National Clinical Programme for Older People

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Knowledge and Skills Framework for Healthcare Professionals Working with Older People

Document Control

Document reference number:	CDI/0081/1.0/2024.
Document drafted by:	National Clinical Programme for Older People
Revision number:	1.0
Responsibility for implementation:	All Health Care Organisations and Professionals providing Older People's Services and delivering Older People's Care
Date of last update:	8/12/2023
Responsibility for evaluation and audit:	National Clinical Programme for Older People
Document status:	Final
Group status:	Approved
Approval date:	19/4/2024
Approved by:	Health Service Executive
Revision date	19/4/2026
No. of Pages	127

Table of Contents

Interactive Document

These buttons should be used for prompt access to each section of the framework document

Shared and Discipline Specific Knowledge and Skills

Inner circle - brings you to Shared Knowledges and Skills across Interprofessional team.

Outer circle - brings you to Discipline Specific Knowledges and Skills.

Interactive Document

Click here to bring you back to table of contents page

Foreword

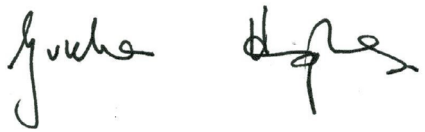
Ireland is growing and ageing at the same time. Whilst our population is now over 5 million for the first time since the Great Famine, people in Ireland can also anticipate being the longest living in the EU, with life expectancy at birth being 80.4 years for men and 84 years for women. Looking to the near future and to within the working life of many current healthcare professionals, our successful ageing will change our societal and healthcare landscapes. It is anticipated that our population aged 60 years and over will double from 950,000 in 2019 to a projected 1.9 million people by 2051 (Sheehan and O'Sullivan, 2020).

While increased life span is positive it has not been matched by an increase in health span. (Seals, Justice et al. 2016) A key challenge for healthcare services in Ireland is to support older adults to live healthy lives which are disability free for as long as possible. (Sheehan and O'Sullivan, 2020). As people age they are more at risk of experiencing frailty and multi-morbidity and interdisciplinary team working is key to supporting the often complex needs of older people accessing healthcare services.

Care provided through interdisciplinary teams, which includes the older person in care planning and goal setting, is associated with better outcomes. It is essential that healthcare professional working with older people, have the necessary training and skills to provide integrated, evidence based care, that can enable older people to live at home for as long as possible.

This "Knowledge and Skills Framework for Healthcare Professionals working with the Older Person" has been co-produced by a range of healthcare professionals, and will be a valuable tool to support the provision of high quality integrated care across all relevant healthcare settings. This framework will support increased awareness of the knowledge and skills of individual disciplines working with older people, and also the knowledge and skills required of interdisciplinary teams working with older people. Whilst the former goal has great value in its own right, it is the understanding of the need and the development of the latter which is the 'gravy' in this guide. The critical appraisal and consensus building approach adopted by the different healthcare professional groups has identified five core domains of shared knowledge and skills which are central to the provision of contemporary high quality care. They are the essential building blocks of shared values, understanding each other's role, teamwork, communication and collaboration.

I would like to thank all the individuals who gave generously of their time to support the development of this framework.



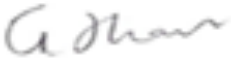
Professor Graham Hughes

Clinical Lead, National Clinical Programme for Older People.

Supporting Statements

Nurses work with older people across the health service, providing care at each point from health promotion to end of life. Research commissioned by Office of the Nursing & Midwifery Services Director (ONMSD) in 2017 informs the key knowledge and skills required for nurses who care for older people and gerontological nursing practice.

The career pathways open to nurses working in these care areas continues to expand and this framework will help support the identification of training and education opportunities for these nurses into the future enabling capability as part of the Multidisciplinary Teams.



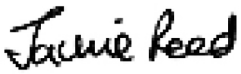
Dr. Geraldine Shaw

Nursing & Midwifery Services Director & Assistant National Director

The National HSCP Office welcome the development of this Knowledge and Skills Framework, which describes the competencies required to deliver high quality, person centred care to Older People in Ireland. HSCP provide intervention to Older People across health care settings and support improvement in function across a variety of areas associated with healthy ageing including sensory, nutritional, physical, cognitive and psychological capacity.

Slaintecare emphasises the central role of interdisciplinary working in supporting improved standards of patient care. This Framework will support engagement between colleagues and within multi-disciplinary teams, across different healthcare settings, to ensure the needs of the Older Person are met by the most appropriate team members.

It will also enable HSCP to work to their full potential, and can support the identification of training and education opportunities for all HSCP working in Older Persons services. It will be an invaluable resource in the provision and development of services for Older People and in the development of interdisciplinary team working.



Jackie Reed

National Lead Health & Social Care Professions

Supported by following professional bodies and offices:

Oifig an Stiúrthóra Seirbhísí Altranais & Cnáimhseachais | Office of the Nursing & Midwifery Services Director

Health & Social Care Professions

IASW Irish Association of Social Workers

INDI Irish Nutrition + Dietetic Institute

AOTI Association of Occupational Therapists of Ireland

Irish Society of Chartered Physiotherapists

IASLT The Irish Association of Speech + Language Therapists

PSI The Pharmacy Regulator An Rialtóir Cógaisíochta

The Psychological Society of Ireland Cumann Síceolaithe Éireann

Authors

Interprofessional Steering Group Membership

- John Brennan, Independent Social Worker, Chair
- Helen Whitty, Programme Manager, National Clinical Programme for Older People
- Dr Sarah Donnelly, Assistant Professor in Social Work/Director of Graduate Studies, School of Social Policy, Social Work and Social Justice, UCD
- Aoife Niland, Senior Dietitian, Clare Integrated Care Programme for Older Persons
- Dr Sharon Kennelly, Clinical Specialist Community Dietitian, Older Persons, CHO8
- Sarah Cosgrave, Advanced Nurse Practitioner for Older Persons, St Vincents University Hospital
- Deirdre Lang, Director of Nursing/National Lead Older Persons Services, Office Nursing & Midwifery Services Director
- Paul Maloney, Occupational Therapist Manager in Charge III, Beaumont Hospital
- Niamh McMahon, Chief 2 Pharmacist, St.James's Hospital & Trinity College Dublin
- Sinead Coleman, Clinical Specialist Physiotherapist, St James's Hospital
- Gillian Harte, Senior Physiotherapist, Tallaght University Hospital
- Siobhan Quinn, Senior Physiotherapist in Older Persons Care, Tallaght University Hospital
- Ruth Wade, Senior Physiotherapist Older Persons, Tallaght University Hospital
- Dr Niall Galligan, Principal Clinical Psychologist / Neuropsychologist, Our Lady's Hospice and Care Services
- Patrice Reilly, Social Work Dublin North Integrated Care Team Older Persons aligned to Beaumont Hospital & Operational Lead Dublin North City Integrated Care Team Older Persons aligned to the Mater Hospital
- Anne Claffey, Senior Speech and Language Therapist, Regional Hospital Mullingar
- Catherine Devaney, Health and Social Care Professions Clinical Advisor, Older Persons, National Clinical Programme for Older People

Contributors

- Dr PJ Harnett, General Manager of the National Clinical Advisory and Group Lead Older Persons Office, HSE
- Marian Mullaney, Service Improvement Manager, National Integrated Care Programme for Older Persons
- Dr Deirdre O'Donnell, Assistant Professor Health Systems, UCD Centre for Interdisciplinary Research, Education and Innovation in Health Systems
- Marie O' Shea, Project Manager, UCD Centre for Interdisciplinary Research, Education and Innovation in Health Systems

Recommended Citation

This report should be cited as follows:

Brennan, J., Claffey, A., Coleman, S., Cosgrave, S., Devaney C, Donnelly, S., Galligan N., Harte G., Kennelly S., Lang, D., Maloney, P., McMahon, N., Niland A., Quinn, S., Reilly, P., Wade R., Whitty, H. Knowledge and Skills Framework for Healthcare Professionals Working with the Older Persons Steering Group (2023). Knowledge and Skills Framework for Healthcare Professionals Working with the Older Persons. Dublin: Health Service Executive

Or

Knowledge and Skills Framework for Healthcare Professionals Working with the Older Persons Steering Group. (2023). Knowledge and Skills Framework for Healthcare Professionals Working with the Older Persons. Dublin: Health Service Executive

Abbreviations

AAC	Alternative and Augmentative Communication
ABI	Acquired brain n Injury
ACP	Advanced Care Practice
ANP	Advanced Nurse Practitioner
AD	Alzheimer's Disease
ADL	Activity of Daily Living
ADMA	Assisted Decision Making Act
ADR	Adverse Drug Reaction
AG	Advisory Group
ALS	Amyotrophic Lateral Sclerosis
AOTI	Association of Occupational Therapists of Ireland
ARMD	Age Related Macular Degeneration
BP	Blood Pressure
BPSD	Behavioural and Psychological Symptoms of Dementia
CA	Cancer
CGA	Comprehensive Geriatric Assessment
CHO	Community Healthcare Organisation
CIT	Community Intervention Team
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CrCl	Creatinine Clearance

CT	Computed Tomography
CV	Cardiovascular
CVD	Cardiovascular Disease
DM	Diabetes Mellitus
ECG	Electrocardiogram
ECLECTIC	Embedding collective leadership to foster collaborative inter-professional working in the care of older people
EDS	Eating Drinking and Swallowing
eGFR	Estimated Glomerular Filtration Rate
EPOA	Enduring Power of Attorney
FEDS	Feeding Eating Drinking and Swallowing
GI	Gastrointestinal
GP	General Practitioner
HCP	Health Care Professionals
HIQA	Health Information and Quality Authority
HPRA	Health Products Regulatory Agency
HSCP	Health and Social Care Professional
HSE	Health Service Executive
IADL	Instrumental Activities of Daily Living
IASLT	Irish Association of Speech and Language Therapists
IASW	Irish Association of Social Workers
ICPOP	Integrated Clinical Programme for Older People
ID	Intellectual Disability

IDDSI	International Dysphagia Diet Standardisation Initiative (IDDSI)
IDT	Interdisciplinary Team
IIOP	Irish Institute of Pharmacy
INDI	Irish Nutrition and Dietetic Institute
IPTOP	International Association of Physiotherapists working with Older People
ISCP	Irish Society of Chartered Physiotherapists
KPI	Key Performance Indicator
LGBTQI	Lesbian Gay Bisexual Transgender Queer Intersex
LOS	Length of Stay
LRTI	Lower Respiratory Tract Infection
LTC	Long Term Care
MCI	Mild Cognitive Impairment
MDT	Multidisciplinary Team
MM	Multimorbidity
MRI	Magnetic Resonance Imaging
MS	Multiple Sclerosis
MUST	Malnutrition Universal Screening Tool
NHSS	Nursing Home Support Scheme
NICPOP	National Clinical Programme for Older People
NMBI	Nursing and Midwifery Board of Ireland
NOK	Next of Kin
NSAIDS	Non-steroidal Anti-inflammatory Drugs
OA	Osteoarthritis
OPAG	Older Persons Advisory Group
OT	Occupational Therapy
PD	Parkinson's Disease

PEG	Percutaneous Endoscopic Gastrostomy
PPPGs	Procedures, Protocols Policy and Guidelines
PSI	Pharmaceutical Society of Ireland
PT	Physiotherapy
PVD	Peripheral Vascular Disease
QI	Quality Improvement
QOL	Quality of Life
RA	Rheumatoid Arthritis
RD	Registered Dietitian
RCOT	Royal College of Occupational Therapy
RCPI	Royal College of Physicians of Ireland
SIADH	Syndrome of Inappropriate Antidiuretic Hormone
SLT	Speech and Language Therapist
SMART	Specific, Measurable, Achievable, Realistic, Timed
TBI	Traumatic Brain Injury
TIA	Transient Ischemic Attack
TILDA	The Irish Longitudinal Study of Ageing
TPN	Total Parenteral Nutrition
TUG	Timed Up and Go
URTI	Upper Respiratory Tract Infection
UTI	Urinary Tract Infection
WCPT	World Confederation for Physical Therapy
WFOT	World Federation of Occupational Therapy
WHO	World Health Organisation

Introduction

Introduction

Background

The Health Service Executive (HSE), Royal College of Physicians of Ireland (RCPI) and the National Clinical Programme for Older People (NCPOP) identified the need for a Knowledge and Skills Framework to outline and describe the knowledge and skills required of Healthcare Professionals (HCPs) to deliver quality, person-centred care, to older people across healthcare settings in Ireland. A knowledge and skills framework describes the knowledge and skills that Healthcare Professionals need to apply in their work to provide quality care and services. Knowledge and skills frameworks are designed to help individuals and organisations improve their performance. By making explicit the outcomes that should be achieved by a competent individual, frameworks of knowledge and skills support self-development for individual clinicians and can impact on how work is carried out and distributed within organisations (Mitchell & Boak, 2009). In healthcare, knowledge and skills frameworks have also been adapted or used at a management level to guide and influence recruitment, career advancement and promotion, training and development (Rankin, 2008, Mitchell & Boak, 2009).

Effective care of older people needs to be delivered by interdisciplinary teams, who embed gerontological knowledge and skills into their service (Conroy & Turpin, 2016). In gerontology, interdisciplinary practice teams have demonstrated favourable patient outcomes over usual care (The American Geriatrics Society, 2012). The HSE (2021) asserts that the integration of care within our health and social care services is key to improving experiences and outcomes for older people. Older people can have complex care and social needs, which require a healthcare workforce knowledgeable about the ageing process, skilled in assessment and management of chronic illness, and who have the ability to practice in an interdisciplinary milieu (Mezey, Mitty, Burger & McCallion 2008). There is increasing recognition that clinicians and specialists with new knowledge and skills, relative to more traditionally defined roles and professional boundaries, are required to deliver healthcare to older people (Berloviene et al., 2019)

Ireland's Changing Demographics and impact on the delivery of Healthcare for Older People

People in Ireland are living longer, with an average life expectancy at birth for men of 80 years of age, and for women of 84 years of age (Eurostat, 2017a). Improved life expectancy is changing population demographics. The number of people aged 60 or over in the Republic of Ireland is estimated to double from 950,000 in 2019 to a projected 1.9million people by 2051. (Sheehan et al, 2020). The Department of Health's Capacity Review (2018) outlines that by 2031 the 65-74 age cohort see an increase of 42.9%, the 75-84 age cohort will see an increase of 75.9% and the 85+ age cohort will see an increase of 95.5%.

As people age there is increased prevalence of chronic diseases, with 64% of adults aged 75 years and older reporting the presence of three or more chronic conditions. The prevalence of frailty also increases with advancing age, with a quarter of those aged 75 and older, and nearly half of those aged 85 and older experiencing physical frailty. (TILDA Wave 5 Key Findings: The Older Population of Ireland on the Eve of the COVID-19 Pandemic.)

A key challenge for healthcare services in Ireland is to support older adults to live healthy lives which are disability free for as long as possible (Sheehan et al, 2020). There is however a growing gap between life expectancy and healthy life expectancy (The Aging Readiness and Competitiveness Report). The Economic and Social Research Institute (ESRI) report on projections of demands for public and private Healthcare in Ireland 2015-2030 found that demand for public services are projected to increase across all areas of health and social care, with the greatest increase in areas primarily used by older people, namely, long-term and intermediate care as well as home support care (Wren, M. A. et al., 2017.)

The Irish healthcare system needs to adapt to meet the demands associated with an ageing population. Developing age-attuned care pathways and new ways of working within interdisciplinary teams is crucial to providing integrated person centred, quality and safe care, that enables older people to stay well and remain at home where appropriate, while providing access to urgent care when needed. With the increasing population of older people, a strong strategic focus on change and integrated care within the Irish Health Service has ensued in order to develop and enhance the interprofessional delivery of healthcare to older people (HSE, 2021).

Policy Context

Government policy on healthcare reform is set out in the Sláintecare report published in 2017 which is an all-party agreement of health reform set to deliver integrated care across health and social care services over the next 10 years. The Sláintecare Implementation Strategy and Action Plan 2021-2023 sets out the priorities and actions for the next phase of the reform programme. The vision of Sláintecare is to achieve a universal single-tier health and social care system, where everyone has equitable access to services based on need, and not ability to pay that offers the right care, in the right place, at the right time (DoH, 2021). Sláintecare has been designed to create a modern, responsive health and social care service which meets the changing needs of Ireland's population. The proposed new service model of coordinated health and social care is required to meet the needs of our older population, with its more complex set of clinical and social care needs, and to address the growing prevalence of chronic disease. (Sláintecare Report, 2017) Implementing integrated services and pathways for older people with complex health and social care needs enables a shift in the delivery of care from the acute hospitals towards community based, planned, co-ordinated care.

Aligned to Sláintecare proposals and priorities, the HSE's Enhanced Community Care (ECC) strategic reform programme is a significant investment in community health services, which seeks to deliver new and enhanced services in primary care and community settings and supports the move toward a more community-centric model of healthcare. This means more services will be available closer to where people live, with a core focus on older people and those living with chronic disease.

