipline which has developed as life expectancies around the world increase and the demand for a specialist workforce grows every day.

One of the ADHERe projects, Gerontological Nursing (GersNurs) Competencies (GNC) provides guidance for practitioners to demonstrate their competence as gerontological nurses. The GNC consists of what we call 11 core competencies and 36 domains of practice which are related to each of the core competencies. There are also two levels of competence with each of the domains of practice being described as either beginner or advanced levels of practice.

CORE COMPETENCIES	
1	Living well for older people across communities and groups
2	Maximising health outcomes
3	Communication effectively
4	Facilitating transitions in care
5	Facilitating choices within legal and ethical frameworks
6	Partnering with family carers
7	Promoting mental health and psychological wellbeing
8	Providing evidence-based dementia care
9	Providing optimal pain management
10	Providing palliative care
11	Enabling access to technology

Figure 1: Gerontological Nursing Competencies: Eleven core competencies

The GNC resource includes a workbook (Appendix A) which provides guidance on how to use the GNC to develop a portfolio of evidence to demonstrate competence to practice as a specialist gerontological nurse. The workbook includes resources for mentees who are working towards generating their portfolio and mentors who are providing support and guidance to the mentees. The goal of ADHERe is to have the GNC resource available on the ADHERe website for aged care,

community and healthcare organisations who wish to provide support for their registered nurses to have their practice as gerontological nurses acknowledged through the generation of their portfolio of evidence.

The workbook is available as a word document which is distributed as a PDF document in an email to potential mentees, mentors and managers working aged care, community and healthcare organisations. The workbook consists of a set of resources which mentees and mentors can use to generate a portfolio of evidence (mentees) and support and guide mentees to generate a portfolio of evidence (mentors). The aim of the ADHERe group is to develop the resources in the word document into interactive resources within an online environment where practitioners can complete the workbook resources, at home or in their workplace, and upload their evidence of gerontological competence as a web-based portfolio.

The GNC requires practitioners to complete five steps:

- Step 1: Mentoring: Establishing a mentoring relationship;
- Step 2: Self-assessment of current gerontological competence;
- Step 3: Goal setting to achieve gerontological competence;
- Step 4: Action planning to generate evidence for a portfolio; and
- Step 5: Generating a portfolio of evidence to demonstrate gerontological evidence.

In the workbook there is guidance on how to complete the five steps. These five steps are colour coded to make the workbook easy to use and the accompanying appendices are also colour coded so it is visually easy to locate forms associated with each of the five steps in the GNC. At this stage in the project, mentees and mentors must either type up their responses in a word version of the GNC workbook or print out forms and hand write their notes. The self-assessment tool in Step 1 would be much more useful to practitioners if it were digitalised and they could have a score generated or a visual representation of the outcome of their self-assessment. The goal setting (Step 3) and action planning (Step 4) forms would also be more useful if practitioners could complete these using drop down menus in a digital format. Storing the portfolio of evidence (Step 5) online would also enable practitioners cross-reference the same piece of evidence across different competencies which would enhance the usability of the GNC.

The purpose of this proposal is to explain how students in engineering and informatics could help the ADHERe team achieve their goal of making the GNC available as an interactive online resource for practitioners working with older people and their family carers. Specifically, the project would consist of students completing the following work:

- consultation with the ADHERe GNC team to finalise what is desired;
- create a web-based environment in which practitioners can engage with the GNC material in an interactive way and generate a portfolio of evidence to demonstrate their gerontological nursing competence, made up of the 4 steps required to complete the GNC:
    - Step 1: Mentoring: Establishing a mentoring relationship;
    - Step 2: Self-assessment of current gerontological competence;
    - Step 3: Goal setting to achieve gerontological competence;
    - Step 4: Action planning to generate evidence for a portfolio;
    - Step 5: Generating a portfolio of evidence to demonstrate gerontological evidence.

Appendix A: Gerontological Nursing Competency Workbook

Gerontological Nursing Competencies

Accompanying Documentation

Nursing in Aged Care Collaborative (NACC) Partners

Nursing in Aged Care Collaborative (NACC) Members

Name	Organisation	Position
Kristene Rice	Anglicare	GM Quality and Service Support
Tracey Osmond	Scalabrini Village	Director, Clinical Governance and Quality
Elaine Griffin		Director, People, Learning and Culture
Jolan Stokes	HammondCare	Hammond College Manager, Health and Hospitals
Mary McConachie	Anglicare	Quality and Compliance Manager - Residential
Melissa Jansson		Nurse Education, Quality and Service Support
Linda Justin	Uniting	Learning @ Uniting Lead
Carolyn Moir	BaptistCare	Care Improvement Consultant
Donna Lennon		Care Improvement Consultant
Name	**Organisation**	**Position**
Victoria Traynor	UoW	Associate Professor
Nicole Britten	UoW	Project Manager
Lynn Chenoweth	UNSW	Professor of Nursing, Centre for Healthy Brain Ageing

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Use our WordPress site to complete the Gerontological Nursing Competencies:
https://gerontologicalnursingcompances.wordpress.com

Acknowledgements

The content of this workbook was informed by work undertaken by ADHERe, and Anne Moehead and her colleagues who host the Dementia Network. Their prior activities enabled the development of this comprehensive workbook for participants completing the Gerontological Nursing Competencies (GNC).

Changes requested

- Explanation of leadership and management responsibilities
- Explanation of novice-expert
- Image of all competencies

Welcome

Welcome to the pilot trial of implementation of the Gerontological Nursing Competencies (GNC). You were invited to participate in this trial by your organisation because you are a committed gerontological nurse who has a leadership role or is a future leader. Your organisation identified you as a: (i) mentor or (ii) mentee for the pilot trial. Mentors will support mentees through the implementation of the GNC, and the GNC project team will support the mentors and mentees during the pilot trial. At the end of the trial, all mentees will have a portfolio of evidence which demonstrates their competence as a gerontological nurse.

Many of you participated in the 2015 GNC Competencies Workshop, when the first draft of the GNC was developed, and completed e-Delphi surveys used to refine and finalise the GNC. Your continued support in the development of the GNC is invaluable: the GNC would not exist without the individual contributions you have made. We also welcome all colleagues who are new to the GNC and look forward to your contribution to the initiative.

This document is a workbook to guide: (i) mentors and (ii) mentees implementing the GNC. In addition, because this is a pilot trial we need your feedback about the usefulness of this workbook and aspects of the workbook which need to be further developed prior to the official launch of the GNC and their posting on the ADHERe website for others to use. We seek your feedback in a range of ways throughout this pilot trial.

We are undertaking this pilot trial as a research study so we can share the findings in publications about how the GNC were developed. Ethical approval to undertake this research has been provided by the University of Wollongong (UoW) Human Research Ethics Committee (HREC). Participation in the pilot trial is independent from participation in our research study. Consent to record your ongoing feedback about the pilot trial will be sought from each individual mentor and mentee. If you do not wish to have the information you provide recorded in the research, you are still able to participate in the pilot trial. If you do not provide your consent to participate in the research, we will simply exclude the information provided by that mentor or mentee from the findings.

We are privileged to have the opportunity to work with each of you and are appreciative of you and your organisation volunteering to participate in the pilot trial of the GNC.

Nicole Britten and Victoria Traynor
Project Manager Academic Lead

"I finished my nursing degree 9 months ago and after applying for a number of new graduate positions I was successful in obtaining one in aged care. Aged care was definitely not my first choice but I accepted it to get my career going.

At first I felt overwhelmed by all the aged care processes and then I was fortunate enough to be offered the opportunity to participate in the Aged Care Collaborative Pilot Project.

This turned my thoughts and ideas about aged care upside down!

The competencies provided me with structure and enabled me to identify my strengths and areas for improvement and professional development. In fact it gave me a pathway to follow.

Since completing this process my confidence in my clinical practice has increased, which has enabled me to feel as though I can contribute to the team and feel valued for my contribution.

I now am seeking opportunities to remain employed in aged care so as to build on these and further develop my expertise."

Story from a new graduate in aged care who demonstrated her Essential Gerontological Nursing Competence using the GNC

Introduction

This workbook will explain to practitioners, educators and managers how the Gerontological Nursing Competencies (GNC) can be used in the workplace to help Registered Nurses (RNs) demonstrate their competence as gerontological nurses. The GNC can be used for future career planning and this workbook will demonstrate how the GNC can achieve this for you, whether you have a role as a practitioner, educator or manager.

