



Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care

March 2004



**Produced by the American Association of Colleges of Nursing
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March 2004

The American Association of Colleges of Nursing (AACN) and the John A. Hartford Foundation (JAHF) are pleased to present *Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care*. Through a generous grant from the Foundation, AACN has spearheaded an initiative to develop a set of gerontological competencies for **all** advanced practice nurses, both nurse practitioners (NPs) and clinical nurse specialists (CNSs), who provide care to older adults. As the percentage of the elderly population continues to increase dramatically, the demand for nurses who can competently care for older adults is also rising.

The *Nurse Practitioner and Clinical Nurse Specialist Competencies* builds on the AACN *The Essentials of Master's Education for Advanced Practice Nursing* (1996) and nationally recognized guidelines and standards established by other APN organizations. This new document outlines the competencies and critical content areas that should be integrated into the educational programs of all NPs and CNSs who care for older adults.

Many organizations participated in this endeavor. We commend each of the organizations and the individuals who represented them, both on the National Expert Panel and the Validation Panel, for the work and energy they contributed to this project. Throughout the consensus-building process AACN sought to ensure that a range of competencies that reflect both NP and CNS practices were identified and could be incorporated into the broader set of competencies for each of the advanced practice nursing specialties. It is our hope that this document will provide the necessary information and guidance to assist educators in incorporating geriatric nursing content into the advanced practice nursing curriculum.

Sincerely,

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ACKNOWLEDGMENTS

AACN is grateful to the John A. Hartford Foundation for its ongoing support of this important initiative. Special thanks go to Dr. Sarajane Brittis for her hard work and commitment to this project.

AACN also thanks Dr. Mathy Mezey, Dr. Terry Fulmer, Ms. Elaine Gould, and Ms. Amy Berman of the John A. Hartford Foundation Institute for Geriatric Nursing for their continuous efforts and dedication not only to this project but to the geriatric nursing education initiatives.

Introduction

The purpose of this document is to describe national, consensus-based competencies of new graduates of master's and post-master's programs preparing nurse practitioners (NP) and clinical nurse specialists (CNS) in specialties that provide care to older adults but are not specialists in gerontology. This set of competencies is not intended to alter or replace competencies developed for the various advanced practice nurse (APN) specialty roles. Rather the competencies described in this document complement other specialty competencies and are intended to highlight those areas of competence and evidence-based knowledge that NPs and CNSs providing care to older adults should have in order to improve health outcomes, quality of life and level of functioning of the growing population of older adults. Competencies specific to one role or dependent upon specialty or practice setting are not included. Also, some CNSs and NPs practice at a higher level of competence particularly in specific areas. The competencies delineated in this document are intentionally broad and include only those aspects of APN care to older adults that encompass both CNS and NP practice. These national consensus-based competencies describe a minimum set of competencies for NPs and CNSs caring for older adults. Because of the broad nature of these competencies, some may already be included as core competencies defined by the practice specialty. In addition, the specialized-focus and complexity of care provided by advanced practice nurses prepared as geriatric nurse practitioners or gerontology clinical nurse specialists are not addressed in this document.

The Issue

Older people constitute a growing majority of people who receive nursing care in the United States. In 2002, 12 percent of the nation's population (more than 35 million people) were over 65 years of age, about one in every eight Americans. This represents an eleven-fold increase in the last 85 years and a 40 percent increase in the last 5 years. By 2030, there will be about 70 million older persons, making up 20 percent of the population, or one in five Americans (AOA, 2004).

The health status of older people is diverse. Health status often is influenced by income level, living arrangements, and need for physical and psycho/social supports. Many of the ailments afflicting the older adult are represented in the 28 priority areas identified as responsive to health promotion and prevention activities in *Healthy People 2010: National Health Promotion and Disease Prevention Objectives* (U.S. Department of Health and Human Services, 2000). A major focus of health promotion in the elderly is to minimize the loss of independence associated with functional decline and illness (Rowe & Kahn, 1999). The predominant health problems of older people are chronic rather than acute and are exacerbated by the normal changes of aging and the increased risk of illness associated with old age. Despite this picture, the majority of older people report themselves to be in "good" health as measured by level of function and general self-perception of health.

Older adults form the core business of healthcare: approximately 50 percent of patients in hospitals, 85 percent of homecare patients, and more than 90 percent of nursing home residents are age 65 years and older (Bednash, Fagin & Mezey, 2003). In home care, the fastest growing area of healthcare, there were over 90 million visits to approximately 2.5 million Medicare beneficiaries in 2000 (Centers for Medicare and Medicaid Services, September 2002). Fifty-two

percent of these were nursing visits and approximately 30 percent were for nursing aide services (Mitty & Mezey, 1999).

Academia and professional nursing organizations have attempted to improve the quality and increase the quantity of America's foremost primary caregiver, the registered nurse. In addition, APNs have been educated to provide high quality care in multiple specialties to diverse patient populations. These efforts, however, have not adequately prepared the number of nurses necessary to address the dramatically increasing demand for care of older adults. Over 157,200 registered nurses have been prepared to practice as either nurse practitioners (NPs), clinical nurse specialists (CNSs), or both (Spratley et al., 2001). Currently, however, only three percent of APNs are certified in geriatrics (American Nurses Credentialing Center, 2002; Spratley et al., 2001). Three hundred twenty-six schools prepare master's and/or post-master's level NPs; and 218 schools prepare master's and/or post-master's level CNSs (Berlin, Stennett, & Bednash, 2004). The number of master's and post-master's NP programs and the number of master's and post-master's CNS programs are broken down by specialty in Tables 1-3. Those NP and CNS programs that prepare graduates in specialties that provide care to older adults but are not specialists in gerontology are highlighted. These programs (1,531) represent a majority (73 percent) of NP and CNS programs (Berlin, Stennett, & Bednash, 2004).

A concentrated effort is needed to stimulate innovations in curricular design and clinical experiences so that institutions of higher education and health care systems may increase their capacity to train future APNs with competencies to appropriately care for older patients.