National Clinical Programme for Older People

The overall purpose of the NCPOP is to improve and standardise the quality of care for older people in Ireland (HSE, 2021). Through the course of ongoing work with clinical representatives from multiple healthcare professions (in the form of an Interprofessional Interest Group), NCPOP identified an opportunity to advance interprofessional and integrated delivery of care to older people through the development of a knowledge and skills framework. While there are international knowledge and skills type frameworks and literature that provide guidance to Irish clinicians and services, the existing evidence base is limited in its breadth, the volume and quality of literature available is not consistent across the multiple professions who form part of the core healthcare team for older people, and in its applicability to the clinical services and structures in Ireland. The NCPOP and its collaborators identified a significant opportunity to develop a knowledge and skills framework that is directly applicable and accessible to interdisciplinary clinicians involved in the care of older people in Ireland.

Purpose and Objectives of the Framework

Purpose and Objectives of the Framework

Purpose of "Knowledge and Skills Framework for Healthcare Professionals working with Older People":

The aim of this project was to develop a knowledge and skills (K&S) framework for healthcare professionals working with older people across various health care settings in Ireland including acute, primary and community care. The development of the framework was completed twofold. The first phase involved the agreement of the **shared K&S across the members of the core team** involved in the provision of healthcare to older people. The second phase addressed the **specific knowledge and skills for each individual discipline**. To our knowledge, this is the first time an interprofessional team have worked together to reach consensus on what K&S were shared and common to all team members. This supports new ways of working and service developments in HSE older person services.

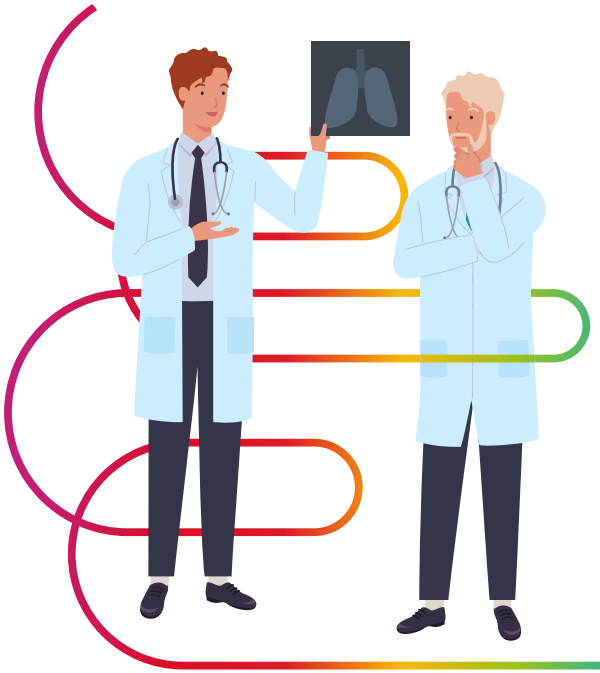
The purpose of the "Knowledge and Skills Framework for Healthcare Professionals working with Older People" is to support both the individual healthcare professional and the interprofessional team to:

- Identify professional development requirements and opportunities
- Support interdisciplinary team working
- Support service development and provision of quality healthcare to older people.

It is envisaged that this K&S framework may be adapted or used to inform academic curricula, professional development programs, and potentially influence professional recognition, advancement and recruitment. This will facilitate and encourage improved inter-professional and interorganisational collaboration in the delivery of quality, person-centred care to older people across healthcare settings in Ireland.

The K&S framework will also underpin and support the implementation of the Eclectic Framework (NICPOP UCD, 2021). The ECLECTIC framework provides a step-by-step guide for getting started in building competences for interprofessional collaboration within interdisciplinary teams integrating care for older people. It is intended that the ECLECTIC framework is used in conjunction with this knowledge and skills framework.

Both frameworks, used together, will support healthcare professionals to develop their proficiency to improve the quality and safety of care for older people across various healthcare settings as well as part of an interdisciplinary team.



The need for this document was identified by NCPOP to support the development of newly established older persons teams including the community specialist teams for older people, and the frailty at the front door teams. These integrated teams were established to meet the diverse and complex needs of older adults at risk of hospital admission, who required a team-based approach. This working group for this document consisted of disciplines who form part of the core members of these teams. However, it is envisioned that this document will have wider implications for other healthcare professionals who are integral to meeting the varied and complex healthcare needs of older people. This document is a starting point in describing both shared and discipline specific knowledge and skills required by healthcare professionals to meet these needs. It is hoped that future versions of the document can include knowledge and skills applicable to the wider group of healthcare professionals working with older people.

Objectives of Framework

The key objectives of this project were to develop a knowledge and skills framework for healthcare professionals working with older people that:

- Express the knowledge and skills required for the delivery of quality person-centred care to older people, describing them in language that is sufficiently specific and clear for use across clinical settings in Ireland.
- Support integrated care, collaborative leadership and promote new ways of working.
- Detail the knowledge and skills of Health and Social Care Professionals (HSCPs) to support the implementation of the Eclectic framework available for download at: https://www.hse.ie/eng/about/who/cspd/ncps/older-people/resources/eclectic-framework-report-and-step-by-step-guide.pdf
- Support the continuing professional development of HCPs working with Older People.

Target Audience for the Knowledge and Skills Framework:

Healthcare professionals:

- Guides or informs their CPD and growth
- Improves their understanding of each other's roles as well as their shared knowledge and skills
- Provides a foundation for good team-working and creates conditions for interprofessional collaboration

Clinical Supervisors & Line Managers:

- Guides induction, training and professional development of healthcare professionals
- Assists in the identification of professional development needs
- Makes good practice objective and identifiable
- Facilitates advocacy for inclusion of specific roles on teams

Educators:

- Facilitates development of learning outcomes for programme and module development
- Identifies the rationale for CPD programmes
- Informs practice placement induction
- Facilitates advocacy for curricula reform

Methodology

Methodology

The requirement for the development of an Older People Knowledge and Skills Framework was identified by members of the National Clinical Programme for Older People (NCPOP). To facilitate the development of this framework an interprofessional steering group was established in 2019. This steering group comprised of representatives from healthcare professionals who form part of the core team involved in the provision of healthcare to older people in Ireland (Dietetics, Nursing, Occupational Therapy, Pharmacy, Physiotherapy, Psychology, Social Work and Speech and Language Therapy).

To support this work a common understanding of interdisciplinary working, as that utilised in the ECLECTIC Framework report, was agreed. This understanding was adopted from the review on the role of multidisciplinary teams within geriatric medicine developed by Ellis and Sevdalis (2019). This described interdisciplinary working as:

"Members come together as a whole to discuss their individual assessments and develop a joint service plan for the patient. Practitioners may blur some disciplinary boundaries but still maintain a discipline-specific base (for instance, aspects of functional assessments may be shared across disciplines). Teams integrate closer to complete a shared goal (Ellis & Sevdalis, 2019, p. 500) which in turn require a team-based approach to be managed, including allied health professionals, social work and nursing alongside medicine. The 'engine room' of the speciality has thus for many years been the multidisciplinary team (MDT)."

Key aims and objectives for the framework were agreed, and a list of key stakeholders was identified. The NCPOP programme manager provided input into the expert panel process and facilitated regular in-person and virtual meetings of the steering group, throughout the project duration, which was finalised in 2023 with the publication of the framework.

The initial focus of the expert panel was the drafting of the shared knowledge and skills which applies to the practice of healthcare professionals who form part of the core team involved in the provision of healthcare to the older person. This focus was driven by the centrality of interdisciplinary working to the provision of quality person-centred care for older people (American Geriatric Society, 2012) and the conviction that improved integration of services means that clinicians who work with older people need knowledge and skills that relate to the needs of older people. (Berloviene et al., 2019). Healthcare professions have historically worked in an unidisciplinary approach or alongside other each other. More recently, this siloed approach to multidisciplinaryteam (MDT) working has undergone significant transformation towards more integrated, interdisciplinary care pathways to improve the quality of care delivered to older people in Ireland.

Identification of Shared Knowledge and Skills:

An empirical literature review was completed to identify existing frameworks and evidence in relation to professional standards or guidelines for health care and social care professionals working with older people. An additional search was carried out to identify discipline specific professional standards and guidelines (where they existed eg. Therapy Project Office Competency Documents, 2008) for each of the professions who form part of the core team involved in the provision of healthcare to older people in Ireland. The review was further expanded to include knowledge and skills type frameworks developed for other clinical populations and contexts (e.g. Palliative Care, Society for Acute Medicine) and competency frameworks specific to the delivery of interprofessional health care. The grey literature was also reviewed for relevant documentation.

This literature review was used as a foundation to draft knowledge and skills for healthcare professionals working with older people in Ireland. The draft knowledge and skills were revised numerous times based on review and discussion among the expert panel members.

Following critical appraisal and evaluation of the literature and using a process of consensus decision-making, the expert panel identified five domains of shared knowledge and skills, which are common to healthcare professionals involved in the care of older people across clinical settings in Ireland.

Domains of Shared Knowledge and Skills:

1. Principles of Gerontological Care
2. Communication
3. Roles and Responsibilities
4. Interprofessional collaboration
5. Ethics and values

The Eclectic Framework "Getting Started in Developing Core Competencies for Interprofessional Collaboration in Integrated Care for Older People: A Step-by-Step Guide" also emphasizes proficiency in communication and knowledge of team roles and responsibilities as central components of interprofessional collaboration. The Eclectic framework provides resources to further develop the shared knowledge and skills domains 2, 3 and 4 in this framework.

Following this initial phase, and the agreement of shared knowledge and skills, the next phase of development focused on the building of Discipline Specific Knowledge and Skills for HCPs involved in older person's care.

Discipline Specific Knowledge and Skills

For the development of Discipline Specific Knowledge and Skills, each profession convened a discipline specific advisory group (AG) through their relevant discipline specific professional body, consisting of specialist colleagues working across a variety of healthcare settings. Through an iterative process of building, refining and improving content, each AG developed discipline specific knowledge and skills detailing those unique traits expected for their respective profession in working with older people. During this process, and in consultation with the expert panel, each AG also identified any overlap between professions.

Levels of Knowledge and skills

Within healthcare, continuing professional development (CPD) describes "the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional life" (Health and Social Care Professionals Council, 2021). While CPD is not synonymous with career progression, the successful completion of CPD, in conjunction with other educational and training activities, is an integral part of the process of career progression. Therefore, knowledge and skills frameworks often align to levels of expertise and/or professional grades or bands of employment in order to better describe the expectations of individual clinicians (Clyne, McCoubrey & Hamilton, 2008; Palliative Care Competence Framework Steering Group, 2014; Frank, Snell & Sherbino, 2015; The Motor Neurone Disease Association, Parkinson's UK, Therapists in Multiple Sclerosis, The Multiple Sclerosis Trust, 2020, Scope of Nursing and Midwifery Practice Framework NMBI 2015, National Council for the professional development of nursing and midwifery; Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts, 2008, Advanced Practice (Nursing) Standards and Requirements, NMBI, 2017).

In the development of this framework, the expert panel's exploration of the professional grades across the constituent professions (Dietetics, Nursing, Occupational Therapy, Pharmacy, Physiotherapy, Psychology, Social Work and Speech and Language Therapy) uncovered broad and varied levels of career progression. All the professions described some form of newly qualified/entry/staff grade level, but from there the professions diversified out into different pathways of career progression incorporating clinical roles, management roles and within some professions and settings, a hybrid of both. Extensive discussion led to a consensus agreement across all disciplines that the Knowledge and Skills Framework would not align to professional grades. Aligning the Framework to the existing professional grades also limits the opportunity to develop and promote new or emerging roles (e.g., advanced practice roles) in some professions.

In order to progress beyond these issues, a consensus building approach led to the adoption of two levels of descriptors: Core and Enhanced. These terms were selected specifically, to avoid confusion related to existing professional titles. It is the intention of the expert panel that individual clinicians from varying professions and settings will be able to draw upon the knowledge and skills outlined at these two levels as is relevant to their own professional grade and circumstances.

Summary:

The methodology described above has yielded a knowledge and skills framework which provides a comprehensive suite of knowledge and skills with specific outcomes that a competent health care professional across the disciplines of Dietetics, Nursing, Occupational Therapy, Pharmacy, Physiotherapy, Psychology, Social Work and Speech and Language Therapy should be able to demonstrate at core and enhanced practice level.

It also:

- Outlines knowledge and skills that are 'shared' by all clinicians working within these disciplines across all clinical setting in Ireland, and supplementary 'Discipline specific' knowledge and skills that apply only to clinicians working within that particular profession
- Supports professional development of HCPs
- Has the potential to be adapted to inform academic curricula, professional development programs and planning, post-qualification training at a service and organisational level.
- Can be used in conjunction with respective professional standards, codes of conduct and guidelines set by statutory regulatory bodies, individual professional bodies and groups, specific employer organisations' ethos, policies and approved practices.
- Can be used in conjunction with the ECLECTIC framework to support health care professionals to develop the necessary knowledge and skills for safety and quality in the provision of integrated person-centred care for older people across various health care settings.

Multimorbidity

Multimorbidity

Age-related diseases are illnesses and conditions that occur more frequently in people as they get older; meaning age is a significant risk factor in their development. The most common aging-related diseases include neurodegenerative diseases, cancer (CA), cardiovascular diseases (CVD), and metabolic diseases (Li et al. 2021).

Multimorbidity (MM), disability and frailty are distinct clinical entities that are causally related, often associated and may overlap. All three occur frequently and have important clinical consequences. What really affects quality of life (QOL) is function and not disease, and the best predictor of function is frailty (Joint Action on Frailty, 2019).

MM refers to the presence of two or more chronic conditions (NICE, 2016). Chronic conditions are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living" (US Department of Health and Human Services, 2010, p.2). Traditionally MM focused primarily on the prevalence of diagnosed chronic diseases (Rijken, van Kerkhof, Dekker & Schellevis, 2005), however increasingly, the term encompasses ongoing conditions such as learning disability, symptom complexes such as frailty or chronic pain, sensory impairment such as sight or hearing loss, as well as alcohol and substance misuse (NICE, 2016). Patterns emerge of conditions that commonly co-occur, for example 28% of patients with Alzheimer's disease (AD) also have congestive heart failure, 27% have chronic obstructive pulmonary disease (COPD), 22% have diabetes mellitus (DM), and 20% have a diagnosis of CA (Anderson & Horvath, 2002). In the Irish context, data from the Irish Longitudinal Study of Ageing (TILDA) show the estimated lifetime prevalence of MM for Irish older adults is 73.25% (Hernandez, Reilly & Kenny, 2019). In clinical populations attending geriatric services, the prevalence of MM increases to >90% (Muth et al., 2019)

Estimates of the prevalence of common single conditions, which affect older people in Ireland, based on TILDA data are outlined below in Table 1 (Hernandez, Reilly & Kenny, 2019; Kenny, Hernández, O'Halloran, Moriarty & McGarrigle, 2020; McNicholas & Laird, 2018). The combinations of these (and other) health conditions, which affect older people living with multimorbidity, vary greatly, and are influenced by gender and age (Hernandez, Reilly & Kenny, 2019).

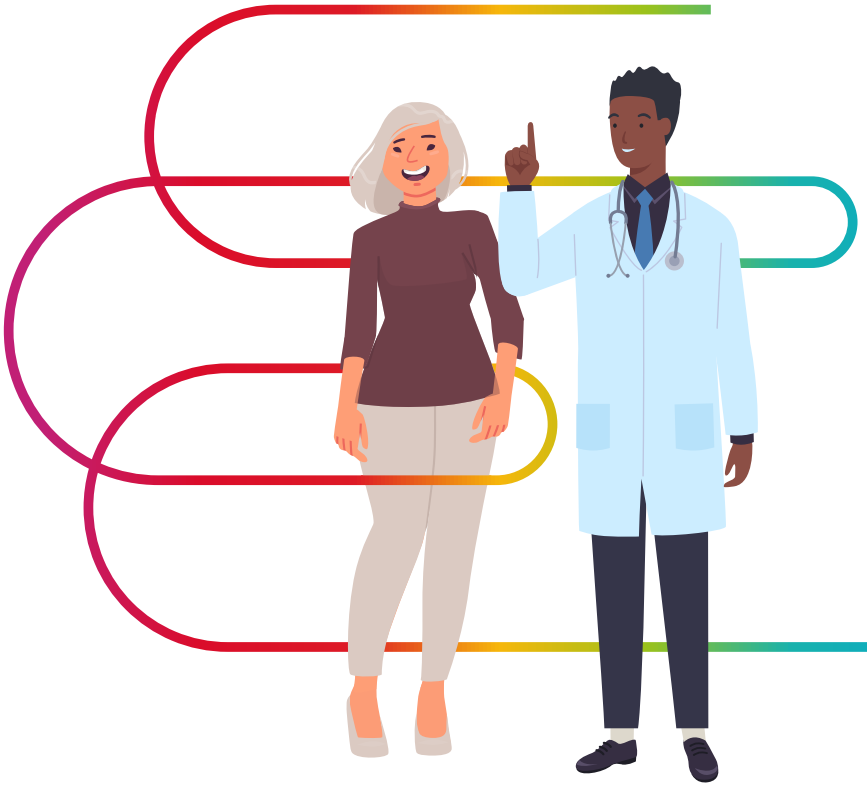


Table 1: Estimates of the prevalence of common single conditions

Prevalence of common conditions	% Prevalence among adults aged 50+
Falls (ever reported a fall)	52%
High cholesterol	51%
Physical inactivity	48%
Phenotype pre-frailty	45%
Hypertension	44%
Prior Smoking	43%
Pain	36%
Arthritis	35%
Obesity	23%
Osteoporosis	16%
Cataracts	14%
Current smoking	13%
Depression	11%
Heart arrhythmia	11%
Phenotype frailty	11%
Asthma	10%
Diabetes	10%
Thyroid problems	8%
Angina	6%
Heart murmur	6%
Cancer or a malignant tumour	5%
Heart attack	5%
Lung disease	5%
Ulcers	5%
Age related macular degeneration (ARMD), Glaucoma, Transient ischaemic attack (TIA), Alcohol abuse, Poor hearing, Poor vision, Stroke, Varicose ulcers, Anaemia, Heart failure, Kidney disease, Liver disease,	<5%

MM can contribute to frailty and disability; conversely, most older persons who are frail or disabled have multiple chronic conditions. Comprehensive Geriatric assessment (CGA) is critical to the assessments of both MM and frailty as it facilitates clinicians in determining the inter-related nature and hierarchy of issues raised by a person's chronic conditions. Clinicians who have the requisite knowledge and skills in working with older people will demonstrate the ability to assess MM, and to evaluate how an older person's health conditions and their treatments interact, as it relates to their area of clinical assessment and intervention (NICE, 2016).