The GNC was developed by the Nursing Aged Care Collaborative (NACC) to meet an important gap in the professional development needs of RNs working with older people and their family carers, as well as a lack of recognition of the specialty of gerontological nursing. NACC partnered with the University of Wollongong (UoW) and the University of New South Wales (UNSW) to develop the GNC and this workbook. The NACC want to demonstrate to practitioners, educators and managers how implementing the GNC can add value to individual practitioners and organisations providing nursing care to older people and their family carers.

It is intended that the GNC be used as a positive tool by practitioners, educators and managers which enables individuals and organisations to explicitly demonstrate the contribution RNs make to the delivery of high-quality health, aged and community care services to older people and their families. To achieve this, this workbook will provide guidance to practitioners, educators and managers about how RNs can demonstrate their competence as specialist gerontological nurses. The outcome from implementing the GNC will be RNs who produce a portfolio of evidence that demonstrates their competence as gerontological nurses and the contribution they make to promoting the well-being of older people and their family carers.

Background to the development of the GNC

A review of the literature found that the only widely used competencies for gerontological nursing were published in the United States. These competencies were not 'translated' for use in other countries. A Nursing in Aged Care Collaborative (NACC), made up of not-for-profit aged care providers (n=5) and universities (n=2): Scalabrini, Anglicare, HammondCare, BaptistCare, Uniting (n=5), the University of Wollongong (UoW) and University of New South Wales (UNSW), undertook a study to develop Gerontological Nursing Competencies for use across Australian nursing homes and community care settings by Registered Nurses (RNs) working with older people and their family carers. NACC initiated this work with a face-to-face stakeholder consultation activity during a workshop. Eighty senior RNs reviewed a comprehensive list of competencies identified from the literature review and generated a draft list of gerontological nursing competencies. These were the subject of an e-Delphi study with 409 RNs working in aged care across 10 countries. At the completion of the consultation process, 11 gerontological competencies and 33 domains of practice (DoP) were developed.

Levels of practice

The Gerontological Nursing Competencies (GNC) are divided into two levels of practice (LoP) which are reflected in the domains of practice (DoP) developed for each competency. RNs will choose which LoP reflects their level of competence in gerontological nursing. Their choice of LoP will be determined by their gerontological nursing experience, leadership and management responsibilities and career aspirations.

Essential

The Essential domains of practice reflect the work required of all RNs working in nursing homes and community care settings with older people and their family carers. It is likely that all RNs new to gerontological nursing, regardless of their previous experience, are likely to first work towards the Essential domains of practice. After completing their Essential LoP, RNs can choose to work towards Enhanced LoP to fulfil their career aspirations.

Enhanced

The Enhanced domains of practice reflect the specialist work required of RNs working in nursing homes and community care settings with older people and their family carers. RNs who work at Enhanced LoP will have 'in-charge', nurse educator, clinical nurse specialists and clinical nurse educator roles. RNs aspiring to take on management and leadership roles in gerontological nursing can see what is required of them at an Enhanced LoP. RNs can use the Gerontological Nursing Competencies to create opportunities which will enable them to work towards their Enhanced domains of practice.

Why be involved?

Registered Nurses

- Increase job satisfaction
- Aid with portfolio development
- Use to support promotion
- Expand level of clinical skills
- Secure a different job
- Use in writing goals for performance appraisals
- Support applications for education to attend conferences or courses

Managers

- Content for Registered Nurse position descriptions
- Inform education sessions in the service
- Structure performance agreements
- Ensure Registered Nurses are working to their potential
- Expand the level of clinical knowledge in your organisation

"After practising nursing in acute care settings for about 25 years, I decided to try my hand at aged care. I thought it would be easy – there can't be much in aged care that I don't already know, is there? How wrong I was!

Not only was the philosophy and focus of practice completely different, it was hard to find the information I needed to help me on my way. I was used to having lots of support and shared resources at my fingertips in acute care; these were not so easy to access in aged care.

Then I found the Gerontological Nursing Competencies. The first thing they helped me do was to reflect on what aged care practice actually looked like, and then I could figure out which bits of my acute practice to bring along and what to leave behind. The competencies really helped me to discover what I needed to know, and with the help of a mentor, I was quickly moving in the right direction.

I now understand what's unique about gerontological nursing practice and I'm confident that the care that I deliver makes a real difference to people in aged care."

Story from an experienced acute care Registered Nurse who demonstrated her Essential Gerontological Nursing Competence using the GNC

Implementation of the Gerontological Nursing Competencies (GNC)

There are five steps to undertake when implementing the GNC and developing your portfolio of evidence to demonstrate your competence as a gerontological nurse (Figure 1). Each step is colour coded and each section in the workbook has matched colour coding to help you progress through your implementation of the GNC. A range of forms are provided in the Appendices to assist you in completing the GN.

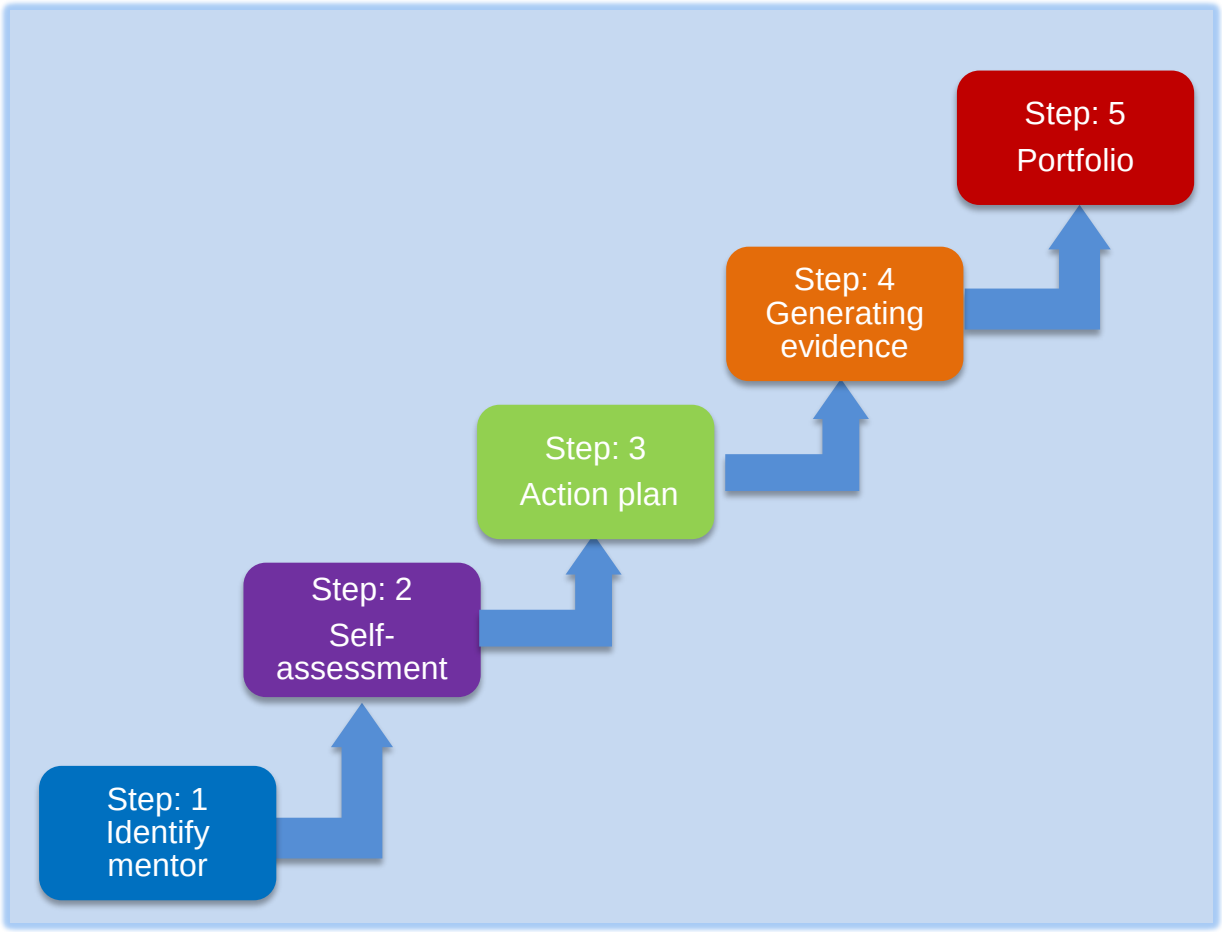

Figure 1: Summary of five-step Gerontological Nursing Competencies (GNC) implementation process