TABLE 1.
Schools with Students Enrolled in NP Programs by the National NP Certification Examination that the Program Prepares the Majority of Graduates to Take.*

Clinical Track/National Certification Exam	Master's NP N=323: valid N=299 respondent schools	Post-Master's NP N=285: valid N=276 respondent schools
Family NP	262	236
Adult NP	131	122
Pediatric NP	94	86
<i>Gerontological NP</i>	62	56
Women's Health NP	50	42
Neonatal NP	44	35
Adult Acute Care NP	59	51
Adult Psychiatric/Mental Health NP	41	45
Family Psychiatric/Mental Health NP	6	4

(Berlin, Stennett, & Bednash, 2004)

Highlights indicate programs that prepare graduates to provide care for older adults, but who are not gerontology specialists.

* Information pertaining to nurse practitioners is the result of a collaborative effort between the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties.

All nurse practitioner data are owned jointly by the two organizations.

TABLE 2.
Schools with Students Enrolled in CNS Programs by the National CNS Certification Examination that the Program Prepares the Majority of Graduates to Take. *

Specialty Area/National Certification Examination	Master's CNS N=218: valid N=199 respondent schools	Post-Master's CNS N=99: valid N=92 respondent schools
Acute and Critical Care CNS-Adult	52	23
Acute and Critical Care CNS-Pediatric	9	5
Acute and Critical Care CNS-Neonatal	15	5
Community Health CNS	72	26
<i>Gerontological CNS</i>	45	16
Home Health CNS	3	1
Pediatric CNS	25	10
Psychiatric/Mental Health CNS-Adult	61	39
Psychiatric/Mental Health CNS-Child & Adolescent	7	6
Medical-Surgical CNS	90	41

(Berlin, Stennett, & Bednash, 2004)

Highlights indicate programs that prepare graduates to provide care for older adults, but who are not gerontology specialists.

*Information pertaining to clinical nurse specialists is the result of an agreement between the American Association of Colleges of Nursing and the National Association of Clinical Nurse Specialists.

All clinical nurse specialist data are owned jointly by the two organizations.

TABLE 3.
Schools with Students Enrolled in Combined NP/CNS Programs by the National NP and CNS Certification Examination that the Program Prepares the Majority of Graduates to Take. *

National Certification Examinations	Master's NP/CNS Valid N=52 respondent schools	Post-Master's NP/CNS Valid N=37 respondent schools
Adult Acute Care NP/Acute & Critical Care CNS-Adult	9	7
Adult NP/Acute and Critical Care CNS-Adult	2	
<i>Adult NP/Gerontological CNS</i>	8	
Adult NP/Psychiatric & Mental Health CNS-Adult	8	7
Adult NP/Medical-Surgical CNS		5
Adult Psychiatric & Mental Health NP/ Psychiatric & Mental Health CNS-Adult	15	12
Family NP/Community Health CNS	4	
Family NP/Medical-Surgical CNS	1	
Family NP/Psychiatric & Mental Health CNS-Adult	4	1
<i>Gerontological NP/Gerontological CNS</i>	10	7
Neonatal NP/Acute & Critical Care CNS-Neonatal	4	2
Pediatric NP/Pediatric CNS	12	

(Berlin, Stennett, & Bednash, 2004)

Highlights indicate programs that prepare graduates to provide care for older adults, but who are not gerontology specialists.

*Information pertaining to combined nurse practitioner/clinical nurse specialists is the result of agreements with the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties; and the American Association of Colleges of Nursing and the National Association of Clinical Nurse Specialists.

All combined NP/CNS data are owned by the three organizations.

Background

The John A. Hartford Foundation, located in New York City, recognizing that nurses play a critical role in the care of older adults, has committed over \$35 million thus far to strengthen gerontologic nursing capacity in both academic and clinical settings. In June 2001, the American Association of Colleges of Nursing (AACN) received a grant from the Foundation to champion innovation in geriatrics in undergraduate and graduate nursing education curricula. One grant initiative provided for the development of a set of core gerontological competencies for all APNs who provide care to older adults but are not specialists in gerontology. In addition, the grant supported efforts to widely disseminate and promote the integration of these competencies within APN curricula.

Development of Competencies for Advanced Practice Nurses

In 1990, the National Organization of Nurse Practitioner Faculties (NONPF) released the first set of core domains and competencies. NONPF subsequently updated and revised them in 1995, 2000 and 2002. The domains of NP practice identified here are based on the *Domains and Competencies of Nurse Practitioner Practice* (NONPF, 2002).

In 1996, AACN published *The Essentials of Master's Education for Advanced Practice Nursing*. This document provides a framework for educators in designing and assessing master's nursing education programs for APNs. The Graduate Core Curriculum Content, content that should be included in all master's education programs, and the Advanced Practice Nursing Core Curriculum Content, essential content for all nursing education programs preparing APNs providing direct patient care services, are outlined. The *Master's Essentials* also defined a third component of master's education: Specialty Curriculum Content, clinical and didactic learning experiences identified by the specialty nursing organizations.

Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health was published in April 2002 by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. These Nurse Practitioner Primary Care Competencies are national consensus-based core and specialty competencies for the five primary care NP specialties that build on the NONPF *Domains and Core Competencies* and the competencies of the other NP certification and education organizations. This competency development project was co-chaired by AACN and NONPF.

Efforts to develop Nurse Practitioner Primary Care Competencies coincided with a national effort to strengthen care of the older adult in graduate nursing education and practice (DHHS, 2001). This fortuitous timing allowed for the initial integration of competencies for the care of the older adult into the specialty competencies for the adult, family, and women's health NP (NONPF & AACN, 2002).

The National Association of Clinical Nurse Specialists (NACNS) publication, *Statement on Clinical Nurse Specialist Practice and Education* (2004), articulates a framework for CNS practice, which is organized into three spheres of influence. Within each sphere, outcomes and core competencies of CNS practice are identified. The core competencies are universal

regardless of specialty focus of practice. The competencies delineate the unique contributions of CNS practice to healthcare and help distinguish CNS practice from the practice of other APNs. CNS competencies are interpreted and actualized in specialty practice. The generic nature of the competencies provides an opportunity to define specific competencies for the care of older adults in the existing framework and competencies.