Multimorbidity negatively impacts older people due to increased treatment burden (Sheehan et al., 2019, Eton et al., 2012), adverse events, use of unplanned care, death, disability, poor functional status, polypharmacy, multiple healthcare appointments and uncoordinated care (NICE, 2016). A tailored approach to the management of MM that focusses on interprofessional collaboration and the integration of interventions into existing health systems has been shown to be more efficacious than disease specific and reductionist approaches favoured in single disease paradigms and models (Salive, 2013, NICE, 2016).

Frailty

Frailty

An ageing population is one of the success stories of modern society. However, it also poses a real and significant challenge to individuals, and families, and for social, economic, and healthcare systems. While many people remain well, engaged and active into later life, increasing age brings an increasing chance of long-term medical conditions, frailty, dementia, disability, dependence and/or social isolation (Oliver et al., 2014).

The clinical condition of 'frailty' is regarded as one of the most-challenging consequences of population ageing (Clegg et al. 2013). It develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home.

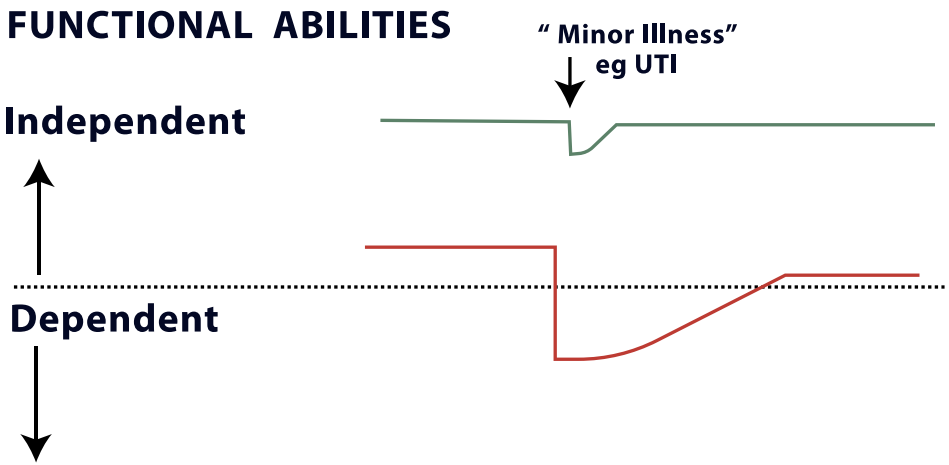


Figure 1: Vulnerability of frail elderly people to a sudden change in health status after a minor illness (Clegg et al., 2013)

People with frailty have a substantially increased risk of falls, disability, long-term care and death. Frailty is a graded abnormal health state, which ranges from the majority who are mildly frail and need supported self-management, to those who are moderately frail and would benefit from interventions such as case management, to those who have advanced frailty where anticipatory care planning and end-of-life care may be appropriate interventions (NHS, 2014).

Frailty is a dynamic functional state. Its onset and progression amongst older adults can be reduced and even reversed, provided that early intervention and correct management strategies are set in place. The ADVANTAGE JA (2019) consortium recognises that frailty can manifest in diverse forms and is a complex state affecting multiple body systems. It develops as a consequence of multiple causes in which several body systems seem to play a major role (especially the nervous, endocrine, immunological and musculoskeletal). It is associated with a higher propensity for comorbidities and complications, such as disability, morbidity, hospitalisation, institutionalisation, and death.

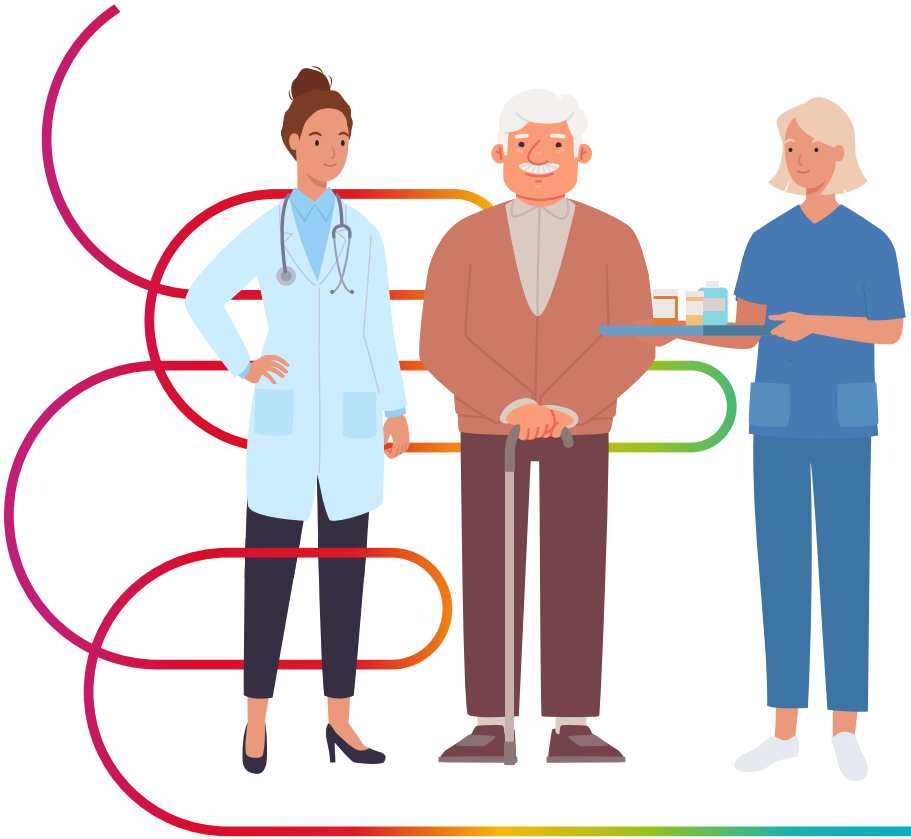
The prevalence of frailty varies according to the identification tool used, the age group and the setting considered. In TILDA, the prevalence of frailty in community-dwelling adults aged 65 and over have been estimated to be 3-4% by the FRAIL scale, 6-7% by the Frailty Phenotype, 16-17% by the Clinical Frailty Scale, and 21-22% by the Frailty Index. The prevalence of frailty is higher in those aged 75 years and older and in residential care settings. The use of different frailty tools may suit different purposes in different settings. The identification of frailty is an indication for CGA, which will often identify potentially remediable factors to ensure optimum ageing according to individual preferences and goals (Romero-Ortuno et al., 2021).

Dementia

Dementia

Dementia is a syndrome characterised by progressive cognitive impairment, associated with impairment in functional abilities and, in many cases, behavioural and psychological symptoms. While a number of different diseases can produce the symptoms of dementia, Alzheimer's disease accounts for a majority of cases. Vascular Dementia is the second most common dementia sub-type with other less common causes including mixed dementia (Alzheimer's Disease and Vascular Dementia), Dementia with Lewy Bodies, Frontotemporal dementia (FTD), Korsakoff's Disease, Huntington's Disease, Creutzfeldt-Jakob Disease (CJD) and HIV-associated dementia (HAD) (Department of Health 2014). It is estimated that there are 64,141 people living with dementia in Ireland (HealthAtlas/HSE, 2020). This is expected to increase to 150,151 by 2045, if current trends continue. The World Health Organisation identified dementia as the 7th leading cause of death.

Despite the strong association between dementia and old age, it is not solely a disease of old age. There are significant numbers within the overall dementia population with early onset dementia. People with Down Syndrome face an increased risk in this regard. Currently, it is estimated that there are approximately 4,000 people under the age of 65 years with dementia in Ireland. Dementia can bring many challenges both for the person with dementia and people caring for them. Timely and effective diagnosis is required to access person-centred care and therapeutic strategies that have secondary and tertiary prevention benefits that help to maintain quality of life, support the person to prepare for future impairment, and prevent crises and family breakdown (Krolak-Salmon et al, 2019)



Falls

Falls

Falls and fractures have a significant impact on the health, wellbeing, and social participation levels of older people. They can result in a loss of independence and can affect a person's ability to participate in activities which they need and want to do in their daily lives.

International studies suggest that between 1 in 3 people aged 65 and older, and 1 in 2 people aged 80 and older, fall at least once a year. (Strategy to prevent falls and fractures in Irelands ageing population, 2008). The majority of over 65's in Ireland live at home. Half of serious traumatic falls of adults aged over 65 years of age happen at home and at a low height of 2 metres (MTA 2018). An estimated 60,000 over 65 require medical attention for a fall each year (TILDA 2017). In 2020 there were 3,666 hip fracture patients in Ireland, up from 3601 the previous year. (Hip fracture data base National Report 2020).

With increasing age, a prior fracture and a prior fall, the older person's falls risk increases.

Over 300,000 people in Ireland have Osteoporosis which increases the risk of harm from a fall. The lifetime incidence of osteoporotic fractures is estimated to be 40-50% in women and 13-22% in men. www.osteoporosis.ie

There are many risk factors that can cause falls. These risks are categorised intrinsic (occur within the body) or extrinsic (outside the body). It is the number and the combination of risks which increases their risk of falling. Behaviours can also increase risk. Many risk factors can be modified or changed to reduce the risk of falls. Modifiable risks include medications (polypharmacy), nutrition, bone-health (osteoporosis), strength and balance, fear of falling, cognition, continence, vision, auditory, foot-health/footwear and environment. Two risks are non-modifiable risk factors - age and history of falls.

A multifactorial falls assessment (MFA) is an evidence based approach recommended by NICE 2017. Multi-factorial falls screening/interventions is potentially worthwhile to the client in reducing falls (Hopewell, 2019). The National Institute for Health and Care Excellence (NICE) 2013 clinical guideline's recommendation is 'Not to use fall prediction tools to predict inpatients' risk of falling in hospital'. NICE further recommends using a multi-factorial risk assessment instead of using one- size -fits –all interventions. All staff working with older people should develop and maintain basic professional knowledge and skills in falls assessment and prevention. Individuals who complete a multi-factorial screen or assessment have a responsibility to action a plan to address the risks identified. This may include onward referral to the appropriate disciplines. Any older person who is falling or afraid of falling or has sustained an injury or loss of function or has increased care needs due to a fall should have the opportunity to access further assessment, intervention and support as necessary.

The evidence for prevention of falls and fractures is particularly strong for strength and balance exercise programmes and for fracture liaison services. There is strong evidence that exercise as a single intervention can reduce the risk of falling and rate of falling for those living in the community. Multi-factorial interventions need to address the individual risks, including the inpatient environment (Sherrington 2019). Falls risk is strongly linked to frailty due to deconditioning, decline in walking and functional decline.

Comprehensive Geriatric Assessment

Comprehensive Geriatric Assessment

Comprehensive Geriatric Assessment (CGA) is considered the gold standard in the care of the older person.

It is an organised approach to assessment, designed to determine an older person's medical condition, mental health, functional capacity, and social circumstances. It's purpose is to develop and implement a coordinated and integrated plan for treatment, rehabilitation, support and long-term follow-up. CGA is based on the premise that a full evaluation of a frail older person by a team of healthcare professionals may identify a variety of treatable health problems resulting in a coordinated plan and delivery of care, thus potentially leading to better health outcomes (HSE 2015). Rather than the traditional way of working separately, CGA results in all members of the interprofessional team working closely together to ensure an integrated assessment and response to the older person's individual needs. CGA has the potential to improve the care they receive in hospital, reduce unnecessary hospital admissions, lengths of stay (LOS) and readmissions (Oliver et al. 2014).

The four main dimensions covered in a CGA should include physical, functional, psychological and social assessment as follows:

Physical assessment	**Functional assessment**
• Presenting complaint	• Activities of daily living
• Past medical history	• Balance
• Medication reconciliation and medication review	• Mobility
• Nutritional status	
• Alcohol	
• Immunisation status	
• Advanced directives	

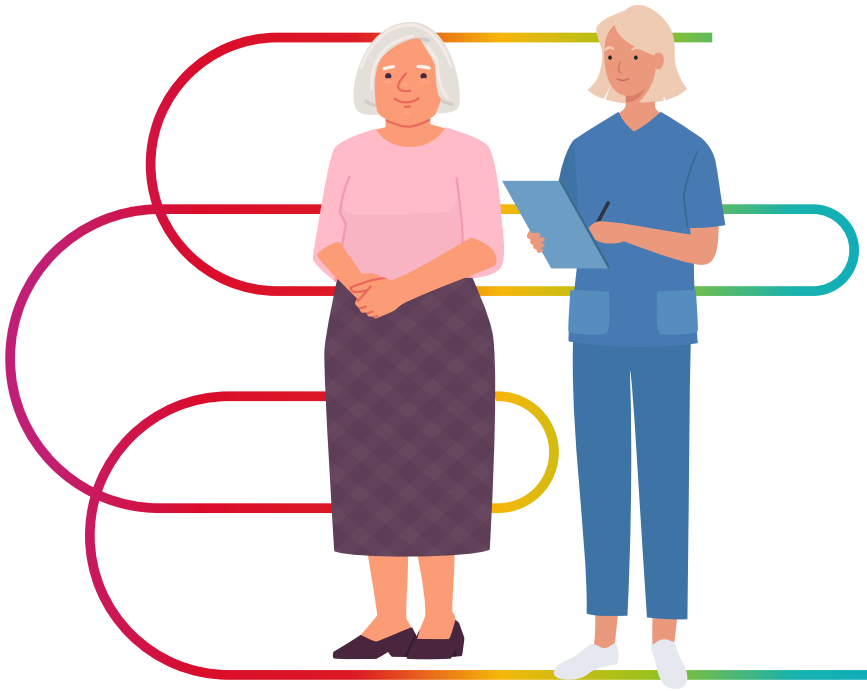
Psychological assessment	**Social assessment**
• Cognition	• Living arrangements
• Mental Health	• Social support
	• Carer stress
	• Financial circumstances
	• Living environment

When is a CGA indicated?

The National Clinical Programme for Older People (NICPOP) recommends that all older adults identified as being frail or at risk of frailty should have a timely CGA performed and documented in their permanent health record (HSE 2015). Substantial evidence shows that in hospital, those who receive an inpatient CGA on specialist geriatric wards are more likely to return home, are less likely to have functional decline and have lower mortality rates than those who are admitted to general wards (Ellis et al. 2011). The content of the assessment may vary depending on different settings of care (e.g. home, clinic, hospital, nursing home). A key element of a CGA is that the environment in which its delivered is gerontologically attuned (Clegg 2011). If indicated, a CGA should be initiated as soon as possible after admission to hospital by a skilled, senior member of the MDT, and used to identify reversible medical problems, target rehabilitation goals and plan all the components of discharge and post-discharge support needs (BGS 2014). Furthermore, due to it preventative, proactive nature in identifying and planning for managing a person's needs, CGA may reduce hospital and unnecessary long term care (LTC) admissions, decrease falls and long-term mortality and ultimately lead to increased independence and improved wellbeing for the older person and their carer (Stoop et al. 2019; Beswick et al., 2008; Melis, Adang, et al., 2008; Stuck, Siu, Wieland, Adams, & Rubenstein, 1993).

Who should carry out a CGA?

Members of the CGA multidisciplinary core team should include experienced individuals drawn from medical, nursing, pharmacy and health and social care professions. This multidisciplinary team (MDT) is responsible for the co-ordinated assessment, discussion and recommendation or implementation of treatment plans.