The Gerontological Nursing Competencies

Level of Practice (LoP)	
Essential	Enhanced

Table 1: Summary of Gerontological Nursing Competencies: Competency (C), Domain of Practice (DoP) by Level of Practice (LoP)

Competency		**LoP**
Comp 1	**Competency 1: Living well for older people across communities and groups**	
1.1	**Acknowledgement of the person** - Promote dignity and respect for individuals and recognise the importance of 'life story work' - Enable the model of care and focus on the capacity of individuals - Provide a range of social activities at different times, locations and days - Support choices of how and where to live and transition into new locations and new ways of living	**Essential**
1.2	**Lifestyle engagement** - Promote continuity of social and community engagement - Respect choice and the right to informed decision making, especially in decisions involving risk - Promote the integration of lifestyle engagement with care needs based on the values and preferences of older people - Actively engage to ensure that older people retain their personal, civic, legal and consumer rights and are assisted to achieve active control of their own lives - Ensure older people receive lifestyle support and programs as appropriate for their identified needs and preferences	**Essential**
1.3	**Diversity** - Promote sexuality and intimacy, religiosity, culture and spirituality through the provision of physical spaces, resources and social routines which enable participation in activities to ensure diversity is actualised - Promote a culture that is accepting and generous about different ways of life	**Essential**
1.4	**Anti-ageist and anti-discriminatory language and practice** - Model the use of respectful language during interactions with older people and employees and in documentation - Challenge 'infantilisation'—for example, 'There's a (good) girl.' - Actively discourage 'institutional language' ('sweetie', 'love', 'pet', 'darl') - Advocate on behalf of older people in a manner that respects their autonomy and legal capacity	**Essential**

Competency		LoP
Comp 2	**Competency 2: Maximising health outcomes**	
2.1	**Physiological changes associated with ageing** - Maintain knowledge of normal ageing and knowledge of abnormal physiological responses in older people - Maintain current knowledge of common age-related disease trajectories and co-morbidities	**Essential**
2.2	**Pharmacology in ageing** - Take an active role in medication management - Maintain knowledge of adverse effects - Work inter-professionally to prevent or manage poly-pharmacy	**Essential**
2.3	**Health promotion and health education** - Proactively develop care plans across care needs with older people and family carers - Take responsibility for evaluating the implementation of care goals - Arrange activities to promote functional capacity—for example, diverse physical activity programmes and diet and cooking programmes - Arrange leisure and social activities which promote health and well-being, including regular access to the outdoor environment - Develop strategies to enable older people to engage in meaningful and effective health education initiatives	**Essential**
2.4	**Integrated care** - Understand the link between assessment results and intervention required - Understand what equipment and/or resources are needed and available - Understand the provision of services and how to prevent unnecessary hospital admissions - Refer to relevant external services and multi-disciplinary teams to deliver integrated care	**Essential**
2.5	**Assessment and goal planning** - Proactively assess and plan goals to reflect holistic needs with older people and their family carers - Possess high-level assessment skills and appropriately use assessment tools, ensuring cultural appropriateness - Use a variety of assessment techniques to systematically collect relevant and accurate information for goal planning to develop a plan of care in consultation with older people - Demonstrate flexibility in assessment, goal planning and care delivery to reflect changing care needs—for example, acute deterioration - Have the capacity to effectively evaluate and re-develop goals with older people and family carers	**Enhanced**

Competency		LoP
Comp 3	**Competency 3: Communicating effectively**	
3.1	**Communication as a process and outcome** - Communicate effectively, respectfully and compassionately with older people and their family carers - Transfer critical communication across professional networks - Promote a culture of empathy for those who express their distress non-verbally - Develop and implement counselling or advanced counselling skills - Implement strategies to prevent psychological distress - Recognise changes in behaviour as communication and/or as an expression of need	**Essential**
3.2	**Environment** - Consider environmental factors to promote effective communication—for example, consideration of light, signage and noise - Use communication aids to address sensory loss, including non-verbal strategies and contemporary technology - Maximise privacy and comfort	**Essential**
3.3	**Culture of enabling communication** - Write and format information brochures and social resources in plain English, using visual aids, flow charts instead of words, large print and multi-lingual versions, including use of interpreters - Arrange forums for older people and family carers about service delivery to adopt an explicitly collaborative model of communication that enables involvement - Undertake an annual service evaluation collaboratively and creatively - Address feedback from older people and family carers in a person-centred way and ensure the process reflects a collaborative way of working - Ensure case conferences and meetings between older people and family carers are authentically collaborative - Share care plans with older people and family members and record agreement	**Enhanced**

Competency		LoP
Comp 4	**Competency 4: Facilitating transitions in care**	
4.1	**Transitions in care** - Understand legal accountabilities in managing transitions in care - Support older people and family carers during relocation into residential aged care facilities - Support decision making between older people and family carers to access services appropriate for their needs - Facilitate family carers to be actively involved in palliative and end of life care - Maintain awareness of the availability and function of advocacy services - Facilitate safe and effective transitions across levels of care, including acute, community-based and long-term care for older people and their family carers - Determine the need for a different level or type of care based on an assessment of an individual's acuity, stability, resources and need for assistance	**Enhanced**
4.2	**Health and social networks** - Articulate high-level knowledge about available services - Maintain the capacity to access and refer to available services for older people and family carers - Refer to and liaise with the multi-disciplinary teams and specialist services as required to meet changes in older people's conditions	**Enhanced**

Competency		LoP
Comp 5	**Competency 5: Facilitating choices within legal and ethical frameworks**	
5.1	**Legislation** - Maintain awareness of legislative frameworks governing aged care such as advanced care plans, living wills, power of attorney and legal guardianship - Understand the variety of legal instruments that may govern decision making made on behalf of older people (for example, advanced care plans, living wills, power of attorney and legal guardianship) and ensure care is planned and delivered in respect of these instruments where enacted	**Essential**
5.2	- Maintain the capacity to provide support for the older person and family carer when needs or values and beliefs are contradictory - Recognise circumstances requiring referral to advocacy services - Be aware of elder abuse scenarios and legislated reporting obligations - Intervene to eliminate or minimise the use of physical, chemical and environmental restraints	**Essential**
5.3	**Decision making** - Ensure ongoing assessment of decision making is informed by 'situational capacity' for older people - Ensure older people who are considered vulnerable are enabled to actively participate in decision making - Promote a culture that respects the choices of older people, including informed decision making involving risk - Recognise vulnerability and risk for adverse outcomes relating to ageing and social changers, while reinforcing strengths and abilities - Explore values and beliefs of older people and their family carers prior to any decision making - Involve the people responsible when no family carer has been nominated	**Essential**
Comp 6	**Competency 6: Partnering with family carers**	
6.1	**Family carer needs** - Recognise family carers experiencing distress and health problems - Refer or facilitate family carers to access support and services - Promote the sharing of information with family carers - Understand the capacity of family carers to deliver care and to support the care needs of older people - Assess a family's knowledge and skills to draw on their own abilities and resources for self-care and health promotion	**Essential**
6.2	**Collaboration** - Support and engage with family carers to be actively involved in decision making and care delivery - Understand the impact of complex family dynamics and the need to advocate for older people - Support family carers to understand the needs of older people through transitions of health and care	**Essential**
Comp 7	**Competency 7: Promoting mental health and psychological well-being**	
7.1	**Grief and loss** - Support older people through life transitions—for example, living with a chronic illness or the death of a loved one	**Essential**

Competency		LoP
7.2	**Assessment** - Correctly use cognitive, depression and delirium screening and assessment tools - Provide specific screening and referral for (but not limited to): • suicide risk • grief and loss • past trauma • unresolved issues • sexual abuse • substance abuse	**Essential**
7.3	**Mental health and psychological well-being interventions** - Understand the impact of dual and complex diagnoses on older people and ensure all mental health needs are comprehensively managed - Be aware of life-based experiences that may impact the mental and psychological well-being of older people—for example, stolen generation; refugee; post-traumatic stress - Articulate, and refer to, appropriate mental health support services, including those specialising in the care of older people - Understand the role of complementary therapies and the right of older people to access these - Promote physical and social activity for well-being	**Enhanced**
Comp 8	**Competency 8: Providing evidence-based dementia care**	
8.1	**Dementia specific care** - Understand living with a dementia - Understand the main types of dementia - Develop non-pharmacological strategies to address unmet need - Refer to dementia care competency framework	**Essential**
8.2	**Assessment** - Maintain awareness of cognitive screening and assessment tools and have the capacity to correctly interpret results - Be able to differentiate between dementia and health factors that can exacerbate dementia—for example, depression and non-dementia related confusion, delirium, polypharmacy and comorbidities such as pain, trauma and mental health conditions - Assess for environmental impacts such as malnutrition, sensory deficit, environmental stress and loneliness	**Essential**
8.3	**Interventions and evaluation** - Develop care plans interventions that are grounded in an understanding of each older person and their life history - Articulate and demonstrate effective behavioural support strategies responsive to the individual older person - Maintain awareness of the range of therapies and interventions available to support the well-being of people with dementia—for	**Essential**

Competency		LoP
	example, complementary therapies, Montessori, music therapy and aromatherapy - Be capable of effectively evaluating the outcomes of interventions	
Comp 9	**Competency 9: Providing optimal pain management**	
9.1	**Assessment** - Maintain awareness of current evidence-based practice related to optimal pain management - Use valid and reliable tools for assessing pain and associated symptoms - Understand the importance of and variation in cultural, ethnic and linguistic expressions of pain used by older people - Provide specific pain assessment for individuals living with a dementia and, in particular, atypical presentation of pain as agitation or confusion - Emphasise the recognition of non-verbal expressions of pain—for example, restlessness and sleeplessness - Understand the physiology and complexity of chronic pain in older people - Demonstrate high-level pain assessment skills for individuals living with a dementia and recognise atypical presentations of pain - Ensure multidisciplinary collaboration in pain assessment and treatment goals, including the physiotherapist in the assessment, location, severity and treatment of pain - Articulate and monitor the impact of chronic pain on the mental well-being of older people - Set treatment goals in collaboration with older people and family carers	**Essential**
9.2	**Intervention and evaluation** - Develop pain management interventions which account for the differences between acute pain, acute-on-chronic pain, chronic/persistent pain and pain at the end of life - Understand how to optimise the pharmacological management of pain, including regular administration of analgesia and ongoing monitoring and evaluation of pain - Advocate with medical practitioners for effective pain management and refer to specialist pain management services for severe and complex pain management - Facilitate a multimodal approach using non-pharmacological therapies—for example, meditation, massage or physical activity - Understand that analgesia is a medication and demystify opioid use - Use quality systems to measure and monitor the pain management system	**Essential**

Competency		LoP
Comp 10	**Competency 10: Providing palliative care**	
10.1	**Spiritual care** - Enable spiritual and faith-based rituals - Recognise and support older people and family carers in distress about dying - Ensure the advance care plan includes specific details about wishes for end of life - Promote the use of dedicated space for older people who are dying and their family carers - Enable and support reflection, contribution and legacy - Enable self-care and emotional support for the members of the care team	**Essential**
10.2	**The palliative approach** - Understand the models of care delivered to residents with life-limiting illnesses - Demonstrate competence in processes, including facilitating advance care planning, conducting care conferences and initiating end of life care pathways	**Essential**
10.3	**End of life care** - Identify and assess older people entering the comfort/terminal stage - Understand end of life cultural and spiritual needs - Implement end of life care pathways - Support the implementation of complementary and alternative therapies - Refer to specific palliative care competencies	**Essential**
Comp 11	**Competency 11: Enabling access to technology**	
11.1	**eHealth** - Evaluate and promote use of technologies for monitoring health	**Essential**
11.2	**Social network**s - Promote older people's use of social networking to support mental health and well-being—for example, Skype, online social forums, online games, social media, eBooks and online music	**Essential**
11.3	**Assistive technology** - Promote the use of technologies for rehabilitation plans e.g. Wii - Appropriately use technology and assistive devices to promote and maintain optimal function, independence and safety	**Enhanced**

Step One: Mentoring

> 'Mentoring can be provided by someone in the same or different area of practice. In a mentoring relationship, the supervisor undertakes to share knowledge and expertise for an extended period, in order to further the nurse professional development'
>
> (HETI, 2013; p. 56)

WHAT is mentoring?

Mentoring is used to improve and nurture the skills, knowledge and expertise of a competent learner by pairing them with an experienced and knowledgeable professional. The senior professional (the mentor) invests and shares their time, effort, knowledge and expertise with a less experienced professional (mentee) to nurture their knowledge, skills and professional growth. The mentee seeks out a more experienced professional of their choosing. During the trial period of implementation of the GNC, mentees will find a mentor in their workplace to help them work through this document.

WHY is mentoring important?

Mentoring is a way to nurture and support Registered Nurses (RNs)to continue to grow professionally and develop their careers. Mentoring helps to maintain and develop leadership skills and opportunities for nurses to work in senior roles.

WHEN is mentoring provided?

Mentoring is usually commenced at the instigation of the mentee. The frequency of the meetings depends on the availability of the mentor and the mentee.

Mentoring relationships may last for a number of years. During this project, your mentoring relationship might be limited to the six months of the trial implementation project. Alternatively, if the mentee and mentor are willing, the mentoring relationship can continue beyond the trial implementation as long as the mentee and mentor wish to continue the relationship.

HOW is mentoring provided?

Mentoring can occur within or outside workplace relationships, that is, mentees can choose a mentor from within their work organisation or from an external organisation. Mentees find a mentor themselves or they seek help from a senior colleague, in their organisation or from an external colleague, to recruit a potential mentor. Mentees and mentors need to have an initial meeting where expectations of the mentoring relationship are discussed and a decision is made about commencing a mentoring relationship. It is most common for mentoring relationships to be formally established using forms to record how the mentoring relationship will be set up, progressed, monitored and evaluated.

For the purposes of the trial implementation of the GNC, mentors and mentees were allocated by Advisory Group members. Mentors and mentees are colleagues from the same organisation. The usual processes for setting up, managing and monitoring the mentoring relationship will be adopted during this trial implementation of the GNC. The forms provided in this workbook (Appendices 1, 2 and 3) will be used by the mentors and mentees to record mentoring relationship process.

Mentor and mentee responsibilities

Below is a list of mentor and mentee responsibilities that need to be considered and reviewed prior to agreeing to the mentor/mentee relationship. Mentors and mentees can use the list of responsibilities to guide conversations about mentoring before completing the **Mentoring Agreement** (Appendix 1).

Responsibilities of the mentor

- Do your groundwork when establishing a new mentoring relationship. Developing mutually agreed expectations of mentoring builds a solid foundation and helps address any future issues.
- Work at developing trust in the mentoring relationship so that issues can be discussed honestly and freely. This makes mentoring more meaningful and relevant.
- Ensure you demonstrate to your mentee that you view mentoring as a priority. Make sure that mentoring time is not hijacked by other competing demands.
- Regularly seek feedback from the mentee about the quality of the relationship and the content of mentoring.
- Be prepared to tailor mentoring to meet the specific and changing needs of the mentee.
- Address disengagement as a matter of priority.
- Develop an understanding of your mentee's (and your own) learning styles and use this information to strengthen the learning and make mentoring more meaningful.
- Review the logistics around mentoring such as timing, venue and frequency, and ensure they continue to be suitable and are not impacting on attendance.
- Think of mentoring as building on strengths rather than working on deficits.
- Be mindful that mentoring can be anxiety-provoking for some staff, and ensure expectations are realistic and achievable.
- Regularly find opportunities to give positive feedback when the mentee successfully uses the learning from mentoring in their practice. This not only reinforces the value of mentoring and increases the mentee's clinical confidence; it also ensures that residents and clients receive quality care.

Responsibilities of the mentee

- Take responsibility for self-directed, lifelong learning, including a commitment to ongoing professional development.
- Actively participate in the mentoring process.
- Openly express needs and expectations related to mentoring.
- Make the best use of mentoring by coming prepared. This includes having an agenda with points to be discussed so time can be used effectively.
- Make an effort to create and protect time for mentoring. Try to keep scheduled mentoring appointments, be on time and try to avoid interruptions.
- Be prepared to openly identify and discuss practice issues which are challenging and the skills that need developing.
- Contribute to reflective discussion about practice experiences and learnings.
- Be open to learning and improving clinical practice skills and incorporating this learning into your work practice. Be prepared to be challenged in a supportive way.
- Be open to receiving support and feedback during mentoring and take time to reflect and respond to this feedback.
- Take responsibility for seeking help when required, even if outside the regular mentoring time. This ensures patient safety and well-being are always put first.
- Commit to regularly reviewing the mentoring process and give honest feedback if it needs to be adapted to meet changing needs.

Now that you have reviewed this list of responsibilities, please complete the **Mentoring Agreement** (Appendix 1). Once you have both signed the agreement and discussed how you would like your relationship to work, you can move onto the next step, the **Self-Assessment** (Appendix 4).

There are separate **Mentee and Mentor Evaluation Forms** that can be used at the conclusion of the project (Appendices 2 and 3).

TOP TIPS FOR MENTORING

- ✓ Foster a learning environment.
- ✓ Monitor and evaluate progress.
- ✓ Build trust to sustain the mentorship relationship.
- ✓ Provide guidance and support with challenges.
- ✓ Promote reflection and insight into previous experiences.
- ✓ Listen and facilitate self-awareness and independence.

(HETI, 2013)

Step Two: Self-assessment

Completing the Gerontological Nursing Competencies self-assessment

This activity will take approximately 30 to 45 minutes to complete.

The second step in the enhancement of your Gerontological Nursing Competencies is to undertake a **Self-Assessment Form** (Appendix 4). This tool is to be used to enable you to reflect on your current sense of gerontological nursing competence. You can return to the self-assessment activity at any time and reassess your sense of gerontological nursing competence.

During the self-assessment activity, you are asked to rank your sense of competence for each domains of practice (DoP) within the 11 core competencies. In the **Self-Assessment Form**, the core competencies are displayed in bold headings and are numbered from 1 to 11. The 33 DoPs associated with the core competencies are listed in a table under each of the associated core competencies. In addition, each DoP is identified as a designated level of practice (LoP): Essential or Enhanced.

RNs are invited to review their self-assessment for each DoP using a capabilities scale (Figure 2):

Level of individual capacity in role as an RN working with older people				
1 Novice	2 Advanced beginner	3 Competent	4 Proficient	5 Expert

Figure 2: Level of capacity in role as a gerontological nurse for one level of practice (LoP) in the Gerontological Nursing Competencies (GNC)

The aim of the **Self-Assessment** is to allow you to track the development of your aged care nursing practice over time. You may have a number of years of practice in the specialty or you may just be starting out. It doesn't matter what your initial rating is – just be certain that it's a realistic reflection of your practice today.

The matrix will:

1. assist you to track your practice development progress; and
2. facilitate your conversations with a more experienced aged care Registered Nurse whom you have identified as a mentor.

Self-Assessment 1st Assess – Green				
/ /				
2nd Assess - Red				
/ /				
3rd Assess - Blue				
/ /				
1	2	3	4	5

Figure 3: Extract from Self-Assessment form to illustrate how your changing level of competence can be recorded

Use the self-assessment rating scale for each of the competencies outlined on the following pages. Red, Green or Blue relates to the coloured pen to use. Using different colours will allow differentiation between the ratings and provides a visual representation of how your capabilities have improved over time.

You can seek support in your journey towards increased capacity as a gerontological nurse in a range of ways:

- seek out a mentor, for example, a nurse educator, team leader, clinical nurse specialist or clinical nurse consultant, to provide you with feedback on your capability development in the workplace. For the purpose of the trial mentors and mentees have been allocated from the same organisation this is where you will access yours; and/or
- join a 'community of practice' that will inform and enhance your aged care knowledge (such as monthly discussion forums or specialty nursing groups).

Review self-assessment

This activity will take approximately 15 to 30 minutes to complete.

Once you have completed your self-assessment, you will need to review this and, if you would like to, show your mentor.

Note:

- ✓ **To achieve practice at the ESSENTIAL level would require you to practise consistently at Level 3 or above in all Essential competencies.**
- ✓ **To achieve practice at the ENHANCED level would require you to practise consistently at Level 3 or above in all the Enhanced competencies.**

These levels are only suggestions. It is up to you, with input from your mentor, to decide on a competency goal that is relevant to your current practice and reflects your professional development and career aspirations.

Step Three: Setting goals/completing a mind map

Once you have completed your **Self-Assessment** and reviewed the results, you can go ahead and set a **competency goal**. You may want to liaise with your mentor, other clinicians or your manager to decide which level of competency you should be working at.

Your competency goal can be set at a level that reflects your current experience and expertise or it can be set at a level that reflects your aspirations for professional development or at a level that you and your mentor or manager agree is adequate for someone working in your position. If you achieved only 1 to 3 on the Essential competencies in your self-assessment, this informs you that your knowledge or experience in gerontological nursing is limited and your initial goal should be automatically set to an Essential level of practice.

Developing an action plan for your future professional development activities

This activity will take approximately 30 minutes to 1 hour to complete.

Now that you have completed the self-assessment step, we invite you to develop an **Action Plan** (Appendix 5) for your future learning.

When you develop an action plan of any kind, there are several tasks which must be completed before you begin writing. The aim of this activity is to provide you with guidance on completing an action plan for your future learning so you can develop more advanced aged care clinical skills to more effectively fulfil your role as a Registered Nurse working with older people.

Before you write your action plan for future learning goals, you must identify:

- what competency (skills, knowledge and attitudes relevant to your work role) you want to achieve;
- specific learning goals which will contribute to you achieving the competency you decide to work towards in your role;
- a mentor who can provide you with guidance about how to achieve the competency you choose to work towards in your action plan;
- resources (personnel, organisational or educational) you will need to achieve the competency you choose to work towards in your action plan; and
- a timeline and review dates to achieve the competency, consisting of immediate, short-term and long-term deadlines in your action plan.

Mind mapping

One way of choosing the competency you want to work towards in your action plan is to undertake a **mind map** to generate ideas about what you need to do to achieve your learning goals. You can then record these ideas in your **Action Plan**. We will provide guidance on how to develop a mind map.

What is a mind map?

It is:

> 'Graphical technique for visualising connections between several ideas or pieces of information. Each idea or fact is written down and then linked by line or curves to its major or minor (or following or previous) idea or fact, thus creating a web of relationships. Developed by the UK researcher Tony Buzan in his 1972 book 'Use Your Head', mind mapping is used in note taking, brainstorming, problem solving, and project planning. Like other mapping techniques its purpose is to focus attention, and to capture and frame knowledge to facilitate sharing of ideas and concepts.'
>
> (Business Dictionary, N.D.)

You can create your mind map by writing it on paper, drawing images, making a collage or recording it electronically on your computer. There are many apps available if you would like to do it electronically. Choose whatever method best suits you. Below is an example of what a mind map could look like.

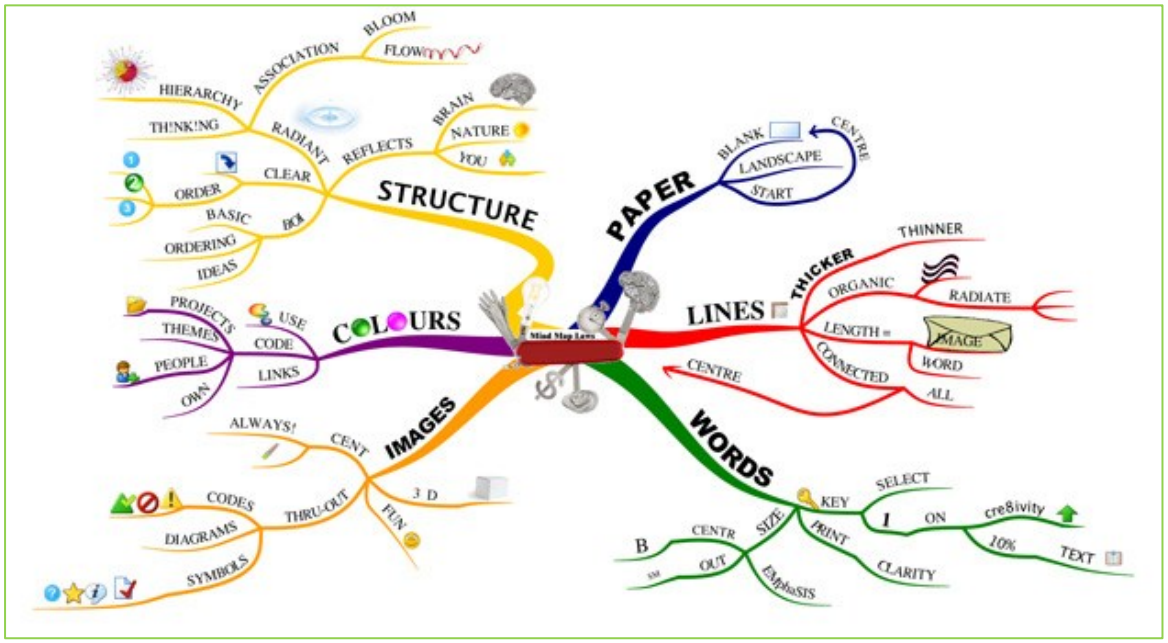

Figure 4: Sample mind map

How do I create a mind map?

Buzan (1972), who developed the first mind maps, provides the following guidelines for creating mind maps:

1. Start writing in the centre of a piece of paper or Word document with an image of the topic, using at least 3 colours;
2. Use images, symbols, codes, and dimensions throughout your mind map;
3. Select key words and print using upper or lower case letters;
4. Each word/ image is best alone and sitting on its own line;
5. The lines need to be connected, starting from the central image. The central lines are thicker, organic and thinner as they radiate out from the centre;
6. Make the lines the same length as the word/image they support;
7. Use multiple colours throughout the mind map, for visual stimulation and also to encode or group;
8. Develop your own personal style of mind mapping;
9. Use emphasis and show associations in your mind map; and
10. Keep the mind map clear by using radial hierarchy, numerical order or outlines to embrace your branches.

Wikipedia (2014)

How do I create a mind map? Filmed demonstration

How do I create a mind map?

Watch this YouTube clip *How to Make a Mind Map: The Basics*
http://www.youtube.com/watch?v=wLWV0XN7K1g (2 minutes)

MacGrercy (2009)

After watching this film you can start planning your mind mapping activity. First of all, though, it will be useful to spend some time considering how to prioritise what competencies and learning goals you choose to work towards achieving. This may involve a discussion with your mentor.

How do I prioritise what competency and learning goals I choose to work towards achieving?

This activity will take approximately 1 to 1½ hours to complete.

To stop you feeling overwhelmed by the number of competencies you identify as important for you to achieve in your mind mapping activity, it will be useful to prioritise **one competency** and **three learning goals** to include in your **Action Plan**. It is recommended that your three learning goals consist of:

(i) a short-term goal;
(ii) an intermediate goal; and
(iii) a long-term goal.

If you find there are other competencies you want to achieve, you can record them in separate mind maps. You can work towards achieving these competencies when you have achieved the one you prioritise as most important to you in your current role. Use an **Action Plan** to record your goals and how you will achieve these (Appendix 5).

Writing SMART goals

Many of you would remember SMART goals from your training. When writing your goals please remember the principles of SMART goals (Appendix 5).

> **SMART** goals need to be **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely
>
> *(Doran 1981)*

Step Four: Generating evidence

In collecting and collating evidence, Registered Nurses need to consider:

- the type or combination of evidence that will best reflect their learning;
- what evidence to present for public viewing and what should be kept personal and private;
- how to protect the anonymity and confidentiality of clients, staff and institutions;
- whether formal consent is needed to include information from clients, staff or institutions;
- that portfolio materials can be seen as professional records of care events and called upon in courts of law as evidence.

Note: It is not the number of pieces of evidence that matter but their quality and relevance.

Ideas for inclusion as evidence in portfolio

	ESSENTIAL level of practice	ENHANCED level of practice
Education (participation)	**Completes:** one-off aged care learning activities, such as a face-to-face workshop or a short online module.	**Completes:** substantial aged care professional development learning activities, such as an online course or a series of workshops.
Education (delivery)	**Delivers:** short ad hoc teaching sessions about a specific best practice aged care issue to own unit or team.	**Delivers:** organised aged care specific seminars or workshops with invited audiences to colleagues in own organisation.
Policy	**Implements:** policies related to best practice aged care in clinical work.	**Member:** of a working group in own organisation to review or develop a new policy related to best practice aged care.
Clinical care	**Case study:** works with individuals and family carers to deliver evidence-based aged care.	**Case study:** works within a multi-disciplinary team to ensure individuals and family carers are enabled to become partners in care and have access to evidence-based aged care.
Leadership	**Role modelling:** implements evidence-based aged care practice.	**Advice and support:** known 'go-to' person regarding best practice aged care.
Research	**Implements:** best practice aged care evidence in own practice.	**Participates:** in a work-based practice improvement initiative, including an audit or a research project, to implement best practice aged care.

Giving and receiving feedback

We have included this section for people who are new to mentoring to provide examples of how to give and receive feedback successfully and what not to do.

Giving and receiving feedback
(https://www.youtube.com/watch?v=PRIlnUAKwDY)

The film consists of two role play scenarios in which a mentor demonstrates giving feedback to an undergraduate medical student after a medical student has completed a simulated learning activity in a clinical skills laboratory. This film begins with a 2 minute role play scenario of 'how not to give feedback'. The section is followed by a 6 minute role play scenario of a mentor providing exemplar feedback in which positive and constructive feedback in provided.

(St. George's, 2010a)

It is useful to complete the Mentee and Mentor Evaluation Forms (Appendices 2 and 3). These provide insight into what is working and what needs to improve.

Step Five: Portfolio development

This step is often the most daunting for Registered Nurses as they try to work out how to keep all their evidence and put it into a portfolio. The most important step is to keep it simple. Everyone prefers to do this in a different way and it is a personal decision.

In this section we include some examples of paper options for reflection. Some employers also have platforms that can be used and some people prefer apps. If you have trouble deciding which format you would like to use, speak with your mentor. They may already be using a method that might work for you. No way is wrong; you just have to choose what will work for you.

Apps available

- Ausmed is useful for tracking CPD/education.

Employer-based platforms

- Scalabrini and Uniting have 'E3'.

Paper-based examples of portfolios

- HammondCare College (Appendix 6).
- GNC example to record evidence generated for the GNC (Appendix 7).

If you choose to keep a paper-based portfolio, you will need a folder to keep it in. Colleagues may choose to complete the forms but keep them digitally. For this project and for your mentor to be involved, a paper version might work best. It is up to you.

Appendices

1. Mentoring Agreement
2. Mentee Evaluation Form
3. Mentor Evaluation Form
4. Self-Assessment
5. Action Plan
6. HammondCare Summary of Evidence
7. Summary of Evidence

Appendix 1: Mentoring Agreement for the Gerontological Nursing Competencies

Mentee name	
Role	
Workplace	
Mentor name	
Role	
Workplace	
Goals for this mentoring relationship	

Assessment activity

Meet with mentor to discuss current level of competence and which level of competence I plan to work towards. Definition of 'meet' = face-to-face, telephone or online/email contact with mentor.

Assessment activity

Identify what mentee and mentor agree to do and how.

Mentee
Mentor

Mapping evidence activity

Meet with mentor to identify existing evidence which can be used to demonstrate level of competence I plan to work towards.

Mapping evidence activity

Identify what mentee and mentor agree to do and how.

Mentee
Mentor

Action planning activity

Meet with mentor to identify the activities I will complete to generate additional evidence to demonstrate the level of competence I will work towards achieving.

Action planning

Identify what mentee and mentor agree to do and how.

Mentee
Mentor

Verification activity

Submit the portfolio of evidence to the mentor for review.

Verification

Identify what mentee and mentor agree to do and how.

Mentee
Mentor

Meeting times

Include frequency, length and format of communication:

Dates and format of meeting

Date	Format of meeting

Method for recording and monitoring of meetings: (who will take minutes, etc)

Strategies for addressing difficulties along the way

For example, not making meetings, missing arranged meetings, being over-critical or regularly rejecting suggestions.

Review dates

Interim review date/s	
Final review date	

Confidentiality

We agree that the content of all meetings will remain confidential between the mentor and mentee. However, where there are issues regarding clinical risk and/or performance management, information may need to be shared with relevant parties.

Should information need to be shared, the mentor will advise the mentee in advance of this occurring, including what information will be shared, with whom and for what purpose.

Mentor signature	**Mentee signature**
Date	

Appendix 2: Mentee Evaluation Form

Mentor's name					
Mentee's name (optional)					
Mentor professional role					
Mentee professional role					
Questions	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
My mentee was accessible and available					
My mentee communicated regularly with me					
My mentee was engaged and proactive in developing learning goals					
My mentee was concerned about clinical performance and worked to improve deficiencies					
My mentee contacted me regularly for feedback					
My mentee utilised other resources and learning experiences					
My mentee demonstrated interest/concern towards me in my quest to offer assistance					
My mentee's behaviour and attitude were professional and courteous					
My mentee learnt at least one important new thing from me					
My mentee took into account gender, ethnic and cultural issues when interacting with me					
I recommend my mentee for future mentoring programs					
Overall my mentee participated in the mentoring activities					
I anticipate an extended future relationship with my mentee					
Any other comments?					

Appendix 3: Mentor Evaluation Form

Mentee's name					
Mentee professional role					
Mentor's name (optional)					
Mentor professional role					
Questions	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
My mentor was accessible and available					
My mentor communicated regularly with me					
My mentor assisted me in development of learning goals					
My mentor assisted me with improving my clinical performance					
My mentor provided helpful and thoughtful feedback					
My mentor provided opportunities to me for further learning or educational experiences					
My mentor was able to guide and direct me to appropriate resources					
My mentor demonstrated interest/concern towards me					
My mentor's behaviour and attitude are an example of professionalism					
I learned at least one important new thing from my mentor					
My mentor took into account gender, ethnic and cultural issues when interacting with me					
My mentor provided a sounding board for my ideas, goals and aspirations					
I anticipate an extended future relationship					
I would recommend this mentor to others					
Any other comments?					

Appendix 4: Self-Assessment

Level of individual capacity in role as an RN working with older people				
1 Novice	2 Advanced beginner	3 Competent	4 Proficient	5 Expert

Self-Assessment 1st Assess – Green				
/		/		
2nd Assess - Red				
/		/		
3rd Assess - Blue				
/		/		
1	2	3	4	5

Competency 1 – Living well for older people across communities and groups In order to facilitate living well for older people across communities and groups, the Registered Nurse will:						
1.1 Acknowledgement of the person		1	2	3	4	5
ESSENTIAL	Promote dignity and respect for individuals and recognise the importance of 'life story work' Enable the model of care and focus on the capacity of individuals Provide a range of social activities at different times, locations and days Support choices of how and where to live and transition into new locations and new ways of living					
1.2 Lifestyle engagement		1	2	3	4	5
ESSENTIAL	Promote continuity of social and community engagement Respect choice and the right to informed decision making, especially in decisions involving risk Promote the integration of lifestyle engagement with care needs based on the values and preferences of older people Actively engage to ensure that older people retain their personal, civic legal and consumer rights and are assisted to achieve active control of their own lives Ensure older people receive lifestyle support and programs as appropriate for their identified needs and preferences					
1.3 Diversity		1	2	3	4	5
ESSENTIAL	Promote sexuality and intimacy, religiosity, culture and spirituality through the provision of physical spaces, resources and social routines which enable participation in activities to ensure diversity is actualised Promote a culture that is accepting and generous about different ways of life					
1.4 Anti-ageist and anti-discriminatory language and practice		1	2	3	4	5
ESSENTIAL	Model the use of respectful language during interactions with older people, employees and in documentation Challenge 'infantalisation'—for example, 'There's a (good) girl.' Actively discourage 'institutional language' ('sweetie', 'love', 'pet', 'darl') Advocate on behalf of older people in a manner that respects their autonomy and legal capacity					

Competency 2 – Maximising health outcomes In order to maximise health outcomes for older people, the Registered Nurse will:						
2.1 Physiological changes associated with ageing		1	2	3	4	5
ESSENTIAL	Maintain knowledge of normal ageing and knowledge of abnormal physiological responses in older people Maintain current knowledge of common age-related disease trajectories and co-morbidities					
2.2 Pharmacology in ageing		1	2	3	4	5
ESSENTIAL	Take an active role in medication management Maintain knowledge of adverse effects Work inter-professionally to prevent or manage polypharmacy					
2.3 Health promotion and health education		1	2	3	4	5
ESSENTIAL	Proactively develop care plans across care needs with older people and family carers Take responsibility for evaluating the implementation of care goals Arrange activities to promote functional capacity—for example, diverse physical activity programmes and diet and cooking programmes Arrange leisure and social activities which promote health and well-being, including regular access to the outdoor environment Develop strategies to enable older people to engage in meaningful and effective health education initiatives					
2.4 Integrated care		1	2	3	4	5
ESSENTIAL	Understand the link between assessment results and intervention required Understand what equipment and/or resources are needed and available Understand the provision of services and how to prevent unnecessary hospital admissions Refer to relevant external services and multi-disciplinary teams to deliver integrated care					

2.5 Assessment and goal planning		1	2	3	4	5
ENHANCED	Proactively assess and plan goals to reflect holistic needs with older people and their family carers Possess high-level assessment skills and appropriately use assessment tools, ensuring cultural appropriateness Use a variety of assessment techniques to systematically collect relevant and accurate information for goal planning to develop a plan of care in consultation with older people Demonstrate flexibility in assessment, goal planning and care delivery to reflect changing care needs—for example, acute deterioration Have the capacity to effectively evaluate and re-develop goals with older people and family carers					

Standard 3 – Communicating effectively

In order to maximise health outcomes for older people, the Registered Nurse will:

3.1 Communication as a process and outcome		1	2	3	4	5
ESSENTIAL	Communicate effectively, respectfully and compassionately with older people and their family carers Transfer critical communication across professional networks Promote a culture of empathy for those who express their distress non-verbally Develop and implement counselling or advanced counselling skills Implement strategies to prevent psychological distress Recognise changes in behaviour as communication and/or as an expression of need					
3.2 Environment		1	2	3	4	5
ESSENTIAL	Consider environmental factors to promote effective communication—for example, consideration of light, signage and noise Use communication aids to address sensory loss, including non-verbal strategies and contemporary technology Maximise privacy and comfort					

3.3 Culture of enabling communication strategies		1	2	3	4	5
ENHANCED	Write and format information brochures and social resources in plain English, using visual aids, flow charts instead of words, large print and multi-lingual versions, including use of interpreters Arrange forums for older people and family carers about service delivery to adopt an explicitly collaborative model of communication that enables involvement Undertake an annual service evaluation collaboratively and creatively Address feedback from older people and family carers in a person-centred way and ensure the process reflects a collaborative way of working Ensure case conferences and meetings between older people and family carers are authentically collaborative Share care plans with older people and family members and record agreement					

Competency 4 – Facilitating transitions in care

In order to facilitate transitions in care for older people, the Registered Nurse will:

4.1 Transitions in care		1	2	3	4	5
ENHANCED	Understand legal accountabilities in managing transitions in care Support older people and family carers during relocation into residential aged care facilities Support decision making between older people and family carers to access services appropriate for their needs Facilitate family carers to be actively involved in palliative and end of life care Maintain awareness of the availability and function of advocacy services Facilitate safe and effective transitions across levels of care, including acute, community-based and long-term care for older people and their families Determine the need for a different level or type of care based on an assessment of an individual's acuity, stability, resources and need for assistance					
4.2 Health and social networks		1	2	3	4	5
ENHANCED	Articulate high-level knowledge about available services Maintain the capacity to access and refer to available services for older people and family carers Refer to and liaise with the multi-disciplinary teams and specialist services as required to meet changes in older people's conditions					

Competency 5 – Facilitating choices within legal and ethical frameworks In order to facilitate choices for older people legally and ethically, the Registered Nurse will:						
5.1 Legislation		1	2	3	4	5
ESSENTIAL	Maintain awareness of legislative frameworks governing aged care such as advanced care plans, living wills, power of attorney and legal guardianship Understand the variety of legal instruments that may govern decision-making made on behalf of the older person (for example, advanced care plans, living wills, power of attorney, legal guardianship) and ensure care is planned and delivered in respect of these instruments where enacted					
5.2 Advocacy		1	2	3	4	5
ESSENTIAL	Maintain the capacity to provide support for the older person and family carer when needs or values and beliefs are contradictory Recognise circumstances requiring referral to advocacy services Be aware of elder abuse scenarios and legislated reporting obligations Intervene to eliminate or minimise the use of physical, chemical and environmental restraints					
5.3 Decision making		1	2	3	4	5
ESSENTIAL	Ensure ongoing assessment of decision making informed by 'situational capacity' for individuals Ensure older people who are considered vulnerable are enabled to actively participate in decision making Promote a culture that respects the choices of older people, including informed decision making involving risk Recognise vulnerability and risk for adverse outcomes relating to ageing and social changes, while reinforcing strengths and abilities Explore values and beliefs of older people and their family carers prior to any decision making Involve the person responsible when no family carer has been nominated					

Competency 6 – Partnering with family carers In order to partner with family carers, the Registered Nurse will:						
6.1 Family carer needs		1	2	3	4	5
ESSENTIAL	Recognise family carers experiencing distress and health problems Refer or facilitate family carers to access support and services Promote the sharing of information with family carers Understand the capacity of family carers to deliver care and support the care needs of older people Assess a family's knowledge and skills to draw on their own abilities and resources for self-care and health promotion					
6.2 Collaboration		1	2	3	4	5
ESSENTIAL	Support and engage with family carers to be actively involved in decision making and care delivery Understand the impact of complex family dynamics and the need to advocate for older people Support family carers to understand the needs of older people through transitions of health and care					

Competency 7 – Promoting mental health and psychological well-being In order to promote mental health and psychological well-being, the Registered Nurse will:						
7.1 Grief and loss issues		1	2	3	4	5
ESSENTIAL	Support older people through life transitions—for example, living with a chronic illness or the death of a loved one					

7.2 Assessment		1	2	3	4	5
ESSENTIAL	Correctly use cognitive, depression and delirium screening and assessment tools Provide specific screening and referral for (but not limited to): suicide risk, grief and loss, past trauma, unresolved issues, sexual abuse, substance abuse					
7.3 Mental health and psychological well-being interventions		1	2	3	4	5
ENHANCED	Understand the impact of dual and complex diagnosis on older people and ensure all mental health needs are comprehensively managed Be aware of life-based experiences that may impact the mental and psychological well-being of older people—for example, stolen generation; refugee; post-traumatic stress Articulate, and refer to, appropriate mental health support services including those specifically specialising in the care of older people Understand the role of complementary therapies and the right of older people to access these Promote physical and social activity for well-being					

Competency 8 – Providing evidence-based dementia care

In order to provide evidence-based dementia care, the Registered Nurse will:

8.1 Dementia specific care		1	2	3	4	5
ESSENTIAL	Understand living with a dementia Understand the main types of dementia Develop non-pharmacological strategies to address unmet need Reference to dementia care competency framework					
8.2 Assessment		1	2	3	4	5
ESSENTIAL	Maintain awareness of cognitive screening and assessment tools and have the capacity to correctly interpret results Be able to differentiate between dementia and health factors that can exacerbate dementia—for example, depression and non-dementia related confusion, delirium, polypharmacy and comorbidities such as pain and trauma and mental health conditions Assess for environmental impacts such as malnutrition, sensory deficit, environmental stress and loneliness					

8.3 Interventions and evaluation		1	2	3	4	5
ESSENTIAL	Develop care plan interventions that are grounded in an understanding of each older person and their life history Articulate and demonstrate effective behavioural support strategies responsive to the individual older person Maintain awareness of the range of therapies and interventions available to support the well-being of the person with dementia – for example, complementary therapies, Montessori, music therapy and aromatherapy Be capable of effectively evaluating the outcomes of interventions					

Competency 9 – Providing optimal pain management

In order to provide optimal pain management, the Registered Nurse will:

9.1 Assessment		1	2	3	4	5
ESSENTIAL	Maintain awareness of current evidence-based practice related to optimal pain management Use valid and reliable tools for assessing pain and associated symptoms Understand the importance of and variation in cultural, ethnic and linguistic expressions of pain used by older people Provide specific pain assessment for individuals living with a dementia and, in particular, atypical presentation of pain as agitation or confusion Emphasise the recognition of non-verbal expressions of pain—for example, restlessness and sleeplessness					
ESSENTIAL	Understand the physiology and complexity of chronic pain in older people Demonstrate high-level pain assessment skills for individuals living with a dementia and recognition of atypical presentations of pain Ensure multidisciplinary collaboration in pain assessment and treatment goals, including the physiotherapist in the assessment, location, severity and treatment of pain Articulate and monitor the impact of chronic pain on the mental well-being of the older people Set treatment goals in collaboration with older people and family carers					

9.2 Intervention and evaluation		1	2	3	4	5
ESSENTIAL	Develop pain management interventions which account for the differences between acute pain, acute-on-chronic pain, chronic/persistent pain, and pain at the end of life Understand how to optimise pharmacological management of pain, including regular administration of analgesia and ongoing monitoring and evaluation of pain Advocate with medical practitioners for effective pain management and referral to specialist pain management services for severe and complex pain management Facilitate a multimodal approach using non-pharmacological therapies—for example, meditation, massage or physical activity Understand that analgesia is a medication and demystify opioid use Use quality systems to measure and monitor the pain management system					

Competency 10 – Providing palliative care

In order to provide palliative care, the Registered Nurse will:

10.1 Spiritual care		1	2	3	4	5
ESSENTIAL	Enable spiritual and faith-based rituals Recognise and support older people and family carers in distress about dying Ensure the advanced care plan includes specific details about wishes for end of life Promote the use of dedicated space for older people who are dying and their family carers Enable and support reflection, contribution and legacy Enable self-care and emotional support for members of the care team					

10.2 The palliative approach		1	2	3	4	5
ESSENTIAL	Understand the models of care delivered to residents with life-limiting illnesses Demonstrate competence in processes, including facilitating advanced care planning, conducting care conferences and initiating end of life care pathways					

10.3 End of life care		1	2	3	4	5
ESSENTIAL	Identify and assess older people entering the comfort/terminal stage of care Understand end of life cultural and spiritual needs Implement end of life care pathways Support the implementation of complementary and alternative therapies Refer to specific palliative care competencies					

Competency 11 – Enabling access to technology

In order to enable access to technology, the Registered Nurse will:

11.1 eHealth		1	2	3	4	5
ESSENTIAL	Evaluate and promote the use of new technologies for monitoring health					
11.2 Social networks		1	2	3	4	5
ESSENTIAL	Promote older people's use of social networking to support mental health and well-being—for example, Skype, online social forums, online games, social media, eBooks and online music					
11.3 Assistive technology		1	2	3	4	5
ESSENTIAL	Promote the use of new technologies for rehabilitation plans e.g. Wii Use appropriate technology and assistive devices to promote and maintain optimal function, independence and safety					

Appendix 5: Action Plan

The name of my mentor who can help me achieve my Learning Action Plan is .....

I will meet with my mentor ..... (location, time and frequency of meetings)

Competency (specific topic area for your learning)	Learning goal	Resources needed to achieve goals	Review date	Due date
1. Short term (3 months)				

Competency (specific topic area for your learning)	Learning goal	Resources needed to achieve goals	Review date	Due date
2. Intermediate (6 months)				

Competency (specific topic area for your learning)	Learning goal	Resources needed to achieve goals	Review date	Due date
3. Long term (1 year)				

Appendix 6: HammondCare Summary of Evidence

Name:…….. Service: …….. Date:……

Date	Time e.g. 1hr	Description of continuous professional development activity *(e.g. education session name, journal article name, online website or self-directed learning activity)*	Name of education provider	Reflection *(In what way has this activity maintained or enhanced your professional practice, knowledge, skills or attributes?)*	Equivalent to CPD points/ hrs

Date	**Time e.g. 1hr**	**Description of continuous professional development activity *(e.g. education session name, journal article name, online website or self-directed learning activity)***	**Name of education provider**	**Reflection *(In what way has this activity maintained or enhanced your professional practice, knowledge, skills or attributes?)***	**Equivalent to CPD points/ hrs**

Appendix 7: Summary of Evidence

Evidence title					
Date completed					
Evidence category	Clinical	Education	Leadership	Policy	Research
Continuing Professional Development (CPD) points/ hrs associated with this evidence					
Knowledge (Provide a narrative of your evidence and experience gained)					
Skills (Document the skills you gained through this experience)					
Attitudes (Have your attitudes changed as a result of this experience?)					
Competencies and domains of practice (Highlight competencies relevant for this piece of evidence)	1. Living well from older people across communities and groups 2. Maximising health outcomes 3. Communicating effectively 4. Facilitating transitions in care 5. Facilitating choices within legal and ethical frameworks 6. Partnering with family carers 7. Promoting mental health and psychological well-being 8. Providing evidence-based dementia care 9. Providing optimal pain management 10. Providing palliative care 11. Enabling access to technology				
Notify mentor (date)					

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