Nurse practitioners and clinical nurse specialists, in a number of practice specialties, provide a significant amount of care to older adults. Therefore, a set of competencies was deemed necessary to ensure that those CNSs and NPs who provide care to older adults but are not specialists in gerontology are prepared to meet this need. An Expert Panel, comprised of CNS and NP educators and practitioners from an array of specialties, met in October 2001 and May 2003 in Washington, DC. A list of Expert Panel members is included in Appendix A. The purpose of the meetings was to elicit input and develop consensus on those competencies that were deemed essential for both CNSs and NPs without a specialty in gerontology. The goal was to create a core set of competencies that address both NPs and CNSs providing care to older adults.

An independent Validation Panel was used to evaluate the work of the Expert Panel. The Validation Panel consisted of broad representation of NP, CNS and nursing related organizations, including perspectives from both education and practice. Thirty-one organizations were invited to nominate up to 3 individuals to participate on the Validation Panel. Twenty organizations nominated individuals, and a total of 40 individuals participated on the Panel. A list of the organizations represented on the Validation Panel is included in Appendix B. The process used to validate the individual competencies replicated the process to develop the *Nurse Practitioner Primary Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (DHHS, 2002). Participants on the Validation Panel were asked to review systematically each competency according to the following criteria:

- Relevance — is the competency a necessary knowledge, skill, or personal attribute for CNSs?
Is the competency a necessary knowledge, skill, or personal attribute for NPs?
Is the competency not relevant for either?
- Specificity — is the competency stated specifically and clearly? (Yes, no, and suggested re-wording);
- Comprehensiveness — in your opinion, is any aspect of knowledge, skill, or personal attribute missing for CNSs or NPs who are not specialists in gerontology but provide care to older adults? Please enter those additional competencies.

The validation process demonstrated overwhelming consensus on the competencies. Eighty-four percent of the Validation Panel, on average, indicated the competencies were relevant for CNSs and 87 percent of the Panel, on average, indicated the competencies were relevant for NPs. Seventy-one percent of the Panel, on average, indicated the competencies were specific enough. The majority of comments from the Panel related to the need for clarification or refinement of competencies. The comments received from the Validation Panel were used to edit and clarify a number of competencies. Based on the feedback from the Validation Panel, two competencies

were deleted, two new competencies were added and eight were changed or significantly reworded.

Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care

Older adults represent a unique population, just as pediatric patients do. Consequently, the presentation of disease and response to treatment differ from other populations. The following areas of content were identified as being essential for all nurse practitioners and clinical nurse specialists caring for older adults.

For older adults, demonstrate knowledge, skills, and behavior of best practices in order to:

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
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
4. Assess health status and identify risk factors in older adults
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 medications, and safely and correctly self-administer medications
8. Assess for pain in the older adult, including the cognitively impaired, and develop a plan of care to manage
9. Identify both typical and atypical manifestations of chronic and acute illnesses and diseases common to older adults
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
13. Promote and recommend immunizations and appropriate health screenings
14. Prevent or work to reduce common risk and environmental factors that contribute to:
 - decline in physical functional
 - impaired quality of life
 - social isolation
 - excess disability in older adults
15. Assist the patient to compensate for age-related functional changes according to chronological age groups
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
17. Maintain or maximize muscle function and mobility, continence, mood, memory and orientation, nutrition, and hydration
18. Use an ethical framework to address individual and family concerns about care-giving, management of pain, and end-of-life issues
19. Strive for restraint-free care, minimizing the use of physical and chemical restraints, and develop the most independent and protective setting possible
20. Account for cognitive, sensory, and perceptual problems, with special attention to temperature sensation, hearing, and vision when caring for older adults
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
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
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
26. Educate older adults, families, and caregivers about normal vs. abnormal events, physiological changes with aging, and myths of aging
27. Educate older adults, family, and caregivers about the need for preventive health care and end-of-life choices
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
29. Advocate within the health care system and policy arenas for the health needs of older adults, especially the frail and markedly advanced older adult
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. Create and enhance positive, health-promoting environments that maintain a climate of dignity and privacy for older adults
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
34. Communicate to other members of the interdisciplinary care team special needs of the older adult to improve outcomes of care
35. Collaborate with the interdisciplinary geriatric and geropsychiatric care team to improve outcomes of care
36. 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, and polypharmacy
37. Address the impact of ageism, sexism, and cultural biases on health care policies and systems

38. Use public and private databases to incorporate evidence-based practices into the care of older adults
39. Apply evidence-based practice using quality improvement methodologies in providing quality care to older adults
40. Use available technology to enhance safety and monitor the health status and outcomes of older adults
41. 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
42. Assesses intergenerational differences in family members' beliefs that influence care, e.g. end-of-life care
43. Recognize the potential for cultural and ethnic differences between patients and multiple caregivers to impact outcomes of care
44. Assess patients' and caregivers' cultural and spiritual priorities as part of a holistic assessment
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 healthcare

Integrating Gerontology Content and Competencies into the NP and CNS Curricula

To facilitate the integration of the APN competencies for older adult care into the various NP and CNS curricula, the 47 competencies have been inserted into the core NP domains (NONPF, 2002) and the core CNS spheres (NACNS, 2004) as defined by these two specialty organizations.¹ These two frameworks are provided as examples of how the APN competencies could be integrated throughout the NP or CNS curricula.

Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care describes minimum competence of NPs and CNSs caring for older adults. Because of the broad nature of these competencies some may already be included as core or specialty competencies defined by the practice specialty. Other competencies may be included in the core curriculum but may require additional emphasis or presentation in a different context. In addition, the individual competencies must be interpreted in relation to the functional role of the individual APN.

Integrating the APN Competencies for Older Adult Care into the NP Curriculum

To facilitate the integration of the APN competencies for older adult care into the various NP specialty curricula, the competencies have been inserted into the *Domains of Nurse Practitioner Practice* (NONPF, 2002). The domains constitute a conceptual framework for NP practice and the foundation for specialty competencies. These domains of practice were first described by NONPF in 1990 and revised in 1995, 2000 and 2002. The NONPF domains provided a framework for the development of *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (DHHS, 2002). The format and description of each domain presented here reflects the framework outlined in this publication. Domain I includes a separate section entitled, "Diagnosis of Health Status," which is not included in the NONPF core competencies. This sub-domain was created for the *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (DHHS, 2002, p.15) to emphasize that NPs are engaged in the diagnostic process, including critical thinking involved in differential diagnosis and the integration and interpretation of various forms of data.

Expert Panel members identified competencies for each of the domains. The wording of each individual competency has not been changed. Only the framework in which they are presented has been changed to facilitate their use in NP curricula. The descriptions for each of the domains and sub-domains included here are taken from *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (DHHS, 2002). For additional description of each domain and core competencies see *Domains of Nurse Practitioner Practice* (NONPF, 2000 & 2002) and *Curriculum Guidelines & Program Standards for Nurse Practitioner Education* (NONPF, 1995).

¹ The use of the NONPF and NACNS frameworks does not imply endorsement by AACN for the proposed organization or integration of the competencies into curricula.

I. HEALTH PROMOTION, HEALTH PROTECTION, DISEASE PREVENTION, AND TREATMENT

This domain incorporates the health promotion, health protection, disease prevention, and treatment focus of NPs related to care of the older adult. Within this role, the NP synthesizes theoretical, scientific, and contemporary clinical knowledge for the assessment and management of both health and illness states.

A. Assessment of Health Status:

These competencies describe the role of the NP in assessing all aspects of the patient's health status, including for purposes of health promotion, health protection, and disease prevention. The NP employs evidence-based clinical practice guidelines to guide screening activities, identifies health promotion needs, and provides anticipatory guidance and counseling addressing environmental, lifestyle, and developmental issues.

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
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
4. Assess health status and identify risk factors in older adults
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 medications, and safely and correctly self-administer medications
8. Assess for pain in the older adult, including the cognitively impaired, and develop a plan of care to manage

B. Diagnosis of Health Status:

The NP is engaged in the diagnosis of health status. This diagnostic process includes critical thinking, differential diagnosis, and the integration and interpretation of various forms of data.

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

C. Plan of Care and Implementation of Treatment:

The objectives of planning and implementing therapeutic interventions are to return the patient to a stable state and to optimize the patient's health. These competencies describe the NP role in stabilizing the patient, minimizing physical and psychological complications, and maximizing the patient's health potential.

13. Promote and recommend immunizations and appropriate health screenings
14. Prevent or work to reduce common risk and environmental factors that contribute to:
 - decline in physical functional
 - impaired quality of life
 - social isolation
 - excess disability in older adults
15. Assist the patient to compensate for age related functional changes according to chronological age groups
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
17. Maintain or maximize muscle function and mobility, continence, mood, memory and orientation, nutrition, and hydration
18. Use an ethical framework to address individual and family concerns about care-giving, management of pain, and end-of-life issues
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

Competencies in this area demonstrate the personal, collegial, and collaborative approach which enhances the NP's effectiveness in providing patient care. The competencies speak to the critical importance of interpersonal transactions as they relate to therapeutic patient outcomes.

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

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

These competencies describe the NP's ability to impart knowledge and associated psychomotor skills to patients. The coaching function involves the skills of interpreting and individualizing therapies through the activities of advocacy, modeling, and tutoring. Recipients of teaching-coaching may include patients, families, nursing and/or other health personnel or systems of care.

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
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
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

These competencies describe the varied role of the NP, specifically related to advancing the profession and enhancing direct care and management. The NP demonstrates a commitment to the implementation, preservation, and evolution of the NP role. As well, the NP implements critical thinking and builds collaborative, interdisciplinary relationships to provide optimal care to the patient.

29. Advocate within the health care system and policy arenas for the health needs of older adults, especially the frail and markedly advanced older adult
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. Create and enhance positive, health promoting environments that maintain a climate of dignity and privacy for older adults

V. MANAGING AND NEGOTIATING HEALTH CARE DELIVERY SYSTEMS

These competencies describe the NP's role in handling situations successfully to achieve improved health outcomes for patients, communities, and systems through overseeing and directing the delivery of clinical services within an integrated system of health care.

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
34. Communicate to other members of the interdisciplinary care team special needs of the older adult to improve outcomes of care
35. Collaborate with the interdisciplinary geriatric and geropsychiatric care team to improve outcomes of care
36. 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

VI. MONITORING AND ENSURING THE QUALITY OF HEALTH CARE PRACTICE

These competencies describe the NP's role in ensuring quality of care through consultation, collaboration, continuing education, certification, and evaluation. The monitoring function of the role is also addressed relative to monitoring one's own practice as well as engaging in interdisciplinary peer and systems review.

37. Address the impact of ageism, sexism, and cultural biases on health care policies and systems
38. Use public and private databases to incorporate evidence-based practices into the care of older adults
39. Apply evidence-based practice using quality improvement methodologies in providing quality care to older adults
40. Use available technology to enhance safety and monitor the health status and outcomes of older adults
41. 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

VII. CULTURAL & SPIRITUAL COMPETENCE

These competencies describe the NP's role in providing culturally competent care, delivering patient care with respect to cultural and spiritual beliefs, and making health care resources available to patients from diverse cultures.

42. Assess intergenerational differences in family members' beliefs that influence care, e.g., end-of-life care
43. Recognize the potential for cultural and ethnic differences between patients and multiple caregivers to impact outcomes of care
44. Assess patients' and caregivers' cultural and spiritual priorities as part of a holistic assessment
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

Integrating the APN Competencies for Older Adult Care into the CNS Curriculum

To facilitate the integration of the APN competencies for older adult care into the CNS specialty curricula, the competencies are presented in the context of the three CNS spheres of influence as defined in the *Statement on Clinical Nurse Specialist Practice and Education* (NACNS, 2004). The spheres (patients/clients, nurses and nursing practice, and organization/system) create an organizational framework for CNS practice and form the foundation for specialty competencies.

The wording and numbering of each individual competency has not been changed. Only the framework in which they are presented has been changed to facilitate their use in CNS curricula. Two Expert Panel members identified the placement of the competencies within each sphere. The descriptions of each sphere and sub-categories under each sphere are taken from *Statement on Clinical Nurse Specialist Practice and Education* (NACNS, 2004). For additional descriptions of each sphere and core competencies see *Statement on Clinical Nurse Specialist Practice and Education* (NACNS, 2004).

I. PATIENT/CLIENT SPHERE OF INFLUENCE

In this sphere, which is foundational to the other spheres, CNSs use their knowledge and skills to assess, diagnose, and treat illness (symptoms and functional problems) and risk behaviors² in patients. To improve nurse sensitive outcomes for older adults, CNSs demonstrate knowledge, skills, and behavior in the design, delivery and evaluation of innovative, cost-effective, quality interventions for illness problems and risk behaviors amenable to nursing interventions.

A. Assessment

CNSs conduct comprehensive, holistic wellness and illness assessments using known or innovative evidence-based techniques, tools, and methods to obtain data about context such as disease, culture, and age-related factors; etiologies (including both nondisease and disease-related factors) necessary to formulate differential diagnoses and identify the need for new or modified assessment methods; and data on the target population prior to designing new programs. CNS assessment of the older adult should include attention to the following special considerations specific to older adults:

1. Differentiate normal aging from illness and disease processes

² Illness is the subjective experience of somatic discomfort, including physical discomfort, emotional discomfort, and/or reduction in functional ability below perceived capability. Functional ability encompasses activities of daily living, self-care ability, decision-making ability, problem-solving ability, social interaction ability, spiritual ability and ability to meet personal needs for such things as sleep and intimacy. Illness is viewed in the human experience of disease, and extends to nondisease conditions that humans may experience. Diseases and illness are two distinctly different phenomena. Illness can be experienced in the presence or absence of disease and is the focus of CNS practice. The goal of nursing care for a person who is ill is to assist in eliminating or decreasing uncomfortable or unpleasant sensations and assist in reaching full potential. Wellness is a subjective experience and is characterized by pleasant sensations and a perception of comfort. It can be experienced in the presence or absence of disease. Risk behavior is an action or habit that threatens wellness and contributes to illness (NACNS, 2004).

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
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
4. Assess health status and identify risk factors in older adults
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 medications, and safely and correctly self-administer medications
8. Assess for pain in the older adult, including the cognitively impaired and develop a plan of care to manage
9. Identify both typical and atypical manifestations of chronic and acute illnesses and diseases common to older adults
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

B. Diagnosis, Planning, and Interventions

Diagnosis and Planning: CNSs synthesize assessment data and develop differential diagnosis of illness problems to describe problems in context; select evidence-based nursing interventions to target the etiologies of illness or risk behaviors; develop interventions that enhance the attainment of predicted outcomes while minimizing unintended consequences; implement interventions that integrate unique needs of individuals, families, groups, and communities; and collaborate with multidisciplinary professionals to integrate nursing interventions into a comprehensive plan of care to enhance patient outcomes.

Intervention: CNSs select evidence-based nursing interventions for patients that target etiologies of illness and risk behaviors; develop interventions that enhance the attainment of predicted outcomes while minimizing unintended consequences; implement interventions that integrate the unique needs of patients; collaborate with multidisciplinary professionals to integrate nursing interventions into a comprehensive plan of care to enhance patient outcomes; and incorporate evidence-based research into nursing interventions within the specialty population.

The following common and special needs should be considered in the diagnosis, planning, and interventions for older adults:

13. Promote and recommend immunizations and appropriate health screenings
14. Prevent or work to reduce common risk and environmental factors that contribute to:
 - decline in physical functional
 - impaired quality of life
 - social isolation
 - excess disability in older adults
15. Assist the patient to compensate for age-related functional changes according to chronological age groups
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
17. Maintain or maximize muscle function and mobility, continence, mood, memory and orientation, nutrition, and hydration
18. Use an ethical framework to address individual and family concerns about care-giving, management of pain and end-of-life issues
19. Strive for restraint-free care, minimizing the use of physical and chemical restraints, and develop the most independent and protective setting possible
20. Account for cognitive, sensory, and perceptual problems with special attention to temperature sensation, hearing and vision when caring for older adults
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
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
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
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
32. Understand payment and reimbursement systems and financial resources across the continuum of care

40. Use available technology to enhance safety and monitor the health status and outcomes of older adults
41. 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
42. Assess intergenerational differences in family members' beliefs that influence care, e.g., end-of-life care
43. Recognize the potential for cultural and ethnic differences between patients and multiple caregivers to impact outcomes of care
44. Assess patients' and caregivers' cultural and spiritual priorities as part of a holistic assessment
45. Adapt age-specific assessment methods or tools to a culturally diverse population

C. Evaluation

CNSs select, develop, and/or apply methods to evaluate outcomes of nursing interventions; evaluate effects of nursing interventions for individuals and aggregates for clinical effectiveness, patient responses, efficiency, cost-effectiveness, consumer satisfaction, and ethical considerations; collaborate with patients and other healthcare providers to monitor progress toward outcomes and making modifications as needed; evaluate the impact of nursing interventions on fiscal and human resources; document outcomes in a reportable manner; and disseminate results of innovative interventions.

To help ensure that clinically effective, efficient, fiscally sound, quality interventions, methods, and programs are not only available to nurses but also available as part of a continuum of knowledge development for care of older adults, CNSs should be particularly attentive to evaluating the following:

APN competencies for older adult care 1-27, 32, 40-45.

II. NURSES AND NURSING PRACTICE SPHERE OF INFLUENCE

CNSs advance nursing practice and improve nurse sensitive patient outcomes by updating and improving norms and standards of nursing care. CNSs provide leadership in the development of evidence-based policies, procedures and protocols, and best practice models and guidelines.

To improve nurse sensitive outcomes for older adults, CNSs demonstrate leadership, knowledge, skills, and behavior to influence nursing practice delivered by nurses and nursing personnel. Competencies for care of older adults in the nursing practice sphere include mentoring, educating, and role modeling innovative nursing interventions.