Domains of Knowledge and Skills for Older Persons Care

Domains of Knowledge and Skills for Care of Older People

Knowledge and skills are defined as:

1. **Knowledge:** the theoretical and practical understanding of a subject acquired through experience or education, including a critical understanding of theories and principles
2. **Skills:** the ability to use one's knowledge effectively and readily in execution or perform

Domains of Knowledge and Skills are categorised as either core or enhanced:

1. **Core:** These reflect the basic level of understanding, knowledge, and skill required for each discipline to provide older persons care as may be expected at graduate level. Typically, clinicians who are working with older people as part of a broader clinical role, or who are gaining post registration clinical experience in working with older people for the first time will be working to achieve core level knowledge and skills.
2. **Enhanced:** The knowledge and skills at this level relate to HCPs with advanced clinical knowledge and skills, achieved through specialist experience and increased clinical engagement with older persons and their families. These knowledge and skills are required for the care of individuals with complex age-related care needs. They would primarily be for HCPs who are static members of the team and whose core clinical practice is with older people. This level would also be involved in service and policy design and the education and professional development of others at local and national level.

Domains of Knowledge and Skills for Care of Older People are categorised and described under the following two domain headings in the Framework:

1. Shared Knowledge and Skills.
2. Discipline Specific Knowledge and Skills.

These domains were identified as being fundamental to all disciplines in providing a person centred, quality focused, interdisciplinary approach to the care of the older person and apply across all healthcare settings

The subheading indicators/reference under each domain outline the knowledge and skills required by HCPs in the context of their role and level of knowledge, skills and experience, irrespective of care setting.

1. Domains of Shared Knowledge and Skills:

The domain of shared knowledge and skills reflects the areas of knowledge and skills that are relevant and shared by all team members working with the older person. Five domains within shared knowledge and skills have been identified through the consensus building process of the expert group

1. Principles of Gerontological Care
2. Communication
3. Roles and Responsibility
4. Teamwork and Collaboration
5. Ethics and Values for Practice

These shared knowledge and skills reflect the core shared areas identified as being essential to the provision of high quality, safe, effective person centred care. These areas of knowledge and skill can be developed either by an individual HCP or by a team involved in care of older people, to develop and improve interdisciplinary team working. Interdisciplinary teams have demonstrated favourable outcomes over usual care for the older person. (The American Geriatrics Society, 2012). Effective care of older people needs to be delivered by interdisciplinary teams, who embed gerontological knowledge and skills into their service (Conroy & Turpin, 2016). The Eclectic Framework, Getting Started in Developing Core Competences for Interprofessional Collaboration in Integrated Care for Older People, provides resources to further develop areas of shared knowledge and skills both at an individual and team level.

2, Discipline Specific Knowledge and Skills:

The discipline specific knowledge and skills reflect the unique traits agreed by an expert advisory group for their respective profession in working with older people. The knowledge and skills in the discipline specific domains outlines the knowledge and skills required by the disciplines in their role of providing care to older people, irrespective of care setting.

Shared Knowledge and Skills

Shared Knowledge and Skills

Domain 1 – Principles of Gerontological Care

Gerontology is the study of the ageing process and the issues that arise as people age. Gerontology covers all elements of this process including, for the purposes of this framework, biological, psychological, social, chronological and functional issues. Age-related, sociological, environmental and economic factors are important perspectives to be addressed in reviewing the principles of gerontological care.

Gerontological care embodies a shared philosophy of care, whereby the older person is at the centre of the care process and his or her wishes are and should be the driver of professional collaboration and decision-making. The rights of the older person are respected at all stages of the care process. The older person is involved in the decision-making about his or her own care in keeping with the Assisted Decision Making (Capacity) Act 2015. The approach to care is a holistic one and collaborative processes help to drive this.

As a healthcare professional you should:

Core Knowledge

Ref	The ageing process
1.01	Understand the principles/ethos of gerontological care that encourage optimal aging and ensure gerontological attuned care is provided to all older people
1.02	Recognise the difference between biological and chronological age
1.03	Be familiar with the influence of culture and ethnicity on the ageing process, health and disease perception, and access to medical care
1.04	Recognise that the ageing process for people with intellectual disabilities begins at a younger chronological age
1.05	Understand the importance of the life course perspective as a multidisciplinary approach to understanding the mental, physical and social health of individuals
1.06	Understand the impact of social determinants of health including the impact of poverty, inequality and discrimination on the ageing process
1.07	Understand the importance of cognitive reserve and brain health
1.08	Recognise the role of health promotion in maintaining wellness
Ref	Advocacy and person-centred care
1.09	Understand that each older person, and their carer where appropriate, is at the centre of all aspects of care
1.10	Recognise that older people are a heterogenous group with differing health, social and functional requirements;
1.11	Understand that each older person needs to be viewed and cared for as an individual regardless of chronological age
1.12	Have an awareness of the potential impact of carer burden on families/carers and carer stress
1.13	Have an awareness of signs and indicators of all forms of abuse and professional reporting requirements
1.14	Be cognisant of the negative impact of ‘ageist language’ when used and how it influences care and outcomes for older people for example, ‘social admission’, “elderly”, ‘acopia’
1.15	Promote and use positive, inclusive language in healthcare interactions
Ref	Age-related conditions
1.16	Have a basic understanding of the physiology of ageing and knowledge of age-related conditions
1.17	Understand and apply knowledge of the core principles of CGA
1.18	Understand the impact of social exclusion, loneliness, and isolation throughout the lifespan and how this can contribute to age-related conditions (Jivraj et al.2012)

1.19	Understand the physiological consequences of reduced mobility and bed rest
1.20	Understand and apply knowledge of frailty and other age-related conditions, including disease cycles and factors that both positively and negatively impact on an older person
1.21	Understand and apply knowledge of screening tools and scales for the identification of frailty and age-related conditions
1.22	Have an awareness of frailty as a potentially reversible condition with early screening and intervention
1.23	Have an awareness of the frailty phenotype which characterises frailty as a syndrome of five core clinical features: (1) low grip strength, (2) slowed walking speed, (3) low physical activity, (4) self-reported exhaustion, and (5) unintentional weight loss.
1.24	Be familiar with, and be able to describe, the terms 'Sarcopenia', 'Frailty', 'Frailty Cycle' and 'Pre-Frail markers'. Understand how you as a healthcare professional can intervene, disrupt or minimise the progression of frailty by recognising it as early as possible in an older person's life
1.25	Understand that older people are at greater risk of experiencing significant polypharmacy, drug-related problems such as inappropriate prescribing, noncompliance with prescribed medication and adverse drug reactions/ interactions leading to a decrease in health-related quality of life and increased risk of hospitalization
1.26	Understand the importance of considering how the older person's physical and mental health needs interact'
1.27	Have an awareness of the signs and indicators of self-neglect

Ref	Palliative and end of life care
1.28	Have an awareness of Palliative Care and support at end of life
1.29	Understand a palliative approach to caring for people living with life limiting conditions
1.30	Understand the role of the Palliative Care team and how to access this service, where appropriate
1.31	Recognise signs that indicate that an older person is approaching end of life

Core Skills

Ref	Assessment and care planning
1.32	Identify and use screening and assessment tools that are appropriate and sensitive to the needs of older people'
1.33	Participate as appropriate within your scope of practice with CGA and the development of a care plan
1.34	Provide therapeutic interventions as determined by CGA
1.35	Design and implement interventions in coordination with MDT to improve overall physical, mental and social functioning, using a goal-orientated rather than a disease-focused approach
Ref	Supporting and optimizing quality of life
1.36	Provide a therapeutic and supportive environment for the older person,and their relative, friend or carer and signpost them to the appropriate support services
1.37	Educate and support colleagues to develop an awareness of age-related conditions and their impact on the older person's quality of life
1.38	Identify frailty in an older person using standardised frailty tools, such as Gait Speed, Timed Up and Go, Edmonton Frailty Scale, Clinical Frailty Scale

Enhanced Knowledge

Ref	The ageing process
1.39	Have an understanding of the strengths and limitations of the various frailty models.
1.40	Have an in-depth understanding of age-related conditions, including how they interact with each other, and their effect on the older person within the bio psy-chosocial context
1.41	Be familiar with recognised best practice documents and demonstrate how they will impact on your practice as a healthcare professional working within the older person services

Enhanced Skills

Ref	Assessment, coordination, care and case management
1.42	Provide older people / their families with appropriate self-management strategies and escalation pathways.
1.43	Adapt the application of frailty and other appropriate screening tools to the relevant setting
1.44	Demonstrate an ability to support intra-professional transfer of care of older patients to the most appropriate setting/service
Ref	Palliative and End of life Care
1.45	Recognise older people with end stage chronic diseases and identify how these conditions may impact on decisions around approaches to treatment of acute illness
1.46	Identify when an older person may benefit from referral to the Palliative Care Team and collaborate with MDT colleagues to facilitate same
1.47	Within your scope of practice, provide assessment and intervention for older people and their carer/family with complex needs at end of life

Domain 2 - Communication

Effective communication is central to all healthcare interactions, and can positively influence health outcomes, promote patient autonomy and improve patient well-being (Shay & Lafata, 2015). Older people are more likely to experience ineffective communication and exclusion from decision-making in healthcare settings than their younger counterparts (Wyman-Ezra & Bengel, 2018). Facilitation of active participation by older people in their care is critical (Barry, 2012). Equally, effective communication between clinicians is essential in providing efficient, person-centred care to older people (Payne et al., 2002).

The ECLECTIC Framework identified communication as a core domain of competence for interprofessional collaboration within interdisciplinary teams integrating care for older people. This domain includes competency in sharing information as well as effective communication skills and behaviours. The ECLECTIC framework describes two competences, under the domain of communication, that are critical for effective interprofessional collaboration within interdisciplinary teams integrating care for older people. Sharing information within the team was understood as core to proficient communication and involved the ability to apply professional judgement as to the information that should be shared as well as utilizing the most appropriate method for the storing and distribution of information within the team. Knowledge, skills and abilities in communicating effectively were also identified in the ECLECTIC framework as core to interprofessional collaboration. This involved the use of appropriate language, mediums and aids when communicating with team members, older people and their family carers as well as other professionals external to the team.

As a healthcare professional you should:

Core Knowledge

Ref	Communication with the older person, relative, friend and carer
2.01	Understand the essential role communication plays in the care of older people
2.02	Understand the impact of our own body language, tone, rate of speech, complexity of speech/language when communicating with an older person and others
2.03	Have an awareness of conditions or factors which can impact communication with an older person, including hearing impairment, visual impairment, literacy, cognitive impairment, delirium, and dementia
2.04	Have an awareness of the impact of carer stress/concerns and listen to and incorporate their perspective in any care plan as relevant
Ref	Effective communication
2.05	Understand that effective communication of information relating to the future of the person living with a chronic progressive condition is an on-going collaborative process and not a single event
2.06	Understand that maintaining relationships is key to effective communication
Ref	Communication methods
2.07	Understand the different types of communication e.g., verbal, non-verbal, visual, written, digital (telehealth) and interpersonal interaction

Core Skills

Ref	Communication with the older person, relative, friend and carer
2.08	Act a conduit of communication between the older person their families and interdisciplinary colleagues.
2.09	Facilitate the use of assistive communication technology where required.
2.10	Use information and communication technology systems, shared integrated communication pathways and shared integrated documentation (where possible) to stream line communication processes to ensure rapid access to information in accordance with legislation and organizational PPPGs.
2.11	Communicate meaningfully, respectfully and sensitively supporting the older person in the expression of their feelings, fears and expectations.
2.12	Provide emotional and social support to the older person and their family/ carer
2.13	Recongise that all behaviour has meaning and bring that knowledge to all interactions with older people, their familes/carers and your team
2.14	Demonstrate the ability to communicate effectively with individuals and families from diverse cultures and different backgrounds
2.15	Demonstrate the ability to involve professional interpreters and/or assistive communication technology to support effective communication where necessary
2.16	Demonstrate the ability to utilise the different types of communication e.g., verbal, non-verbal, visual, written, and interpersonal interaction including telehealth (either one-to-one or with a group or team) to maximise understanding and facilitate meaningful involvement of the older person in decision making relating to their care
2.17	Demonstrate the ability to communicate with the older person and their family in a professional manner that is respectful of their individuality, dignity, identity, personal and social background, expectations and needs
2.18	Demonstrate the ability to build rapport effectively with the older person and their families
2.19	Support individuals and/or their carers to make informed decisions regarding the level of information they wish to receive and want to share with their family
2.20	Demonstrate the ability to promote collaborative person-centred communication with the older person and their relative, friend or carer

2.21	Demonstrate the ability to actively listen to and involve older people and their families in the care planning process including the making of clear and concisely written plans
2.22	Demonstrate the ability to enlist the skills of the MDT and other relevant services and agencies, to enhance and support communication with the older person and their family
2.23	Demonstrate the ability to assess the person's current understanding of his/her health, roles and functional status
2.24	Demonstrate the ability to identify and use strategies to communicate effectively with people with cognitive impairment
2.25	Ensure the older person and their relative(s) or those important to them, in all cases with the person's consent receive and understand relevant and current information concerning their health care/needs
2.26	Demonstrate the ability to facilitate the older person, their relative(s) or those important to them, in all cases with the person's consent, to engage in the therapeutic process to the extent that they wish
2.27	Demonstrate the ability to communicate empathetically and sensitively with people in distress, in a way which is calming and reassuring, and seeks to reduce their distress
Ref	Effective communication
2.28	Demonstrate the ability to adopt a partnership approach gathering pertinent information from both the older person, their relative, friend or carer and other relevant services that will assist in developing an assessment and a treatment plan
2.29	Create and ensure a calm environment that is conducive to respectful communication, caring and knowing what matters to the person
2.30	Demonstrate the ability to communicate at individual, group, team and inter agency level and ensure the voice of the older person is at the centre
2.31	Demonstrate the ability to advocate on behalf of the older person
Ref	Communication methods
2.32	Present oral and written information in an accessible clear, concise and well-structured manner
2.33	Demonstrate the ability to adapt communication method to the older person's literacy and digital literacy skills
2.34	Demonstrate the ability to utilise communication strategies for example; plain language, active listening, maintaining appropriate eye contact, appropriate tone, inviting questions
Ref	Interprofessional working
2.35	Demonstrate the ability to communicate effectively with the MDT
2.36	Give and receive feedback in an open, honest and professional manner

Enhanced Knowledge

Ref	Knowledge of communication with the older person, relative, friend and carer
2.37	Demonstrate an understanding that pain, distress, or confusion may be communicated by behaviours where the older person has difficulties with receptive or expressive language, cognitive impairment or cognitive linguistic difficulties
2.38	Understand the multidimensional communication challenges that may arise when working with people with dementia or delirium, responding with sensitivity and compassion to the needs of individuals and carers

Enhanced Skills

Ref	Communication with the older person, relative, friend and carer
2.39	Recognise the importance of involving older people in individual and group level discussions and demonstrate the ability to facilitate them to participate in a meaningful way
Ref	Effective communication
2.40	Demonstrate expertise as a mediator and advocate for the older person and the family to ensure timely access to appropriate specialist gerontological services, non-specialist interventions and other relevant essential services

2.41	Demonstrate the ability to identify and use a range of appropriate strategies that aim to manage conflict and disagreement within family systems and with other MDT members when they occur
2.42	Demonstrate the ability to facilitate meetings and/or groups as relevant to your role
Ref	Communication methods
2.43	Demonstrate the ability to use and adapt specialised communication methods, or strategies recommended by SLT, to support the needs and wishes of older people with communication impairment
2.44	Demonstrate the ability to use a variety of strategies to engage in highly skilled, compassionate, individualised and timely communication with individuals with life-limiting conditions/at end-of-life, their carers and members of the MDT/other relevant services
Ref	Interprofessional working
2.45	Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations as appropriate.
2.46	Apply experience and specialist skills in gerontology to navigate the systems, referral pathways, processes and procedures to enable effective interagency working that underpin effective person-centred care.
2.47	Demonstrate the ability to recognise, anticipate and contribute to the management of potential conflict in decision-making in the care of the older person setting
2.48	Demonstrate the ability to provide education to colleagues within your area of professional expertise
2.49	Demonstrate a broad range of advanced & specialised communication skills to enable sharing of complex information and ideas
2.50	Engage in critical dialogue with a wide range of audiences with different levels of knowledge and expertise relating to the care of older people

Domain 3: Roles and responsibilities

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day-to-day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge and abilities.

Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

· to ensure the delivery of high-quality person centred care

· to enhance collaboration and

· to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, appropriate and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

Knowledge of the team was identified in the ECLECTIC framework as a core domain of competence for interprofessional collaboration within interdisciplinary teams integrated care for older people. This domain included an understanding of the roles of individual team members and the goals of the overall team as well as proficiency in making referrals within the team and across service providers. In this way, the ECLECTIC framework aligns to this domain of competence in identifying knowledge of roles and responsibilities as critical for safe, quality care for older people across various health settings and in interdisciplinary care teams.

As a healthcare professional you should:

Core Knowledge

Ref	Assessment and interventions
3.01	Understand your role in the assessment, development and implementation of care plans that aim to improve independence, enhance quality of life and optimise function in the older person
3.02	Understand the role and function of CGA in the care of the older person
3.03	Understand the use of screening tools as part of the CGA, and in identifying other disciplines or services that may contribute to the support and care of the older person
Ref	Supporting and optimising quality of life
3.04	Understand the importance of activity, nutrition, and social inclusion in contributing to the health and wellbeing of the older person
3.05	Understand the importance of appropriate supports and reablement/ rehabilitation strategies that allow the older person to live independently
3.06	Understand the impact of environment on function, social participation and quality of life
3.07	Understand the promotion of positive aging and encouraging age friendly communities and health care settings
3.08	Understand the various care pathways/ referral processes that are available within the local service and community that could positively impact on an older person's care
3.09	Have an awareness and knowledge of voluntary and statutory services for older people at local and national level
Ref	Interprofessional working
3.10	Understand the benefits and positive outcomes of inter-professional working and education
3.11	Understand the role of other HCP's working with the older person
Ref	Research, policy and legislation
3.12	Understand audit, quality improvement (QI) and research methodology as it pertains to the care of older people
3.13	Understand the role of national policy, clinical programmes, models of care and Health Information and Quality Authority (HIQA) in development of services for older persons
3.14	Understand the role of regulation and the professional code of conduct/ ethics of your registering authority

Core Skills

Ref	Assessment and interventions
3.15	Make every contact count and use each interaction to promote healthy living/ compensate for disease-related losses and impairments/ prevent further disease-related losses/ promote comfort and facilitate diagnosis, treatment of disease
3.16	Contribute to the implementation of a treatment/care plan in partnership with relevant services and the older person
3.17	Demonstrate an ability to assess, plan, implement and evaluate a plan of care in line with the science of the CGA
3.18	Facilitate collaborative consultations, goal setting and evaluation with the older person, their families/carers and the MDT
3.19	Ensure interventions are outcome-based and relevant to the older person's goals
3.20	Ensure appropriate onward referrals are made to other agencies or professionals
3.21	Facilitate a coordinated effective discharge and follow up, as it pertains to your service or role

Ref	Advocacy and person-centred care
3.22	Demonstrate teamwork and relationship building skills with the ability to promote a culture that values diversity and respect
3.23	Make reasonable adjustment, where required, when supporting people with additional care needs, e.g. Intellectual disability (ID)
3.24	Engage in therapeutic and professional relationships with older people, their family/carer(s), colleagues and other services
3.25	Treat individuals in a fair, equitable and inclusive manner, ensuring confidentiality is maintained in all therapeutic and professional relationships
Ref	Supporting and optimising quality of life
3.26	Demonstrate an ability to provide practical and emotional support to older people and/or their carers/families
3.27	Support, educate and empower the older person and their family/carer(s) in the ongoing management of their condition(s)
Ref	Continuing professional development, self-management and professional advocacy
3.28	Act as an advocate for your profession
3.29	Apply knowledge and skills in decision making to ensure person-centred and effective care for the older person
3.30	Demonstrate an ability to develop an appropriate work-life balance and self-care strategies
3.31	Maintain and develop personal and professional knowledge and skills through continuous professional and personal development
3.32	Demonstrate appropriate planning, prioritisation and organisational skills in relation to yourself and the resources available to you
Ref	Policy and legal context
3.33	Maintain appropriate, accurate and clear records as per local and national guidelines
3.34	Demonstrate ability to prepare and maintain up to date and accurate documentation relevant to the clinical intervention, assessment findings and recommendations as per local documentation policy, and regulatory/legal requirements

Enhanced Knowledge

Ref	Research into practice
3.35	Understand how to translate research into practice

Enhanced Skills

Ref	Development of self and others
3.36	Contribute to the learning and education of others including students
3.37	Demonstrate the ability to deliver presentations and education, relevant to your role, at a local and national level
3.38	Undertake study and maintain a knowledge base at an advanced level to improve the quality and standard of outcomes and service delivery for older person's services
3.39	Develop, facilitate and provide education, leadership, mentorship and professional support to colleagues
3.40	Demonstrate leadership that encourages colleagues to foster a positive learning environment that supports all staff working in gerontology
3.41	Lead, facilitate and engage in further education and research in gerontology
3.42	Provide expert advice to Health Care Professionals regarding patients not under the care of the Older Persons Service.
Ref	Service and quality improvement
3.43	Influence change within your scope of practice
3.44	Develop and promote your profession within the team and within and across services

3.45	Monitor and ensure the quality of services provided through the use of agreed key performance indicators.
3.46	Demonstrate the ability to lead audits, implement change management/QI processes, develop business cases and produce audit/project reports
3.47	Contribute to strategic planning to drive change/quality improvement both within your profession, your service and the broader health care context
3.48	Demonstrate leadership in promoting a vision for gerontological practice that is integrated, age- attuned and person focused with a shift from a disease focus to a health and living focus.
3.49	Demonstrate an advanced ability to innovate and develop practice and service delivery
3.50	Lead and collaborate in the development of standards and policy, procedures, protocols and guidelines (PPPGs)
3.51	Demonstrate the ability to initiate and lead interdisciplinary and cross agency QI projects
3.52	Promote the development of structures and processes that facilitate seamless transitions of care across organisational and professional boundaries
3.53	Advocate to overcome the barriers to seamless transitions of care
Ref	Legal, professional and policy context
3.54	Demonstrate excellent written communication and record keeping skills as per local and national guidelines
3.55	Demonstrate the ability to work within the framework of local PPGs that reflect current evidence-based practice
3.56	Ensure you work within your scope of practice to provide and manage an expert service for the older person their family/carer
3.57	Contribute to the design and development of services that promote comprehensive, integrated care within evolving healthcare structures.
3.58	Engage with national policy/clinical programmes to promote positive ageing and encourage age friendly communities and health care settings

Domain 4: Inter-Professional Collaboration

Inter-professional working means 'collaborative practice: that is the process whereby members of different professions and/or agencies work with each other and with users of services to provide integrated health and social care for the user's benefit' (Pollard, K., et al: 2014:13).

The term *collaboration* implies collective action towards a common goal. Thus, more concretely, Wood and Gray argue that 'collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms and structures to act or decide on issues relating to that domain.' (1991).

Inter-professional collaboration is an important philosophical position in enhancing older people's care and wellbeing. The framework includes the philosophy of and theory behind inter-professional working. It is supported by the ECLECTIC framework that resulted from Part One of the project. The ECLECTIC framework describes three domains of interprofessional collaboration in interdisciplinary teams integrating the care for older people. These three domains align with this framework in identifying knowledge of the team, communication and shared decision-making as central to ensuring safety and quality in person-centred care for older people across various settings including interdisciplinary teams. The ECLECTIC framework provides step-by-step practical guidance for interdisciplinary teams to work together to build their competence in interprofessional collaboration. Together, the two frameworks resulting in part one and part two of this project will support healthcare professionals to develop their professional competence to deliver person-centred care to older people as part of an interdisciplinary team.

Inter-professional collaboration is a key factor in initiatives designed to increase the effectiveness of health services currently offered to the public (D'Amour, et al, 2005). The effective use of collaboration strategies will help to move the historical autonomous discipline-specific model of service delivery to one that is more team-focused and holistic.

Inter-professional working does not take away from discipline-specific interventions. There are times when a specific discipline perspective is the appropriate avenue to follow in providing care (Pollard, et al, 2014).

Each discipline sets out its position on working in a collaborative way with other professionals.

Each discipline demonstrates, through examples, how they work in an inter-professional way.

The introduction of the concept of integrated care in Irish health service provision has provided the impetus for this framework. Core to Slaintecare (2017), the Enhanced Community Care Model (2020), and the commencement of pilot sites in 2016 (ICPOP, 2015), integrated care is an evolving and core aspect of older persons service development in the Irish Healthcare System. Successful integrated care requires effective inter-professional collaboration, strong relationships within and between disciplines, teams, and services not just within the health system but across all sectors, statutory and voluntary, acute and community, public and private.

As a healthcare professional you should:

Core Knowledge

Ref	Working effectively in teams
4.01	Understand the importance of working together and developing strong working relationships based on trust, mutual respect and understanding of different professional opinions in order to provide high quality care to older people
4.02	Understand the need for good communication and willingness to share information, be flexible in thinking and learn from each other
4.03	Understand and identify where professional knowledge and skills may overlap, and recognise that each profession may have clinical areas of specialism and core roles
4.04	Understand the purpose and components of a CGA and the roles individual disciplines play in conducting and interpreting a CGA
4.05	Appreciate the roles, responsibilities and professional boundaries of individual team members who operate within their scope of professional practice, recognising the limitations of their professional roles and when necessary, referring to other healthcare professionals as appropriate, including but not restricted to the following disciplines: · Dietetics · Medicine · Nursing · Occupational Therapy · Pharmacy · Physiotherapy · Psychology · Speech and Language Therapy · Social Work · Others as appropriate
Ref	Service and quality improvement
4.06	Demonstrate an understanding of current services/clinical areas across the spectrum of care and when to refer. Keep up to date with evolving services.

Core Skills

Ref	Working effectively in teams
4.07	Ensure collaboration in completion of a CGA
4.08	Work collaboratively with other members of the interdisciplinary team (IDT) to ensure the care plan of the older person is coordinated, goal orientated in line with core components of CGA
4.09	Engage in effective and respectful shared decision-making with inter- and intra-professional care and support providers, sharing knowledge, perspectives and responsibilities and willingness to learn together
4.10	Adopt a culture of collegiality and respect in professional relationships and ensure that the older person's experience is everyone's responsibility
4.11	Refer to, and/or consult with any of the multiple professionals, agencies and voluntary bodies who work with the older person to achieve positive outcomes

Enhanced Knowledge

Ref	Interprofessional communication
4.12	Understand the importance of developing strong working relationships with all stakeholders and demonstrate a knowledge of stakeholder engagement
4.13	Have an advanced understanding of the principles and processes of integrated care, interdisciplinary learning and education

Enhanced Skills

Ref	Interprofessional communication
4.14	Identify and communicate effectively with all key stakeholders
4.15	Demonstrate inter-agency skills and an ability to network across individuals, teams, services and sectors
Ref	Interprofessional Working
4.16	Demonstrate an ability to lead and support teams in effective team working and resolving conflict
4.17	Participate in interdisciplinary education and learning with colleagues and/or students
4.18	Participate in interdisciplinary shared assessment of older patients i.e. improved knowledge of colleague's role, shared workload, team ethos, greater spread of resources

Domain 5: Ethics and Values

The goal of healthcare is to help people sustain health that is essential to maintaining function. However, at times, specific care strategies or interventions may be burdensome, or go against the wishes of the older person. The older person's care needs and wellbeing should remain central to their care. Ethical practice is about considering how best to provide continuing and integrated care to older people as their health care needs change. Respect for the older person's values and wishes is at the core of each professional's ethical practice.

As a healthcare professional you should:

Core Knowledge

Ref	Research, policy and legislation
5.01	Demonstrate an understanding of the Professional Code of Conduct and Ethics and Frameworks for Ethical Decision-Making as set out by your professional body/association and your discipline's governing body
5.02	Understand local, organisational, and national policies, procedures, guidelines, strategies, and legislation (See Appendix 3)
5.03	Understands consent and the limits of confidentiality.
5.04	Understands and applies a working knowledge of the principles of informed consent
5.05	Understand the ethical, legal, and professional requirements that inform safe and ethical practice.
Ref	Advocacy and person-centred care
5.06	Accept responsibility and accountability for consequences of your actions including inactions and omissions in caring for the older person; reflecting in and on practice.
5.07	Demonstrate an understanding of the principles of person-centered care and human rights-based care in working with older people

5.08	Demonstrate an understanding of the Assisted Decision-Making (Capacity) Act 2015. Understand the steps that should be followed in supporting decision-making and maximizing a person's capacity to make decisions
5.09	Understand and apply the HSE Safeguarding Vulnerable Adults Policy and Children First legislation and procedures, including definitions of abuse. Understand the importance of identifying safeguarding issues and have an awareness of the appropriate referral pathways.
5.10	Have an awareness of relevant national and local guidelines and policies relating to risk assessment in relation to older people
5.11	Understand the importance of applying ethical principles in research with older people
Ref	Socio-cultural context
5.12	Acknowledge and respect the specific local context of practice, including socio-cultural diversity
5.13	Demonstrate the ability to adapt your assessment to respect cultural diversity in relation to communication, touch, food, attire, customs, and/or cultural expectations
5.14	Recognise the impact of inequality, poverty, exclusion and diversity on older people and their families

Core Skills

Ref	Professionalism
5.15	Demonstrate adherence to your discipline's Code of Professional Conduct and Ethics and Frameworks for Ethical Decision-Making
5.16	Work within the scope of the Assisted Decision-Making Act to support decision-making and maximise a person's capacity to make decisions
5.17	Apply the ethical, legal and professional requirements that inform safe and ethical decision making and practice
5.18	Respect confidentiality including advising older people and relative, friend or carer of the limits of confidentiality
5.19	Exercise a professional duty of care to the older person and their relative, friend or carer
5.20	Demonstrate high standards of ethical conduct and quality of care. Act with honesty and integrity in relationships with older people, families, and other team members
Ref	Personal and professional development
5.21	Demonstrate an understanding of the importance of, and ability to, reflect on one's own biases, personal and professional strengths and limitations. Critically evaluate one's own practice and build self-awareness, through ongoing reflective practice
5.22	Maintain and develop personal and professional knowledge and skills through ongoing learning and maintain a record of continuous professional development
Ref	Working with older people: relevant ethics and legislation
5.23	Demonstrate an ability to identify safeguarding issues and the appropriate channels for reporting concerns regarding risks to older people
5.24	Adopt a holistic, solution-focused, and person-centred approach to practice, working in partnership with the older person and family/ carers, ensuring the older person's wishes and self-identified needs are central to all team actions. This may include facilitating an older persons wish to return/remain home (when they have capacity to make that decision) even when you feel it may be unsafe/unsuitable
5.25	Demonstrate the ability to focus on enhancing the quality of the life of the older person and their relative, friend or carer, seeking service user feedback and engaging in best practice methods to measure and evaluate interventions
Ref	Interprofessional teamwork
5.26	Work within the scope and limits of your own professional training, while adopting an interdisciplinary approach
5.27	Recognise any factors or practices which may be considered unethical, oppressive or contributing to inequality of access and communicate with colleagues within the MDT, and wider service/system,

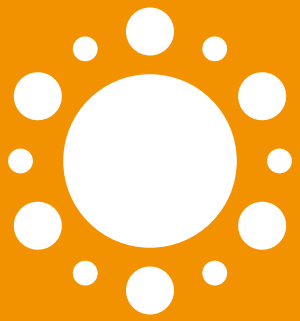
5.28	Recognise when it is appropriate to make decisions in collaboration with others
5.29	Recognise and manage conflicts of interest

Enhanced Knowledge

Ref	Research and service evaluation
5.30	Have an advanced knowledge of person-centred care, service user involvement, co-production and their methodological approaches
5.31	Be aware of the process and procedures around responding to service user feedback
5.32	Understand the principles of representation and inclusion in conducting and interpreting research with older people. Have an advanced knowledge of consent methodologies (for example inclusionary consent, process consent) to facilitate the direct involvement of older people with cognitive and/or communication impairment where appropriate
Ref	Promoting a quality service
5.33	Understand the importance of strong clinical leadership to inspire others within and outside the profession and act as a support/role model
5.34	Have a clear understanding that all MDT members must work together with the aim that the older person has a positive experience within the service and promotes service user feedback to shape ongoing service development

Enhanced Skills

Ref	Complex decision-making
5.35	Demonstrate an advanced ability to understand and analyse ethical dilemmas and contribute to MDT decision making
5.36	Demonstrate an advanced ability to support colleagues to analyse and develop positions about ethical concerns
5.37	Demonstrate an advanced understanding and application of relevant local organisational and national legislation, PPG's
Ref	Advocacy and person-centred care
5.38	Promote and respect older people's engagement in economic, social, cultural, community and family life
5.39	Undertake research and quality improvement projects in an ethical and inclusive manner-ensuring that the welfare of each research participant is protected



DIETETICS

Discipline-Specific Knowledge and Skills - DIETETICS

MEMBERSHIP OF DIETETICS WORKING GROUP

The following CORU registered Dietitians whom are members of a working group from the INDI (Irish Nutrition and Dietetic Institute) Older Persons Nutrition Interest Group (OPNIG) prepared the following document:

- Aoife Niland - Senior Dietitian, Clare Integrated Care Programme for Older Persons
- Ciara Pender - Clinical Specialist Dietitian to the Frailty Intervention Team, MMUH
- Emma Grant - Senior Dietitian, Waterford Integrated Care Programme Older Persons team
- Laura Keaskin - Senior Dietitian, Blanchardstown/Tallaght
- Marie Hannon - Senior Dietitian, Our Lady's Hospice and Care Services, Harold's Cross
- Rosanna Keane - Senior Community Dietitian, Mullingar Frailty Intervention team
- Dr. Sharon Kennelly - Clinical Specialist Community Dietitian, Older Persons, CHO8
- Shauna Clarke - Senior Dietitian Peamount Hospital, Co. Dublin

Introduction

A Dietitian is healthcare professional who has a Bachelor's or a Master's degree specialising in food and nutrition, as well as a minimum 1000 hours of practice placement in both hospital and community settings. Dietitians apply the science of nutrition to promote health, prevent and treat malnutrition and other nutrition-related disorders and provide therapeutic interventions under pinned by evidence based nutritional guidelines for patients, clients and the public in health and illness (INDI, 2021).

Dietitians are the only health professionals who are statutorily recognised to assess, diagnose and treat dietary and nutritional problems at an individual and wider public health level. The title "RD" and "Dietitian/Dietician" is protected by law and regulation so that only qualified practitioners' who have the required education qualifications and continue to maintain their knowledge and skills through continuing professional development, can use that title (CORU, 2005).

Within the Irish system Dietitians work within the following Clinical grades:

Entry Level/Staff Grade Dietitian

Upon entry into the workforce, Entry level/Staff Grade Dietitians utilise knowledge, skills and abilities that have been attained from completion of a Bachelor of Science (Honours) or a Master of Science in Dietetics from a third level institution. Core skills will develop with time through experiential learning, supervision and continuous professional development within various clinical settings whilst operating at entry level/staff grade.

Senior Dietitian

At Senior level, Dietitians build upon existing skills and possess a greater depth of specialist knowledge and complexity of responsibility which may include supervision of entry level/staff grade Dietitians and responsibilities for a clinical area/service.

Clinical Specialist Dietitian

At Clinical Specialist level, Dietitians are expected to demonstrate excellent clinical leadership in driving change, participate in post graduate research and operate with an expert level of proficiency. They consistently demonstrate excellence in a particular clinical area and often manage a greater depth and complexity of responsibility than at senior level.

Role of the Dietitian in Older Persons

In the inter-professional care of older adults, Dietitians should operate at all levels (prevention, diagnosis, intervention, monitoring nutritional status and evaluation of interventions implemented), to maintain or improve nutritional health and promote active and healthy ageing and quality of life in older people (EFAD, 2017). As members of integrated multidisciplinary teams, Dietitians are uniquely qualified to apply scientific evidence to the promotion of healthy eating, individualised nutritional therapy and counselling to individual or groups of older persons (Arvantitakis et al., 2009).

The health professional teams should include a dedicated specialised Dietitian within the care of older persons. The Dietitian can optimise healthcare and research practices and be instrumental in developing and advocating policy change (EFAD, 2015).

The role of the Dietitian is essential in both primary and secondary prevention of disease as well as treatment of disease. In this role, the Dietitian aims to decrease the risk of non-communicable diseases including prevention and treatment of malnutrition, frailty and sarcopenia. Dietitians are also essential in treatment and prevention of dehydration. Dietitians working with older adults have strategic, educational, clinical and administrative roles. Moreover, qualified Dietitians work actively in all care settings for older persons: acute hospital, community, residential care sites, nursing homes, community primary care teams, integrated care and rehabilitation teams (EFAD, 2017).

Knowledge and Skills of Dietitians working with older persons

Dietitians working with older people must demonstrate the knowledge, skills and attitudes, which underpin gerontological care and geriatric nutrition, and to work with an inter-professional approach. Dietitians specialising in the care of older persons, should deliver a 'person-centered' approach, which includes the older person, their families and their carers as partners in the care process. This approach requires an understanding of the individual's food habits in a social and medical context (EFAD, 2017).

In addition to core knowledge and skills for Care of Older Persons that are common to all health care professionals working with Older Persons as outlined in the previous section, dietetic specific knowledge and skills are outlined below

DOMAIN 3 - ROLES AND RESPONSIBILITIES

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day-to-day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge, and abilities. Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, seamless, appropriate, and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

Ref	Core knowledge
DIET 1.01	Dietitians should know which conditions are of relevance to the context of nutritional care of older persons for example - Anorexia of aging, - Malnutrition, - Cachexia, - Over nutrition, - Sarcopenia, - Frailty, - Dehydration, - Dementia, - Delirium - Wound healing, - Chronic kidney disease, - Parkinson's disease, - Dysphagia, - Constipation - Falls and bone health, - Deconditioning/ recovery and rehabilitation needs - CVD
DIET 1.02	Understand the specific aetiology and nutrition management approaches associated with these conditions
DIET 1.03	Understand how these disorders may impact on physical function, disease progression, quality of life and on nutrition care planning
DIET 1.04	Demonstrate in-depth knowledge of relevant malnutrition screening tools used for older people in accordance with local policies and guidelines
DIET 1.05	Demonstrate knowledge of the Nutrition Care Process and its application
DIET 1.06	Understand food and food systems, human nutrition and dietetics and its integration into the provision of services
DIET 1.07	Demonstrate knowledge of biochemical, behavioural and social sciences in the provision of dietetic services
DIET 1.08	Demonstrate knowledge of nutrition support-oral, enteral and parenteral nutrition support
DIET 1.09	Demonstrate comprehensive knowledge of products used in nutrition support-oral nutritional supplements, enteral feeds, parenteral nutrition products, vitamins and minerals used in the care of the older adult
DIET 1.10	Be aware of ethical and legal issues that may arise regarding artificial nutrition support in the older adult population
REF	Core Skills
DIET 1.11	Demonstrate ability to carry out full nutritional assessment using relevant information applying the NCP (nutrition care process) format in all care settings for older persons
DIET 1.12	Demonstrate the ability to develop , implement and monitor nutrition care plans taking into account the older persons health, clinical condition, social circumstances and all other relevant factor
DIET 1.13	Apply knowledge of nutritional care of older persons and related disorders based in full nutritional assessment. For example the International Dysphagia Diet Standardisation Initiative (IDDSI), modified consistency diets and the provision of medications and fluids in older persons with dysphagia
DIET 1.14	Effectively communicate with older persons', their families and their carers to agree appropriate nutrition care plans that meet their needs.
DIET 1.15	Effectively communicate nutritional assessment findings and relevant care plans to the MDT and all relevant health care professionals
DIET 1.16	Use and adapt written dietary advice resources, for example, tailor leaflets and diet sheets to the individual needs of the older adult
DIET 1.17	Implement nutrition care pathways for example, malnutrition screening and onward referral pathways and systems of prioritisation for older persons
DIET 1.18	Advise on suitable nutritional products, vitamins and minerals in consultation with medical staff and the older person/carers
DIET 1.19	Provide expert nutritional advice at an appropriate level to clinicians, clients and carers

DIET 1.20	Develop current, clear, evidence-based resources for older adults, carers and healthcare professionals, suitable for use locally and/or nationally.
DIET 1.21	Systematically search, critique, interpret and apply findings from food, nutrition, dietetic, social, behavioural and education sciences into practice
DIET 1.22	Raising awareness and participation in health promotion
DIET 1.23	Enhancing the IDT's understanding of the role of a Dietitian, nutritional screening, the nutrition care process and their role in the team
DIET 1.24	Act as an expert resource in nutrition and dietetics, as required, to members of the IDT
DIET 1.25	Understand the relative risks in relation to developing nutrition care plans that allow for liberalisation rather than restriction of diets in the nutrition status and quality of life of older persons (EFAD, 2015)

Ref	Enhanced knowledge
DIET 1.26	Analyse and interpret scientific and research developments in nutrition for older persons and report findings to wider dietetic groups and relevant healthcare professionals
DIET 1.27	Understand the various catering and food management systems and advise and implement changes in the production of therapeutic diets to a standard recommended by National Guidelines, for example, IDDSI and the Food Nutrition and Hydration Policy for Adult Patients (2018)
Ref	Enhanced skills
DIET 1.28	Dietitians should demonstrate group work and facilitation skills that results in effective promotion and self-management of health among older persons and their carers
DIET 1.29	Demonstrate ability to develop high quality nutrition resources for older persons, including written information, web-based resources, presentations and education sessions

DIET 1.30	Initiate and coordinate nutritional screening programmes to identify malnutrition risk and etiological factors contributing to malnutrition
DIET 1.31	Develop and contribute to the evidence base on standards and procedures and protocols for the quality management of nutritional care
DIET 1.32	Be actively involved in professional clinical groups, specifically those relating to the area of Care of the Older Adult at local, national and international level e.g. the European Federation of the Associations of Dietitians (EFAD)
DIET 1.33	Actively support and contribute to relevant QI/special interest groups. Form collaboration with research-associated bodies, as appropriate
DIET 1.34	Contribute to the development of specialist nutritional modules for the older adult within the training of healthcare professionals
DIET 1.35	Represent governing body at relevant local and national working groups to develop new local and / or national guidelines pertinent to dietetics and care of older persons
DIET 1.36	Accept leadership roles in local or national committees and organisations to promote nutrition and dietetic practice in integrated care of older persons
DIET 1.37	Engage with professional disciplines and academic/training institutions in developing and evaluating and delivering educational programmes / modules in dietetics in care of older persons
DIET 1.38	Peer review publications by other authors on the topic of nutritional care of older persons
DIET 1.39	Demonstrate expertise to assist informed choices for dietetic care planning. Advocate for and support older adult to make their own choices, be empowered and able to exercise their rights of choice, for example, in enteral feeding.
DIET 1.40	Lead and steer interdisciplinary committees for example, nutrition care teams in residential care sites or hospital nutrition steering committees with the aim of improving nutritional standards

NURSING

Discipline-Specific Knowledge and skills - NURSING

MEMBERSHIP OF NURSING WORKING GROUP

Deirdre Lang, Director of Nursing/National Lead Older Persons Services, Office Nursing & Midwifery Services Director.

Sarah Cosgrave, Advanced Nurse Practitioner for Older Persons, St. Vincent's University Hospital.

Introduction

Nursing encompasses the autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people (ICN, 2002).

The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full of partial independence as rapidly as possible" (Henderson, 1966, p.15).

Nurses work in collaboration with older adults, their families, and communities to support healthy aging, maximum functioning, and quality of life (CGNA, 2020). In addition to providing direct care and coordinating services for older adults, nurses advocate, educate, manage, consult, and conduct research about the dynamic trends, issues, and opportunities related to aging and its effect on older adults. Nurses understand that older adults are heterogeneous in terms of illness severity, functional status, prognosis, personal priorities, and risk of adverse events, even when diagnosed with the same pattern of conditions. Treatment options differ according to the individual's needs, necessitating more-flexible approaches to care in this population (American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012).

Gerontological nursing is the term used to describe the holistic nursing care provided to an older adult across the spectrum of healthcare whether that is in the acute hospital, the community, chronic, rehabilitative, preventive, and or end of life care. Gerontological nursing care is based upon the following assumptions:

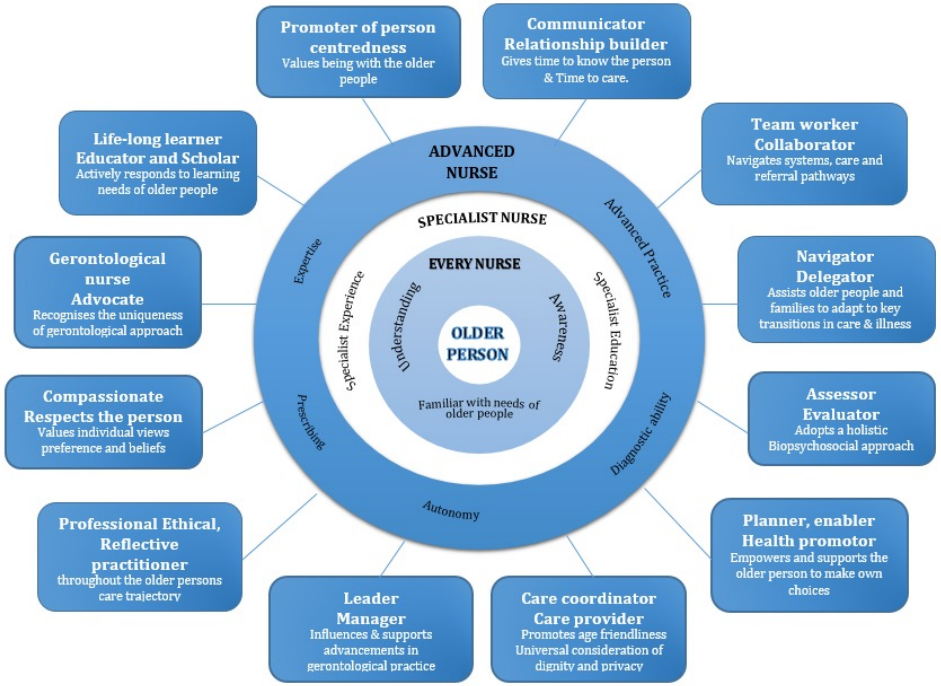
- Ageing is a progressive, irreversible and natural process.
- All people age differently as a result of genetics and life experiences.
- Older adults can age with high mental and physical function.
- Older adults are a heterogeneous population with varied cultural beliefs and life experiences that contribute to individual wellbeing and quality of life.
- Older adults seek fulfilment and interaction with their environment.
- Older adults are capable of making and desire to make informed decisions on how they live and how they die.
- Older adults often experience multiple, interacting acute and chronic conditions.
- The older adult's atypical response to many diseases and illnesses often prompts diagnosis and treatment

(Eliopoulos, 2010)

Nurses in collaboration with their healthcare professional colleagues play a key role in providing expert clinical advice, education and support in primary and secondary care.

Key knowledge and skills in gerontological nursing practice include: communicator; relationship builder; team worker, collaborator, navigator, and delegator; assessor and evaluator; planner, enabler and health promotor; care coordinator; care provider; advocate; manager; being a professional, ethical, reflective practitioner; compassionate caregiver; valuer and respecter of the person; life-long learner and educator, and leader (See Diagram 1).

Diagram 1: An illustration of the varied roles represented within a framework for Gerontological Nursing



Systematic Literature Review and National Focus Groups to Support the Development of a Strategic Vision and Educational Framework for Gerontological Nursing (Coffey et al. 2017)

Gerontological Nursing Pathways

While every registered nurse needs to have an understanding, awareness and familiarity of the needs of older people and the challenges they face, gerontological nursing, with its specific focus on the care of the older person adds to an expanding body of knowledge of gerontology and geriatrics to general nursing practice (CGNA, 2020).

There are a number of career pathways open to nurses in Ireland. The clinical career pathway places an emphasis on the provision of direct patient care and includes the role of staff nurse, clinical specialist and advanced nurse practitioner.

Staff Nurse

Nurses with diverse academic backgrounds provide gerontological nursing care across various settings such as hospitals, ambulatory care, the home, and communities. To excel as a staff nurse working with older adults, specialised education, such as a postgraduate diploma in gerontology is beneficial, though not mandatory.

Gerontological nursing is the term that describes an evidence-based nursing practice that addresses the unique physiological, psychosocial, developmental, economic, cultural, and spiritual needs related to the process of aging and care of older adults. Gerontological nurses have knowledge and understanding of best practice guidelines in the identification and management of the more common conditions of older age, including falls, sarcopenia, delirium, frailty, Parkinson's disease and atypical parkinsonism, multi-morbidity, stroke disease/chronic stroke, chronic inflammatory conditions, osteoarthritis etc. Nursing skills for general nursing practice translate to the gerontological caring environment, approaching nursing care from a holistic whole systems approach (CGNA, 2020).

Clinical Nurse Specialist

The role of Clinical Nurse Specialist (CNS) offers practitioners a career pathway incorporating professional development within an inter-professional team structure. The specialty area is a defined area of nursing practice. This specialist practice encompasses a major clinical focus of care to patients or clients and their families in hospital, community and outpatient settings. The specialist nurse works with medical, pharmacy and Health & Social Care Professional colleagues (NCNM, 2008). The National Council for the Professional Development of Nursing and Midwifery developed a Framework for the Establishment of Clinical Nurse / Midwife Specialist Posts: Intermediate Pathway - 4th edition to guide in the development of CNS posts.

Advanced Nurse Practitioners

Advanced practice nursing is defined as a career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent, autonomous and expert practitioners. Advanced Nurse Practitioners (ANPs) clearly articulate domains of knowledge and skills specific to the area of gerontology and have met the regulatory Board's Criteria for Registration to enter the Advanced Practice Division of the Register (NMBI, 2017). Building on the competences achieved for nurse registration, the standards and requirements specify the competences required to register as an Advanced Nurse Practitioner (ANP), thus facilitating a career pathway for nurses who commit to the challenges and opportunities of achieving higher levels of capability. The National Clinical Programme for Older People (NCPOP) developed a Clinical Guidance Framework to provide a clear pathway for the development of ANP roles, assist ANPs identify their developmental needs and to define a common set of capabilities for ANPs Older Persons, built around NMBI's six domains of competence.

An autonomous ANP in Gerontology is accountable and responsible for advanced levels of decision-making and the management of a patient caseload. The crucial factor in determining advanced nursing practice is the level of decision-making and responsibility, rather than the nature or difficulty of the task undertaken by the practitioner. Nursing knowledge and experience will continuously inform the ANP in gerontological decision-making. The ANP works in collaboration with medical, pharmacy and Health & Social Care Professional colleagues (NMBI, 2017).

Nursing specific knowledge and skills are discussed below under the core domains considered fundamental to all disciplines in providing a person centred, quality focused, interdisciplinary approach to the care of the older person.

Nursing Specific Knowledge and skills

Gerontological nurses work across the spectrum of healthcare with older people providing care at each point from health promotion to end of life. The knowledge and skills outlined in this document refer to those required to deliver gerontologically attuned care and will not refer to disease or systems specific nursing care.

DOMAIN 3 - ROLES AND RESPONSIBILITIES

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day-to-day basis to provide care for older people. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge, and abilities. Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care,
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, seamless, appropriate, and timely. Each discipline should seek to instil in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter et al, 2009).

Knowledge and cognitive processes

The practice of the gerontological nurse is based upon the best available evidence in making decisions, the person's preferences, a sustained focus on quality improvement and the nurse's critical and analytical skills. The nurse endeavours to provide safe, quality nursing practice within person-centred and evidence-based practice frameworks, which are underpinned by a shared gerontological vision and philosophy.

The nurse demonstrates accountability and the judicious use of resources to plan, organise, and deliver effective, timely quality care for the older person. The nurse keeps the person at the centre in all management decisions, whilst being cognisant of the need to balance risks with the preferences of the older person.

As a nurse you should:

Ref	Core knowledge
NUR 3.01	Be familiar with the tools used to underpin a holistic comprehensive approach to assessment which include the physical, psychological, social, cognitive, spiritual and existential needs of the older person.
NUR 3.02	Understand that fundamental to nursing practice is the relationship based on trust, understanding, compassion and support that empowers the older person to make informed choices.
NUR 3.03	Have a working knowledge of the theory and practice of the following geriatric syndromes: frailty, delirium, cognition, falls, polypharmacy, continence and malnutrition.
NUR 3.04	Have a working knowledge of the appropriate investigations related to the older person and the condition(s) they present with.
NUR 3.05	Demonstrate knowledge and understanding of advance care planning.
NUR 3.06	Have the ability to analyse information collected through interviews, observation, assessment and diagnostic tests, in order to reach an accurate nursing assessment of the older person's health and social care needs.
NUR 3.07	Understand the role of the Scope of Practice in the delegation and supervision of patient care activities and be familiar with the processes and responsibilities associated with the delegation of patient care activities.
Ref	Core skills
NUR 3.08	Manage the administration of medicines within the scope of practice, including supporting the older person to manage their own medications, as appropriate.
NUR 3.09	Consider the importance of medicines reconciliation at key transitions points in care.
NUR 3.10	Evaluate the effectiveness of care delivery interventions and recognise and act promptly upon the signs and symptoms of deterioration.
NUR 3.11	Recognise when the older persons care needs are complex and warrants referral to specialist services.
NUR 3.12	Review and revise the plan of care to support the delivery of high quality, safe care.
NUR 3.13	Identify the most appropriate team member to deliver care, which in some instances may involve delegating care to support staff.
NUR 3.14	Initiate risk-reducing activities, while carefully considering the use of all restrictions/restraints (physical and chemical) in line with national guidelines.
NUR 3.15	Demonstrate an ability to anticipate the care needs of the person to support effective discharge planning.
NUR 3.16	Allow grieving for loss of roles, capacities and relationships.
NUR 3.17	Ensure the management of safe and effective transitions of older people between care environments.
NUR 3.18	Facilitate a comfortable death, and one that is remembered with peace and comfort by those important to the older person.
NUR 3.19	Provide holistic end of life care and demonstrate an awareness of the specialist supports available and seek their intervention, as appropriate.
NUR 3.20	Verify and pronounce death, whilst being aware of circumstances where a coroner's examination is required.
NUR 3.21	Maintain dignity and privacy following death, accommodating and being respectful and sensitive to the older person's wishes and families' cultural and spiritual diversities.
NUR 3.22	Provide support for the grieving family and facilitate transition to bereavement/support services, if required.
NUR 3.23	Apply ethical and legal frameworks and knowledge of legal principles to professional nursing practice, throughout the older person's care trajectory and the care of the dying person.
Ref	Enhanced knowledge – Clinical Nurse Specialist

NUR 3.24	Have the experience and specialist knowledge and education in gerontology to promote healthy lifestyle choices and educate older people on frailty prevention measures.
NUR 3.25	Carefully consider and demonstrate an understanding and an ability to address potential ethical questions when caring for the older person; such issues could include resuscitation orders, withholding of treatment, use of artificial hydration and feeding, palliative sedation.
Ref	Enhanced skills: Clinical Nurse Specialist
NUR 3.26	Be capable of accessing resources for the delivery of optimum care, appropriate to older people.
NUR 3.27	Provide leadership in clinical practice and act as a resource and role model for gerontological nursing practice.
NUR 3.28	Use specialist gerontological nursing knowledge to support and enhance the knowledge and skills of the generalist nurse in caring for the older person.
NUR 3.29	Manage nurse led specialist services with MDT input to provide comprehensive care for the older person and their relative, friend or carer.
NUR 3.30	Optimise early identification and assessment of the older person with recognised frailty syndromes.
NUR 3.31	Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence.
NUR 3.32	Contribute to the design, development and implementation of education programmes and resources for the older person, family and/or carer thus empowering them to self - manage their condition.
NUR 3.33	Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms.
NUR 3.34	Co-ordinate investigations, treatment, therapies and patient follow-up.
NUR 3.35	Demonstrate timely use of diagnostic investigations/additional evidence-based assessments to inform clinical decision making.
NUR 3.36	Order relevant imaging and laboratory requests, as appropriate, to facilitate assessment and support clinical decision making.
NUR 3.37	Prescribe appropriate medications and undertakes medicines reconciliation in their scope as a Registered Nurse Prescriber
NUR 3.38	Prescribe and request appropriate radiological investigations within their scope of practice.
NUR 3.39	Be actively involved in nurse-led follow up and review clinics, as per agreed caseload.
NUR 3.40	Identify and agree appropriate referral pathways for the older person with chronic disease including diabetes, renal disease, arthritis, dementia, etc., as well as supporting and monitoring those having falls, non-cognitive symptoms of dementia, polypharmacy and urinary dysfunction.
NUR 3.41	Take a lead role in ensuring the service for the older person is in line with best practice guidelines and standards
NUR 3.42	Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence-based practice.
NUR 3.43	Ensure the management of safe and effective transitions of older persons between care environments.
NUR 3.44	Identify and promote specific symptom management strategies, as well as the identification of triggers which may cause exacerbation of symptoms.
NUR 3.45	Co-ordinate investigations, treatment, therapies and patient follow-up.
NUR 3.46	Develop collaborative working relationships with local Clinical Nurse Specialist, Advanced Nurse Practitioners and other nursing colleagues, as appropriate; developing person centred care pathways, to promote an integrated model of care delivery
NUR 3.47	Establish and maintain a register of older people within the CNS caseload and provide yearly reports/updates on caseload and activity levels, as required for service planning.
NUR 3.48	Identify, initiate and conduct nursing and MDT audit and research projects, relevant to the area of practice.
NUR 3.49	Contribute to the development of gerontological nursing and related care standards and guidelines.

NUR 3.50	Develop your Scope of Practice in line with new service provisions to support improvements in patient outcomes and in the quality and range of available services.
NUR 3.51	Network with other CNS in related professional associations, to assist efficient, effective health service delivery to the older person.
Ref	Advanced knowledge – Registered Advanced Nurse Practitioner
NUR 3.52	Have advanced knowledge of the pathophysiology/ disease trajectory of acute and chronic diseases and conditions, as they relate to the older person.
NUR 3.53	Exhibit comprehensive knowledge of therapeutic interventions including pharmacological and non-pharmacological advanced nursing interventions, supported by evidence-based policies, procedures, protocols, and guidelines, relevant legislation, and relevant professional regulatory standards and requirements.
Ref	Advanced skills – Registered Advanced Nurse Practitioner
NUR 3.54	Accept accountability and responsibility for decision making at an advanced level.
NUR 3.55	Select a professional practice model that provides a framework for practice, focusing on person centred care, interpersonal interactions and the promotion of healing environments, recognising that ANPs work in partnership with their multidisciplinary colleagues.
NUR 3.56	Articulate safe boundaries and engage in timely referral and collaboration for those areas outside his/her scope of practice, experience, and knowledge and skills by establishing, in collaboration with key stakeholders, referral pathways and locally agreed policies, procedures, protocols and guidelines to support and guide the CNS and ANP service.
NUR 3.57	Demonstrate targeted physical examination technique.
NUR 3.58	Conduct a comprehensive holistic health assessment using evidenced based frameworks, policies, procedures, protocols and guidelines to determine diagnoses and inform autonomous advanced nursing care.
NUR 3.59	Synthesize and interpret assessment information; particularly history, prior treatment outcomes, physical findings and diagnostic data to identify normal, at risk and subnormal states of health.
NUR 3.60	Demonstrate timely use of diagnostic investigations / additional evidence based advanced assessments to inform clinical-decision making.
NUR 3.61	Order relevant imaging and laboratory requests, as appropriate to facilitate assessment and support clinical decision making.
NUR 3.62	Analyse results against age appropriate and patient specific norms.
NUR 3.63	Prescribe appropriate medications and undertakes medicines reconciliation in their scope as a Registered Nurse Prescriber.
NUR 3.64	Prescribe and request appropriate radiological investigations within their scope of practice.
NUR 3.65	Assess the impact of: • Acute and chronic conditions and diseases (e.g. dementia, delirium and other neurological conditions). • Chronic symptoms.
NUR 3.66	Be actively involved in nurse led follow up and review clinics, as per agreed caseload.
NUR 3.67	Identify when appropriate to discharge the patient from the ANP caseload and refer back to community services. Discharge patients from the service as per an agreed supporting policy, procedure, protocols, guidelines and referral pathways.
NUR 3.68	Demonstrate accountability in considering access, cost and clinical effectiveness when planning, delivering and evaluating care (for example key performance areas, key performance indicators, metrics).
NUR 3.69	Recognise signs of a life limiting condition and assist the person to access specialist palliative care, where appropriate.
NUR 3.70	Lead on the development of local and national educational programmes.
NUR 3.71	Provide clinical leadership and professional scholarship, in order to develop nursing practice and health policy at local, regional and national level.
NUR 3.72	Contribute to nursing research to shape and advance nursing practice, education and health care policy at local, national and international levels.

NUR 3.73	Facilitate clinical supervision and mentorship through utilising one's expert knowledge and clinical knowledge and skills.
NUR 3.74	Engage in health policy development, implementation, and evaluation (for example key performance indicators from national clinical and integrated care programme/HSE national service plan/ local service need to influence and shape the future development and direction of advanced practice in older people's care.
NUR 3.75	Support person centred care through the implementation of an individual's advance healthcare directive.
NUR 3.76	Demonstrate and share expertise in nursing diagnosis, leading innovative strategies and interventions in communication with older people.
NUR 3.77	Be confident to work within your own ethical and moral values and have the ability to address issues that conflicts with your ethical or moral values.
NUR 3.78	Provide leadership in the translation of new knowledge to clinical practice in gerontological nursing.
NUR 3.79	Use effective communication and research strategies to engage with marginalised and unrepresented groups of older people e.g. travelling community, Lesbian, Gay, Bisexual & Transgender (LGBT) Community.
NUR 3.80	Develop new agile and flexible nurse led services utilising digital platforms, new care environments, to enable access to a senior decision maker within the clinical team.
NUR 3.81	Articulate and promote the advanced practice nursing service in clinical, political and professional contexts {for example presenting key performance outcomes locally and nationally; contributing to the service's annual report; participating in local and national committees to ensure best practice, as per the relevant national clinical and integrated care programme).
NUR 3.82	Build frameworks for partnership, team building and service quality and governance.
NUR 3.83	Demonstrates leadership in open communication with equal contribution, shared decision-making, collective problem-solving, coordination to enable interdependent work, and developing respectful professional relationships.
NUR 3.84	Engage in the design of clinical supervision arrangements to transfer of knowledge and skill with shared understanding of roles across the interprofessional team.
NUR 3.85	Identify opportunities to work collaboratively across services building effective relationships in developing and building Older Persons pathways of care.

* This Domain is complementary to the HSE nationally agreed Nursing Job Descriptions for Staff Nurse/ Clinical Nurse Specialist / Candidate Clinical Nurse Specialist / Candidate Advanced Nurse Practitioner / Registered Advanced Nurse Practitioner Older Persons Services.

Additional reading

https://www.nmbi.ie/nmbi/media/NMBI/Publications/working-with-older-people.pdf?ext=.pdf

OCCUPATIONAL THERAPY

Discipline-Specific Knowledge and skills - OCCUPATIONAL THERAPY

MEMBERSHIP OF OCCUPATIONAL THERAPY WORKING GROUP

Paul Maloney, Occupational Therapist Manager in Charge III, Beaumont Hospital

AOTI: Older Persons Advisory Group (OPAG)

- Aislinn Griffin, St James Hospital, OPAG CPD co-ordinator
- Breege McCafferty, Letterkenny General Hospital
- Fiona Tobin, Tallaght University Hospital
- Jane Meade, St Luke's Hospital Kilkenny
- Joanne Murphy, Clontarf Hospital
- Leigh O'Connell, St Lukes Hospital Kilkenny
- Mellissa McGrath, CHO 4
- Nicola Carrabine, Mater Misericordiae University Hospital
- Ruth Staunton, OPAG secretary
- Ruth Usher, UCC
- Sarah Royane, Mayo general hospital
- Sinead McGirr, Our ladies Hospice, Harold's Cross
- Siobhan Delaney, Royal hospital Donnybrook
- Siobhan Marshall, St Mary's hospital, Phoenix Park, Co-chair OPAG

Other Contributors

- Occupational Therapy Department Beaumont Hospital

Introduction

In order to work as an Occupational Therapist (OT) in the Republic of Ireland, you must be registered with CORU and adhere to its code of professional conduct and ethics. Within the Irish setting, occupational therapists work within the following clinical grades:

Entry Level/Staff Grade Therapist

Upon entry into the workforce, entry level/Staff Grade therapists utilise knowledge, skills and abilities that have been attained from completion of a Bachelor of Science (Honors) or a Master of Science in Occupational Therapy from a third level institution. Core skills develop through experiential learning, supervision and continuous professional development within various clinical settings whilst operating at entry level/staff grade.

Senior Therapist

At senior level, therapists build upon existing skills and possess a greater depth of specialist knowledge and complexity of responsibility which may include supervision of entry level/staff grade therapists and responsibilities for a clinical area/service.

Clinical Specialist Therapist

At Clinical Specialist level, therapists are expected to demonstrate excellent clinical leadership in driving change, participate in post graduate research and operate with an expert level of proficiency. They consistently demonstrate excellence in a particular clinical area and often manage a greater depth and complexity of responsibility than at senior level.

Advanced Clinical Practice (ACP) is not a new level of practice for occupational therapists working within the NHS and encompasses several professions with legal prescribing status who are permitted to operate at this clinical level. There are emerging examples of this role within the Irish healthcare setting where occupational therapists are demonstrating their ability to work autonomously at an expert level of clinical practice, possess advanced complex decision-making skills, be accountable, self-directed and deliver significant examples of quality improvements in terms of service redesign and delivery of services for older persons. It is hoped that ACP occupational therapyroles will be officially recognised and graded within the Irish healthcare setting in the near future.

Occupational Therapists engage with older people across a broad and varied spectrum of services, with many subspecialties sitting under this umbrella. These services span across acute; physical and mental health services, community; physical and mental

services and residential care. The Association of Occupational Therapists of Ireland (AOTI) is the professional body serving, promoting and representing occupational therapists and highlights that occupational therapists offer support to people with physical, psychological and social problems and enable them to live as independently as possible by helping them to complete everyday activities when faced with illness, injury, and disability or challenging life events. This ethos is echoed in the definition of Occupational Therapy by the World Federation of Occupational Therapy which defines the occupational therapists role as 'a client-centered profession where the primary goal is to enable people to participate in everyday life. Occupational therapists work with individuals to enable them to engage in the occupations they want, need or are expected to do and as required, modify the occupation or environment to support engagement (WFOT, 2012). The Royal College of Occupational Therapy (RCOT) have emphasised the unique role that occupational therapists hold within older person's services, some of which include:

- Enabling and supporting older persons to continue with daily activities that maintain their health and wellbeing.
- Understanding the difficulties that older persons may encounter and support social interaction through meaningful activity.
- Demonstrating expertise in the assessment of cognition and development of strategies to compensate for potential difficulties.
- Holistic assessment and management of falls in older persons.
- Providing education to older persons and their families on strategies and adaptations

Occupational Therapists are required to be holistic in our approach and indeed possess the capability to adapt to the changing needs of each individual client and/or service.

In recent years, this ability to adapt to the needs of older persons has been translated into practice through the emergence of new occupational therapy services in a number of clinical areas such as the Emergency Department, integrated and re-enablement focused community teams and emergency response services.

DOMAIN 3 - ROLES AND RESPONSIBILITIES

Roles and responsibilities incorporate the knowledge and skills required within each discipline to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge, and abilities. Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, seamless, appropriate, and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

An Occupational Therapist should:

Occupational performance	
Ref	Core knowledge
OT 1.01	Understand that meaningful activity is critical when engaging with, and developing a strong therapeutic relationship older persons. Meaningful activities can encompass Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). ADL's may include bathing/showering, toileting, dressing, feeding and functional mobility. IADL's may include care of others, financial management, driving and shopping.
OT 1.02	Understand the concept of, and all components of the occupational therapy process.

OT 1.03	Understand how occupational therapists are essential members of the MDT in the assessment, rehabilitation and optimisation of function with older persons with the aim of maximising independence and quality of life.
OT 1.04	Understand how occupational therapists play an essential role in the assessment of visual perceptual deficits that may arise in older persons.
OT 1.05	Understand age related cognitive changes that may arise in older persons i.e. deficits in attention, concentration, executive function and memory and their associated impact on function. Consideration should also be given that deficits may be present as a result of the following: · Mild Cognitive Impairment (MCI) · Chronic progressive conditions such as Dementia, Parkinsons, etc · Delirium · Longstanding/recent Acquired/Traumatic Brain Injury
OT 1.06	Understand how occupational therapists have a key role in the assessment of cognition and assist in the diagnostic process (and treatment plan) of many chronic progressive conditions in older persons.
OT 1.07	Understand the term Delirium, including its most common causes and types encountered including Hyperactive, Hypoactive and mixed.
OT 1.08	Understand the term Dementia including the types encountered under this umbrella group and associated symptoms which may impact on the functional performance of an older person.
OT 1.09	Understand the differences between Delirium, Dementia and Depression symptoms in older persons.
OT 1.10	Understand the core principles, theory and biomechanics of optimal positioning of older persons in bed and/or seating systems, with a clear focus on optimising function and consideration of the person's environment, setting and personal goals.
OT 1.11	Demonstrate basic understanding of fluid balance, input and output and the associated impact on cognition and function in older persons.
OT 1.12	Demonstrate understanding of normal and abnormal blood results and the impact that these can have on physical and cognitive functioning in older persons (if irregularities are present).
OT 1.13	Understand the importance of appropriate supports and cognitive rehabilitation strategies that allow many older persons to live independently with a cognitive impairment.
OT 1.14	Understand the person-occupation environment relationship as it pertains to older person.
OT 1.15	Understand the importance of analysing and adapting environments to increase function, social participation and quality of life for an older person.
OT 1.16	Demonstrate understanding of contra-indications and side effects of common analgesics experienced by older persons, and the possible impact on cognition and function, particularly if multi-morbidities are present.
Ref	Core skills
OT 1.17	Demonstrate the Occupational Therapy process which should include: · Good observation and interviewing technique to build rapport with the older person and gather information. · Use appropriate, standardised and non-standardised assessments and/or tools to identify occupational and functional needs in the areas of self-care, productivity, and leisure. · Collaboratively identify goals for intervention with the older person. · Plan, grade, implement and modify interventions that are outcome based and relevant to the older person's goals. · Directing outcomes in collaboration with the older persons and their families. · Make onward referrals to other agencies or professionals which may, for example, include ALONE, Age Action, Alzheimer's Society, Primary Care Teams in order to optimise responses to the older persons needs · Planning and implementing discharge and follow-up with all relevant parties.
OT 1.18	Demonstrate evidenced based professional reasoning: · Demonstrate a logical and systematic approach to problem solving and decision making with consideration of the multi-morbidities that older persons often present with. · Engage in clinical reasoning based on Occupational Therapy practice and supporting evidence in the area of gerontology.

OT 1.19	Demonstrate use of appropriate and commonly used standardised tools that accurately assess for: · Mild Cognitive Impairment · Dementia · Delirium · ABI/TBI in the older adult
OT 1.20	Demonstrate clinical knowledge and skills when completing the occupational therapy process considering the cognitive, physical, and functional impairments that may present with common renal conditions in older persons.
OT 1.21	Demonstrate ability to assess visual perceptual problems in older persons which may include: · Visual field problems · Visual scanning · Oculomotor control · Visual acuity · Visual attention

OT 1.22	Demonstrate the core principles, theory, and biomechanics of optimal positioning in meeting the needs of older persons when indicated and should be able to: · Assess an older persons seating and pressure care needs with clinical consideration of their occupational performance/postural requirements. · Demonstrate clinical reasoning in determining appropriate seating systems for older persons taking the following into consideration o Agitation Levels o Arousal Levels o Cognitive Status o Current Medical Status o Discharge Destination (if applicable) o Perceptual Status o Physical Endurance o Pressure care and weight distribution including Waterlow Score o Seating Tolerance o Skin Integrity o Visual Status
OT 1.23	Demonstrates ability to use the below rating scales to effectively assess pain levels that an older person may be experiencing: · Numeric rating scale · Descriptive rating scale · Visual analogue scale
Ref	Enhanced knowledge
OT 1.24	Identifies future development needs for occupational therapy practice in order to meet the needs of the service user, community, or population, including those in complex situations.
OT 1.25	Demonstrate enhanced understanding of the importance of fluid balance, (input and output) and impact on function for an older person.
OT 1.26	Demonstrate understanding of signs and symptoms of common renal conditions and how they impact on the older person.

OT 1.27	Demonstrate enhanced understanding of normal and abnormal infection markers and laboratory test results and the impact that these can have on physical and cognitive functioning of an older person (if irregularities are present).
OT 1.28	Demonstrate understanding of nociceptive and neuropathic pain.
OT 1.29	Demonstrate understanding of the World Health Organisation (WHO) analgesic ladder and common analgesics.
OT 1.30	Demonstrate enhanced understanding of pain management. Understands the effects of common opioids and NSAIDS on older persons and need for a different approach to pain management than with younger adults.
Ref	Enhanced skills
OT 1.31	Demonstrate an enhanced understanding of the Occupational Therapy process and skillfully analyse the use and adaptation of occupations related to self-care, productivity and leisure and adapt approach to older persons who may have a number of frailty markers with associated symptoms that impact on functional performance.
OT 1.32	Demonstrate expertise in the assessment of cognitive and functional capacity to enable older persons with cognitive impairment and life limiting conditions to communicate their needs and maximise engagement with others.
OT 1.33	Exercise a high degree of professional autonomy in the analysis of highly complex situations that contribute to the implementation of a treatment or management strategy for older persons.
OT 1.34	Design and implement occupational therapy patient care pathways with the aim of providing excellent standards in care which are based on national/ international best practice guidelines.
OT 1.35	Demonstrate enhanced ability to use and adapt the below rating scales to effectively to assess pain levels in an older person who may or may not have a language impairment. · Numeric rating scale · Descriptive rating scale · Visual analogue scale

Other Frailty Conditions/Syndromes and Considerations

(The below list is not exhaustive, but is a sample of common conditions/syndromes encountered by occupational therapists working with older persons)

Falls considerations in older persons	
Ref	Core knowledge
OT 1.36	Understand the intrinsic and extrinsic factors that may contribute to falls in older persons including common medical conditions and medications that may increase risk of falls i.e. red flags for cardiac related falls.
OT 1.37	Understand the benefits of bone protection in older persons.
OT 1.38	Understand local guidelines and falls pathways for older persons in the acute and/or community settings
OT 1.39	Understand the importance of appropriate equipment that can minimise or monitor falls in older persons.
Ref	Core skills
OT 1.40	Demonstrate ability to gather clear information related to a fall/collapse and frequency, is able to differentiate red flags, is able to identify cause of falls and implement an appropriate management plan for the older person when appropriate.
OT 1.41	Demonstrate ability to effectively communicate with the MDT regarding an older person's falls risk and management plan.
OT 1.42	Demonstrate ability to identify and manage reduced confidence, self-limitation of activity and fear of falling in older persons and adapts treatment interventions as appropriate.
OT 1.43	Demonstrate ability to appropriately manage a fall on the ward/home/ community setting including understanding of postural drops.
OT 1.44	Demonstrate ability to provide advice and education to patients and families on falls management and equipment including non-pharmacological management of postural hypotension.

Ref	Enhanced knowledge
OT 1.45	Demonstrate enhanced understanding of national and international guidelines on falls management in older persons by auditing current practice against said guidelines and striving to embed these guidelines into the local system/pathways.
OT 1.46	Demonstrate enhanced understanding of medical conditions, multi-morbidity and medications that may increase a risk of falls in older persons.
OT 1.47	Demonstrate enhanced understanding of the components assessed in an acute fall's workup: · Investigative questions to ask. · Medical investigations including ECG, Lying/Standing BP, Glucose, bloods, suspect/culprit medications · Silver trauma
OT 1.48	Demonstrate enhanced knowledge of NICE guidelines regarding falls assessment and management.
OT 1.49	Demonstrate enhanced understanding of assessment tools (standardised and non-standardised) available to identify falls risk in older persons.
OT 1.50	Demonstrate enhanced understanding of current thinking/research in the falls arena of older adults.
OT 1.51	Demonstrate enhanced understanding of the considerations needed when assessing a fall in an older person with suspected head injury or an unwitnessed fall including NICE recommendations on need for further imaging.
Ref	Enhanced skills
OT 1.52	Demonstrate enhanced ability to assess for orthostatic hypotension, interpret the results and understands the possible impact on function.
OT 1.53	Demonstrate enhanced ability to address the components of a comprehensive falls assessment (including appropriate assessment tools) and demonstrate how the outcome of this assessment will impact on an older person.
OT 1.54	Demonstrate enhanced ability to clinically reason whether a fall could be syncopal or non-syncopal in origin in an older person and adapt treatment as appropriate.

Respiratory considerations in older persons	
Ref	Core knowledge
OT 1.55	Understand basic anatomy and physiology of the respiratory system and associated age-related changes that may occur in older persons.
OT 1.56	Understand common respiratory conditions and their associated impact on function in older persons.
OT 1.57	Understand the role of Respiratory Physiotherapy, Speech and Language Therapy, Respiratory Clinical Nurse Specialist or Advanced Nurse Practitioner and when/how to refer where appropriate.
OT 1.58	Understand the benefits of pacing and energy conservation in older adults with respiratory conditions.
Ref	Core skills
OT 1.59	Demonstrate understanding of the signs and symptoms of the breathless older person.
OT 1.60	Demonstrate understanding of the importance of chest x-ray results and how these results may alter the occupational therapy assessment and treatment of an older person.
OT 1.61	Demonstrate understanding of appropriate questions/outcome measures to assess a breathless older person at rest and during functional activities.
Ref	Enhanced knowledge
OT 1.62	Demonstrate an enhanced understanding of the reasons for oxygen therapy with older persons, contra-indications and the impact of oxygen use during therapy intervention, including variations in known respiratory conditions such as COPD whilst considering impact on function in an older person.
Ref	Enhanced skills
OT 1.63	Demonstrate enhanced ability to request an x-ray through the appropriate processes, review and interpret relevant respiratory information on a chest x-ray report and anticipate the likely impact of the results on the older persons function prior to assessment & treatment.

Cardiovascular considerations in older persons	
Ref	Core knowledge
OT 1.64	Understand basic anatomy and physiology of the cardiovascular system and associated age-related changes that may occur in older persons.
OT 1.65	Understand the importance of recognising common cardiovascular diseases and risk factors that may be common in older persons.
OT 1.66	Understand common cardiovascular medications and possible implications for older person's cognitive and functional performance.
Ref	Core skills
OT 1.67	Demonstrate ability to assess and monitor basic cardiac function and how the results may alter the OT assessment and treatment i.e. heart rate and working within safe parameters.
Ref	Enhanced knowledge
OT 1.68	Demonstrate enhanced understanding of features of a normal ECG rhythm and Troponin including normal range and reasons for variation, awareness of how the results may postpone/alter the occupational therapy assessment and treatment of an older person.
Ref	Enhanced skills
OT 1.69	Demonstrate enhanced ability to understand and interpret what are safe parameters in patients with cardiac related issues prior to an occupational therapy assessment and/or intervention with an older person.

Orthopaedic considerations in older adults	
Ref	Core knowledge
OT 1.70	Have a basic understanding of the skeletal system and in particular structural changes that may occur with age.
OT 1.71	Understand the signs and symptoms of a fracture and clinically reason whether not an occupational therapy intervention is appropriate.
OT 1.72	Understand the most common types of fractures affecting older persons i.e. humeral, colles, vertebral, hip fractures and the possible associated impact on functional performance.
OT 1.73	Understand the signs and symptoms of an infected wound, risks of infection and possible impact on cognition and function of an older person.
OT 1.74	Understand various weight bearing status and how this may functionally impact an older person.
Ref	Core skills
OT 1.75	Demonstrate ability to adapt an occupational therapy assessment and treatment of an older person depending on the injury and/or site of fracture and baseline level of function.
OT 1.76	Demonstrate ability to assess an older person's function with consideration for their weight bearing status and likely need for taught compensatory strategies.
Ref	Enhanced knowledge
OT 1.77	Demonstrate enhanced understanding of local trauma pathways and informs specialist trauma teams for older persons.
OT 1.78	Demonstrate enhanced understanding and interpretation of language used in results and reports for plain film x-ray, MRI, and CT imaging.
OT 1.79	Demonstrate enhanced understanding of the impact of fractured ribs on an older person's respiratory function and appropriate local pathways. Understands the difference in pain management needs in older adults and the risk of a flail chest.
OT 1.80	Demonstrate enhanced understanding of Arthritis and Arthrosis and their associated impact on function.
OT 1.81	Demonstrate enhanced understanding of the impact of upper/lower limb/ vertebral fractures including stable/nonstable fractures/burst fractures / spinal precautions and their impact on function in an older person.
OT 1.82	Demonstrate enhanced awareness of red flags when assessing back pain in older persons.
OT 1.83	Demonstrate enhanced understanding of the relationship between adequate pain control when fractures require conservative management and occupational therapy e.g. early mobilisation and functional activity as tolerated for pubic ramus fractures with pain well controlled.

Ref	Enhanced skills
OT 1.84	Demonstrate ability to fabricate and fit a variety of splints/appliances in line with local policies or use “off the shelf” splints as appropriate and when clinically indicated in older adults with awareness of other comorbidities that may require consideration i.e. Osteoarthritis (OA) and Rheumatoid Arthritis (RA) affecting the upper limb.
OT 1.85	Demonstrate enhanced ability to educate older persons in relation to compensatory techniques to promote functional independence when clinically appropriate.
OT 1.86	Demonstrate enhanced therapeutic management of an older person who has suffered a fracture and does not require surgical intervention.

Neurological considerations in older persons	
Ref	Core knowledge
OT 1.87	Demonstrate understanding of the central and peripheral nervous system.
OT 1.88	Demonstrate understanding of the components of a neurological assessment and considers the additional complexity that existing frailty markers may add.
OT 1.89	Demonstrate basic understanding of common neurological conditions and associated common symptoms that may impact an older person with existing frailty markers. This list of conditions is not exhaustive but may include: · Dementia · Parkinson’s Disease (PD) · Stroke and Transient Ischemic Attack (TIA)

Ref	Core skills
OT 1.90	Demonstrate ability to complete an OT functional assessment, develop a problem list and treatment plan considering any pre-existing frailty markers and/or neurological condition/s.
OT 1.91	Demonstrate ability to complete the occupational therapy process considering the cognitive, physical, and functional impairments that may be present with the following conditions: (not an exhaustive list) · Dementia · Parkinson’s Disease (PD) · Stroke and TIA
Ref	Enhanced knowledge
OT 1.92	Demonstrate enhanced understanding of local Neurological pathways and how to access acute neurology services for an older person.
OT 1.93	Demonstrate enhanced understanding of the impact of multimorbidity in an older person with a neurological condition.
OT 1.94	Demonstrate enhanced understanding of the on cognition, mobility and/or function.
OT 1.95	Demonstrate enhanced clinical knowledge of common neurological conditions and associated symptoms that may impact on an older person with existing frailty markers. This list of conditions is not exhaustive but may include: · Dementia · Myopathies · Parkinson’s Disease (PD) · Stroke and TIA · Acquired and Traumatic Brain Injuries (ABI/TBI) in older persons

Ref	Enhanced skills
OT 1.96	Demonstrate ability to carry out a comprehensive occupational therapy neurological assessment, develop a problem list, and treatment plan whilst considering the impact of any pre-existing frailty markers and/or neurological condition/s that an older person may be experiencing.
OT 1.97	Demonstrate enhanced clinical skills when completing the occupational therapy process considering the cognitive, physical, and functional impairments that may be present with the following conditions: (not an exhaustive list) · Dementia · Myopathies · Parkinson's Disease (PD) · Stroke and TIA · Acquired and Traumatic Brain Injuries (ABI/TBI) in older persons

PHARMACY

Discipline-Specific Knowledge and skills - PHARMACY

MEMBERSHIP OF PHARMACY WORKING GROUP

The following Pharmaceutical Society of Ireland registered pharmacists, some of whom are members of a working group from the Hospital Pharmacists' of Ireland, Care of Older People Special Interest Group, had input and prepared this section:

- Chairperson: Niamh McMahon, Chief 2 Pharmacist, St. James's Hospital & Trinity College Dublin
- Joanna Carroll, Senior Pharmacist, Beaumont Hospital
- Bernadette Flood, Senior Pharmacist, St Joseph's Centre, Daughters of Charity Disability Support Services
- Helen Heery, Senior Pharmacist, Portiuncla Hospital
- Clare Kinahan, Senior Pharmacist, HSE iSimpathy Project
- Asst. Prof. