Recommended Geropsychiatric Competency Enhancements for Nurse Practitioners Who Provide Care to Older Adults but are not Geriatric Specialists

February 2010

These recommended competency enhancement statements are not intended to ‘stand-alone,’ but rather to enhance existing or to-be-developed competencies for Nurse Practitioners who provide care to older adults but are not geriatric specialists. The enhancements are organized within the existing Older Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care developed in 2004 by AACN/HGNI and placed within the seven NONPF domains.

The geropsychiatric competency enhancements were drafted in Fall 2008 by the Geropsychiatric Nursing Collaborative (GPNC), a project supported by the John A. Hartford Foundation and housed at the American Academy of Nursing. They were reviewed by representatives of key professional organizations, revised, and then endorsed by the GPNC Core Competency Workgroup and National Advisory Panel and disseminated in Winter 2010 to all relevant professional organizations and schools of nursing for endorsement and utilization.

New competency enhancement statements and modifications to existing competencies are highlighted in yellow for ease in identification.

As revisions are made to existing competency documents, we recommend that the intent of these recommended enhancements be included and that the terms ‘health,’ ‘illness,’ ‘frailty,’ ‘care’ or ‘disease’ be broadly defined as both ‘physical and mental.’ Although physical and mental may be assumed, we believe that it is helpful to have both of these dimensions explicitly stated. Likewise, the term ‘psychiatric disorder’ should be used in combination with ‘substance misuse disorder’ to be more inclusive. It is further recommended that an expectation for the use of valid and reliable clinical assessment tools and evidence-based practices and processes be clearly stated and that gender, sexual orientation, and spirituality be made explicit when referring to cultural issues. Finally, the focus of these enhancements is on older adults; we recognize that the work of some advanced practice nurses may have a lifespan perspective, and, thus, some of these enhancements may also apply to other population groups.

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1This competency enhancement document is one of seven developed and recommended by the Geropsychiatric Nursing Collaborative. The seven enhancement documents are aimed at the entry level nurse and the following groups of advanced practice nurses: gerontological NP and CNS, psychiatric NP and CNS, and other APRNs (NP and CNS) who care for older adults but are not prepared as gerontological experts, e.g., women’s health, adult, family and acute care. The entire set of enhancement documents can be accessed at http://www.aannet.org/GPNCresources. For more information, see www.aannet.org/GPNCgeropsych.


3 We recognize that work is in process by the American Association of Colleges of Nursing (AACN) and the Hartford Institute for Geriatric Nursing (HIGN) to combine competencies for the Adult and Gerontological Nurse Practitioner Specialties in accordance with the new Consensus Model. The GPNC enhancements were used to inform the work of the AACN and HIGN expert panels, however, the final AACN and HIGN documents are still in refinement at this time.
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### Domain I : Health Promotion, Protection, Disease Prevention, & Treatment

#### I.A Assessment of Health Status

1. Differentiate normal aging from illness and disease processes.

2. Use standardized assessment instruments appropriate to older adults if available, or a standardized assessment process to assess social support and health status, such as: function; cognition; mobility; pain; skin integrity; quality of life; nutrition; neglect and abuse.

**NEW:** Adapt assessment processes for persons with cognitive impairment and psychiatric/substance misuse disorders.

**NEW:** Conduct a comprehensive assessment that includes the differentiation of normal age changes from acute and chronic medical and psychiatric/substance misuse disease processes, with attention to commonly occurring atypical presentations and co-occurring health problems including cognitive impairment.

3. Assess for syndromes, constellations of symptoms that may be manifestations of other health problems, common to older adults, e.g., incontinence, falling, delirium, dementia, and depression.

**NEW:** Use valid and reliable clinical evaluation tools to conduct a comprehensive mental health assessment across a range of psychiatric/substance misuse disorders that includes assessment of strengths and potential for improvement.

**NEW:** Include evaluation for elder mistreatment in overall assessment.


**NEW:** Identify and assess factors that affect mental health including stressors that may be more common among older adults such as caregiving, multiple chronic illnesses, pain, relocation, trauma, cohort-specific stressors, and losses such as financial (retirement), functional (Instrumental Activities of Daily Living/Activities of Daily Living), social network (death of family members and friends), and role (status changes).

5. Assess the ability of the individual and family to manage developmental (life stage) transitions, resilience, and coping strategies.

6. Assess older adult’s, family’s, and caregiver’s ability to execute plans of care.

7. Conduct a pharmacological assessment of the older adult, including polypharmacy, drug interactions, over-the-counter and herbal product use, and ability to obtain, purchase, and safely and correctly self-administer medications.
### I.B Diagnosis of Health Status

9. Identify both typical and atypical manifestations of chronic and acute illnesses and diseases common to older adults.

**NEW:** Include mental health alterations in the diagnosis of health status.

**NEW:** Differentiate psychiatric presentations of medical conditions, including psychiatric symptoms at the end of life, from psychiatric/substance misuse disorders and arrange appropriate evaluation and follow-up.

10. Recognize the presence of co-morbidities and iatrogenesis in the frail older adult.

11. Identify signs and symptoms indicative of change in mental status, e.g., agitation, anxiety, depression, substance use, delirium, and dementia.

12. Interpret results of appropriate laboratory and diagnostic tests, differentiating values for older adults.

### I.C Plan of Care and Implementation of Treatment

13. Promote and recommend immunizations and appropriate health screening.

14. Prevent or work to reduce common risk and environmental factors that contribute to:

- decline in physical functioning
- impaired quality of life
- social isolation
- excess disability in older adults
- **NEW:** psychiatric & behavioral symptoms

15. Assist the patient to compensate for age-related functional changes according to chronological age groups.

**NEW:** Remain sensitive to verbal cues and non-verbal behaviors in the communication patterns of older adults and their significant others with cognitive, neurological and speech and hearing impairments.

**NEW:** Apply knowledge of issues related to decisional capacity (including the balance between autonomy and safety), guardianship, financial management and durable and healthcare powers of attorney to the treatment of older adults.
16. Refer and/or manage common signs, symptoms, and syndromes (with consideration of setting, environment, population, co-morbidities and multiple contributing factors), with specific attention to:
   - immobility, risk of falls, gait disturbance
   - incontinence
   - cognitive impairment (depression, delirium, dementia)
   - nutritional compromise
   - substance use/abuse
   - abuse or neglect (verbal, physical and sexual)
   - suicide or homicide ideations

NEW: Provide brief intervention/crisis management and make appropriate referrals to mental health care professionals and community agencies with resources to address needs of individuals and families.

NEW: Monitor and evaluate the patient’s response to and concomitant use of alcohol and recreational drugs, psychotropic and other medications including over-the-counter and herbal medication/product use, based on a thorough understanding of the principles of pharmacotherapeutics in older adults.

NEW: Use behavioral, environmental, and pharmacological management strategies to ameliorate behavioral symptoms in individuals who have psychiatric/substance misuse disorders including cognitive impairments.

17. Maintain or maximize muscle function and mobility, continence, mood, memory and orientation, nutrition, and hydration.

NEW: Plan and implement care that promotes optimal function and minimizes development of complications, such as those from polypharmacy.

18. Use an ethical framework to address individual and family concerns about care-giving, management of pain, and end-of-life issues.

NEW: Coordinate transitions across levels of care between acute care and community-based long term care settings (e.g., Home, Assisted Living, Hospice, Nursing Homes) for older adults and their families.

19. Strive for restraint-free care, minimizing the use of physical and chemical restraints, and develop the most independent and protective setting possible.
## II. The Nurse Practitioner – Patient Relationship

20. Account for cognitive, sensory, and perceptual problems with special attention to temperature sensation, hearing and vision when caring for older adults.

**NEW:** Use culturally appropriate, respectful communication that is adapted to patient’s education, cognitive functioning, personal experience, psychiatric/substance misuse disorder, and mental health history.

**NEW:** Demonstrate awareness of personal and societal biases, especially ageism and stigma related to mental illness/substance misuse and dementia, and how these influence all aspects of the care of the older adult, including mental health promotion, screening, assessment, and treatment.

21. Recognize the heightened need for coordination of care with other health care providers and community resources with special attention to the frail older adult and those with markedly advanced age.

**NEW:** Protect safety of elders and others in the community through legal reporting mechanisms when elder mistreatment or destructive behaviors targeted at self or others, such as driving with cognitive impairment, are identified.

22. Develop caring relationships with patients, families, and other caregivers to address sensitive issues, such as driving, independent living, potential for abuse, end-of-life issues, advanced directives, and finances.

23. Review treatment options and facilitate decision-making with the patient, family, and other caregivers or the patient’s health care proxy.

## III. The Teaching – Coaching Function

24. Consider age-related changes when executing teaching-coaching with regards to sensory and perceptual limitations, cognitive limitations, and memory changes.

25. Utilize adult learning principles in patient, family, and caregiver education, such as timing of teaching, longer time to learn and respond, and need for individualized instruction, integration of information, and use of multiple strategies of communication.

**NEW:** Analyze the impact of aging and age-and disease-related changes in sensory/perceptual function, cognition, confidence with technology, and health literacy and numeracy on the ability and readiness to learn and tailor interventions accordingly.

26. Educate older adults, family, and caregivers about normal vs. abnormal events, physiological changes with aging, and myths of aging.

27. Educate older adults, families, and caregivers about the need for preventive health care and end-of-life choices.
### Recommended Geropsychiatric Competency Enhancements for NPs Who Provide Care to Older Adults but are not Geriatric Specialists

#### February 2010

| NEW: | Educate individuals, families, peers, and groups to promote the knowledge and understanding of effective mental health promotion, management of psychiatric/substance misuse disorders, and the interaction between physical and mental health/illness. |
| 28. | Disseminate knowledge of skills required to care for older adults to other health care workers and caregivers through peer education, staff development, and preceptor experiences. |

#### IV. Professional Role

| NEW: | Advocate within the health care system and policy arenas for the health needs of older adults, especially the frail and markedly advanced older adult. |
| 29. | Consider such factors as ability to pay for treatments related to fixed income (retired), entitlements (Medicaid and Medicare), and available resources when providing treatment to clients who may have financial limitations. |
| 30. | Articulate and promote to other health care providers and the public, the role within the healthcare team, of either the NP or CNS, and its significance in improving outcomes of care for older adults. |
| 31. | Work within an interdisciplinary team to promote the mental health and well-being of older clients and their families. |
| NEW: | Demonstrate knowledge of the similarities and differences in roles of various health professionals providing mental health services, e.g., psychotherapist, psychologist, psychiatric social worker, psychiatrist, and advanced practice psychiatric nurse. |
| 31. | Create and enhance positive, health promoting environments that maintain a climate of dignity and privacy for older adults. |
| 32. | Engage in lifelong learning that includes geropsychiatric nursing. |
| 33. | Incorporate findings from research into mental health promotion and the assessment, treatment, and evaluation of mental health problems and psychiatric disorders affecting older adults and their families. |

#### V. Managing and Negotiating Health Care Delivery Systems

<p>| 32. | Understand payment and reimbursement systems and financial resources across the continuum of care. |
| 33. | Promote continuity of care and manage transitions across the continuum of care. |
| NEW: | Assist older adults/caregivers/and their families to negotiate health care delivery systems, including mental health services. |
| 34. | Communicate to other members of the interdisciplinary care team special needs of the older adult to improve outcomes of care. |</p>
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<td><strong>35.</strong> Collaborate with the interdisciplinary geriatric and geropsychiatric care team to improve outcomes of care.</td>
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<td><strong>36.</strong> Participate in the design and implementation of evidence-based protocols and processes of care to reduce adverse events common to older adults, such as infections, falls, polypharmacy.</td>
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<td><strong>VI. Monitoring and Ensuring the Quality of Health Practice</strong></td>
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<td><strong>37.</strong> Address the impact of ageism, sexism, and cultural biases on health care policies and systems.</td>
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<td><strong>NEW:</strong> Advocate for health policy at the local, state, regional, and national level to reduce the impact of stigma on services for prevention and treatment of mental health problems and psychiatric/substance misuse disorders.</td>
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<td><strong>NEW:</strong> Use knowledge to decrease barriers and gaps in systems that provide mental health services with particular attention to health disparities among minority, disadvantaged and older adults with differing culture, ethnicity, gender, sexual orientation and spirituality.</td>
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<td><strong>38.</strong> Use public and private databases to incorporate evidence-based practices into the care of older adults.</td>
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<td><strong>39.</strong> Apply evidence-based practice using quality improvement methodologies in providing quality care to older adults.</td>
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<td><strong>40.</strong> Use available technology to enhance safety and monitor the health status and outcomes of older adults.</td>
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<td><strong>41.</strong> Facilitate access to hospice and palliative care to maximize a peaceful, pain-free, and compassionate death for patients with any end-stage disease, including dementia.</td>
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<td><strong>VII. Cultural &amp; Spiritual Competence</strong></td>
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<td><strong>42.</strong> Assess intergenerational differences in family members’ beliefs that influence care, e.g., end-of-life care.</td>
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<td><strong>43.</strong> Recognize the potential for cultural and ethnic differences between patients and multiple caregivers to impact outcomes of care.</td>
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<td><strong>44.</strong> Assess patients’ and caregivers’ cultural and spiritual priorities as part of a holistic assessment.</td>
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<td><strong>NEW:</strong> Assess and incorporate into the treatment plan the patient's perceptions/interpretations of his or her physical and/or mental health/illness and care preferences as influenced by culture, sexual orientation, gender, ethnicity, and spirituality.</td>
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<td><strong>NEW:</strong> Demonstrate sensitivity to spirituality and culture when caring for older adults and their families who are at the end of life.</td>
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45. Adapt age-specific assessment methods or tools to a culturally diverse population.

46. Educate professional and lay caregivers to provide culturally competent care to older adults.

47. Incorporate culturally and spiritually appropriate resources into the planning and delivery of health care.