A. Assessment

CNSs use/design methods and instruments to assess patterns related to nursing practice outcomes within and across units of care; to assess knowledge, skills, and practice competencies of nursing personnel to advance the practice of nursing; to identify needed

changes in equipment; to substantiate desirable and undesirable patient outcomes linked to nursing practice; and to identify facilitators and barriers to implementing nursing practices that influence nurse-sensitive outcomes.

In the care of older adults, CNSs assist nurses and nursing personnel, and change practice norms and standards to ensure comprehensive assessment including:

APN competencies for older adult care 1-12.

B. Diagnosis, Planning, and Intervention

Diagnosis and Planning: CNSs draw conclusions about the evidence-base and outcomes of nursing practice that require change, enhancement, or maintenance. They anticipate and plan for achieving intended - and avoiding unintended - outcomes of change, including planning for facilitators and barriers and effective resource management.

Intervention: CNSs use evidence-based information to identify nurse-sensitive outcomes. They mentor nurses and collaborate with nursing personnel to implement innovative interventions; and they develop education programs that target specific personnel needs to improve nursing practice and patient outcomes.

To ensure that nurses and nursing personnel implement innovative interventions and programs of care, and that nurses have the requisite knowledge and skills to care for older adults, CNSs demonstrate the following competencies:

APN competencies for older adult care 13-27, 32, 40-46, as well as

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
29. Advocate within the health care system and policy arenas for the health needs of older adults, especially the frail and markedly advanced older adult
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. Create and enhance positive, health promoting environments that maintain a climate of dignity and privacy for older adults
33. Promote continuity of care and manage transitions across the continuum of care
34. Communicate to other members of the interdisciplinary care team special needs of the older adult to improve outcomes of care
35. Collaborate with the interdisciplinary geriatric and geropsychiatric care team to improve outcomes of care
36. 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

37. Address the impact of ageism, sexism, and cultural biases on health care policies and systems
38. Use public and private databases to incorporate evidence-based practices into the care of older adults
39. Apply evidence-based practice using quality improvement methodologies in providing quality care to older adults
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

C. Evaluation

CNSs evaluate the ability of nurses and other nursing personnel to implement changes in practice with individual patients or populations. They evaluate the effect of change on clinical outcomes and nurse satisfaction, and document outcomes and disseminate results to all stakeholders.

CNSs select from among the competencies for care of older adults to evaluate patient outcomes related to nurses and nursing personnel interventions, including:

APN competencies for older adult care 1-47.

III. ORGANIZATION/SYSTEM SPHERE OF INFLUENCE

In this sphere, CNSs influence the organization and system by articulating the value of nursing care at the decision-making level and act as advocates for professional nursing. CNSs lead nursing and multidisciplinary groups to implement innovative patient care programs that address patient needs across the full continuum of care.

A. Assessment

CNSs use/design system level assessment methods and instruments to identify organizational structures and functions that impact nursing practice and nurse-sensitive patient care outcomes. They assess system-level variables, such as culture, finances, and regulatory requirements that influence nursing practice and outcomes. They monitor legislative and regulatory policies that may impact nursing practice.

B. Diagnosis, Planning and Intervention

CNSs identify facilitators and barriers to achieving desired outcomes across the continuum of care. They identify variations in organizational culture that affect outcomes and plan for achieving system-wide outcomes. They lead nursing and multidisciplinary groups to implement innovative patient care programs for diverse populations and contribute to the development of multidisciplinary standards of practice and evidence-based guidelines for care. They develop or influence system-level policies impacting

innovations and programs of care. They provide leadership for policy initiatives that advance health of the public and mobilize necessary professional and public resources to support these initiatives.

C. Evaluation

CNSs use evaluation methods and instruments to identify and evaluate system-level outcomes of care. They evaluate organizational policies related to support and sustainability of programs of care; and they document and disseminate system-wide the outcomes of nursing practice.

To improve nurse sensitive outcomes for older adults, CNSs provide leadership, knowledge, skills, and behavior to influence changes in healthcare organizations at the system-level to facilitate nursing practice for the improvement of quality cost-effective outcomes. CNS competencies for care of older adults in the organization/system sphere include:

APN competencies for older adult care 18, 19, 21-22, 27-41, 43, 47.

REFERENCES CITED IN THE DOCUMENT

Administration on Aging, U.S. Department of Health and Human Services. (2004). Statistics. Available at <http://www.aoa.dhhs.gov/prof/Statistics/statistics.asp>.

American Association of Colleges of Nursing. (1995). *The essentials of master's education for advanced practice nursing*. Washington, DC: Author.

Bednash, G., Fagin, C., & Mezey, M. (2003). Geriatric content in nursing programs: A wake-up call. *Nursing Outlook*, 51, 149-150. New York: Mosby.

Berlin, L., Stennett, J., & Bednash, G. (2004). *2003-2004 Enrollment and graduations in baccalaureate and graduate programs in nursing*. Washington, DC: American Association of Colleges of Nursing.

Expert Panel on Graduate Geriatric Nursing Education and Practice. (2001). *Caring for older Americans: A foundation for a national effort toward building graduate nursing education in gerontology*. Rockville, MD: U.S. Department of Health & Human Services Division of Nursing and John A. Hartford Foundation.

Flaherty, E., Fulmer, T., & Mezey, M., (Eds.) (2003). *Geriatric nursing review syllabus: A core curriculum in advanced practice geriatric nursing*. New York: The American Geriatrics Society.

Mitty, E., & Mezey, M. (1999). Integrating advanced practice nurses into home care: recommendations for a teaching home care program. *Nursing and Health Care Perspectives*, Vol. 19, No. 6, 264-270.

National Association of Clinical Nurse Specialists. (2004). *Statement on clinical nurse specialist practice and education*, (2nd ed.). Harrisburg, PA: Author.

National Organization of Nurse Practitioner Faculties. (1990). *Advanced nursing practice: Nurse practitioner curriculum guidelines*. Washington, DC: Author.

National Organization of Nurse Practitioner Faculties. (1995). *Curriculum guidelines & program standards for nurse practitioner education*. Washington, DC: Author.

National Organization of Nurse Practitioner Faculties. (2000). *Domains and competencies of nurse practitioner practice*. Washington, DC: Author.

National Organization of Nurse Practitioner Faculties. (2002). *Domains and competencies of nurse practitioner practice*. Washington, DC: Author.

Rowe, J., & Kahn, R. (1999). *Successful aging*. New York, NY: Pantheon Books.

Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W. (2001). *The registered nurse population March 2000: findings from the national sample survey of registered nurses*.

Washington, DC: U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions Division of Nursing.

The John A. Hartford Foundation Institute for Geriatric Nursing. <http://www.hartfordign.org> (accessed 4/03)

U.S. Department of Health and Human Services. (2000). *Healthy people 2010 (2nd ed.)*. With Understanding and Improving Health and Objectives for Improving Health, 2 vols. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. (2002). *Nurse practitioner primary care competencies in specialty areas: Adult, family, gerontological, pediatric, and women's health*. Rockville, MD: Author.

Appendix A

NATIONAL EXPERT PANEL

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Continence Specialist, Northwest Urologic Clinic

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University of Pennsylvania School of Nursing

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Director, Gerontology Program, American Association of Colleges of Nursing

Fay Wright, RN, MS, CCRN, BC
Adult Nurse Practitioner

Appendix B

Organizations Represented on the VALIDATION PANEL

American Academy of Nurse Practitioners
American Association of Critical Care Nurses
American College of Nurse Practitioners
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
Asian American Pacific Islander Nurses Association
Association of Women’s Health, Obstetric, & Neonatal Nurses
Commission on Collegiate Nursing Education
Hartford Institute for Geriatric Nursing
Hospice and Palliative Nurses Association
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women’s Health
National Certification Corporation for Obstetric and Neonatal Nursing
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing Accreditation Commission
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Oncology Nursing Society

Appendix C

GERIATRIC RESOURCES FOR ADVANCED PRACTICE NURSING

*From the The John A. Hartford Foundation Institute for Geriatric Nursing
at New York University Division of Nursing*

BOOKS

Beers, M., & Berkow, R. (2000). *The Merck manual of geriatrics (3rd ed.)*. Whitehouse Station, NJ: Merck and Company.

Burke, M., & Laramie, J. (2004). *Primary care of the older adult: A multidisciplinary approach*. New York: Mosby.

Cotter, V. & Strumpf, N. (Eds.). (2002). *Advanced practice nursing with older adults: Clinical guidelines*. New York: McGraw-Hill.

Eliopoulos, C. (2001). *Gerontological Nursing (5th ed.)*. New York: Lippincott, Williams and Wilkins.

Fitzpatrick, J., Fulmer, T., Wallace, M., & Flaherty, E. (Eds.). (2000). *Geriatric Nursing Research Digest*, New York: Springer.

Flaherty, E., Fulmer, T., & Mezey, M. (Eds.) (2003). *Geriatric nursing review syllabus: A core curriculum in advanced practice geriatric nursing*. New York: American Geriatrics Society.

Fontana, D., Pacala, J., Potter, B., & Herr, K. (2003). *Geriatrics at your fingertips (5th ed.)*. New York: Blackwell Publishers.

Forcica, M., Lavizzo-Mourey, R. L. M., & Schwab, E.P. (Eds.). (in press). *Geriatric secrets (3rd ed.)*. Philadelphia: Hanley and Belfus.

Ham, R. J., Sloane, P. D., & Warshaw, G. A. (2001). *Primary care geriatrics: A case-based approach (4th ed.)*. New York: Mosby.

The John A. Hartford Foundation Institute for Geriatric Nursing. (2001). *Best nursing practices in care for older adults: Incorporating essential gerontological content into baccalaureate and staff development education: A curriculum guide*. New York: New York University, Steinhardt School of Education, Division of Nursing, Hartford Institute for Geriatric Nursing.

The John A. Hartford Foundation Institute for Geriatric Nursing. (2004). *Try this: Best practices in nursing in care of older adults (Assessment Series)*. New York: New York University, Steinhardt School of Education, Division of Nursing, Hartford Institute for Geriatric Nursing.

- Hazzard, W. R., Blass, J., Halter, J. B., Auslander, J., & Tinetti, M. (2003). *Principles of geriatric medicine and gerontology (3rd ed.)*. New York: McGraw Hill.
- Hyer, K., Flaherty, E., Fairchild, S., Bottrell, M., Mezey, M., & Fulmer, T. (2001). *Geriatric interdisciplinary team training: The GITT kit*. New York University: New York.
- Kane, R., Abrass, I. B., & Abrass, I. (2003). *Essentials of clinical geriatrics (5th ed.)*. New York: McGraw-Hill.
- Kennedy-Malone, L., Fletcher, K. R., & Plank, L. M. (Eds.). (2003). *Management guidelines for nurse practitioners working with older adults (2nd ed.)*. Philadelphia: F. A. Davis Company.
- Luggen, A. S., Travis, S. S., & Meiner, S. (Eds.). (1998). *NGNA core curriculum for gerontological advanced practice nurses*. Thousand Oaks, CA: SAGE Publications.
- Maddox, G. (Ed.). (2001). *The encyclopedia of aging (3rd ed.)*. New York: Springer Publishing Company.
- Molony, S., Waszynski, C. M., & Lyder, C. (1999). *Gerontological nursing: An advanced practice approach (1st ed.)*. Prentice Hall
- Mezey, M. D., Berkman, B., & Callahan, C. (Eds.). (2001). *The encyclopedia of elder care: The comprehensive resource on geriatric and social care*. New York: Springer Publishing Company.
- Mezey, M., Fulmer, T., & Abraham, I., (Eds.); Zwicker, D. (Managing Ed.). (2003). *Geriatric nursing protocols for best practice (2nd ed.)*. New York: Springer Publishing Company.
- Osterweil, D., Brummel-Smith, K., & Beck, J. C. (2000). *Comprehensive geriatric assessment*. New York: McGraw Hill.
- Ouslander, J., Osterweil, D., & Morley, J. (1997). *Medical care in the nursing home*. New York: McGraw Hill.
- Siegler, E. L., Mirafzali, S., & Foust, J. B. (2003). *An introduction to hospitals and inpatient care*. New York: Springer Publishing Company.
- Sieglar, E., Hyer, K., Fulmer, T., & Mezey, M. (Eds.). (1998). *Geriatric interdisciplinary team training*. New York: Springer.
- Stone, J., Wyman, J., & Salisbury, S. (1999) *Clinical gerontological nursing: A guide to advanced practice (2nd ed.)*. Philadelphia: W. B. Saunders.

GERIATRIC WEB SITES

Aging Associations and Societies

Alliance for Aging Research	www.agingresearch.org
Alzheimer's Association	www.alz.org/
American Association of Homes and Services for the Aging	www.aahsa.org
American Association of Retired Persons	www.aarp.org/
American Geriatrics Society	www.americangeriatrics.org/
American Medical Directors Association	www.amda.com/
American Society on Aging	www.asaging.org/
American Society of Consultant Pharmacists	www.ascp.com
Gerontological Society of America	www.geron.org/
Health Care Financing Administration	www.hcfa.gov/
National Academy on an Aging Society	www.agingsociety.org
National Association of Directors of Nursing Administration–LTC (NADONA-LTC)	www.nadona.org
National Chronic Care Consortium	www.nccconline.org/
National Conference of Gerontological Nurse Practitioners	www.ncgnp.org
National Council on Aging	www.ncoa.org/
National Gerontological Nursing Association	www.ngna.org/

Gerontology Centers/Education Centers/Institutes

Andrus Gerontology Center	www.usc.edu/dept/gero/
Center for Advocacy for the Rights and Interests of the Elderly	www.carie.org
Brookdale Center on Aging	www.brookdale.org/
The John A. Hartford Foundation	www.hartfordign.org
Institute for Geriatric Nursing	
Huffington Center on Aging	www.hcoa.org
JAHF Center of Geriatric Nursing Excellence at Oregon Health Sciences University School of Nursing	www.ohsu.edu/hartfordcgne/
JAHF Center of Geriatric Nursing Excellence at University of Arkansas for Medical Sciences College of Nursing	www.nursing.uams.edu
JAHF Center of Geriatric Nursing Excellence at University of California San Francisco School of Nursing	www.nurseweb.ucsf.edu/www/hcgne.htm/
JAHF Center of Geriatric Nursing Excellence at University of Iowa College of Nursing	www.nursing.uiowa.edu/hartford/index.htm/
JAHF Center of Geriatric Nursing Excellence at University of Pennsylvania School of Nursing	www.nursing.upenn.edu/centers/hcgne/
Merck Institute of Aging and Health	www.miahonline.org/
National Association of Geriatric Education Centers	www.hcoa.org/nagec
Consortium of New York Geriatric Education Centers	www.nygec.org/
Gerontological Nursing Interventions Research Center	www.nursing.uiowa.edu/gnirc/index.htm

Statistics and Government Sites

Administration on Aging	www.aoa.dhhs.gov/aoa/stats/statpage.html
Aging Internet Information Notes	www.aoa.gov/prof/notes/notes.asp
CDC Health Aging	www.cdc.gov/aging/
Department of Health and Human Services (CMS/AHRQ)	www.hhs.gov

Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care

Evercare	www.evercareonline.com/index.html
Fastats	www.cdc.gov/nchswww/fastats/elderly.htm
Federal Forum on Aging Related Statistics	www.agingstats.gov/
Older Americans 2000: Key Indicators of Well-being	
Health Care Financing Administration	www.hcfa.gov/
Healthfinder	www.healthfinder.gov/
Medicare	www.medicare.gov/default.asp
National Center for Health Statistics	www.cdc.gov/nchswww/default.htm
National Institute on Aging	www.nih.gov/nia/
Office of Alternative Medicine	www.nccaa.nih.gov/

Listservs

AGING-DD- (Discussion group for aging and developmental disabilities).
Mailing List address: listserv@lsv.uky.edu

GERIATRIC NURSING EDUCATION LISTSERV (Collaboration and shared resources among participants in geriatric nursing education)
To become a member, email: geriatric_nursing-subscribe@yahoogroups.com

GERINET (Interdisciplinary listserv around geriatric health issues).
Mailing List address: listserv@ubvm.cc.buffalo.edu

GERO-NURSE (Research development and dissemination-University of Iowa Gerontological Nursing Intervention Project). Mailing List address: gero-nurse-request@list.uiowa.edu

Journals/Periodicals

Annals of Long-term Care	www.mmhc.com/altc/
Clinical Gerontologist	www.haworthpressinc.com/
Generations	www.asaging.org/
Geriatric Nursing	www.us.elsevierhealth.com/
Geropsychology Central Abstracts and Journals	www.premier.net/~gero/journals.html
The Gerontologist	www.geron.org/journals/gerontologist.html
Journal of Gerontological Nursing	www.slackinc.com/jgn.htm
Journal of Gerontology- Series A:Medical Science	www.biomed.gerontologyjournals.org/
Journal of the American Geriatric Society	www.blackwellpublishing.com/
Journal of the American Medical Directors Association	www.lww.com
Journals of the Gerontological Society of America	www.gerontologyjournals.org/

Educational Resources

American Academy of Nursing (Building Academic Geriatric Nursing Capacity)	www.geriatricnursing.org/
American Geriatrics Society	www.americangeriatrics.org/
American Association of Colleges of Nursing (Geriatric Nursing Education Project)	aacn.nche.edu/Education/Hartford/index.htm
Geriatric Video Productions	www.geriatricvideo.com/
GeroNet Health & Aging Resources for Higher Education	www.ph.ucla.edu/sph/geronet.html
The John A. Hartford Foundation Institute for Geriatric Nursing (For curriculum guide & online certification review course)	www.hartfordign.org
Last Acts	www.lastacts.org
Merck Manual of Geriatrics	http://www.merck.com/pubs/

Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care

National Gerontological Nursing Association
Nurse Competence in Aging

www.ngna.org
www.hartfordign.org/nca
www.nursingworld.org/nca
www.seniorlaw.com/

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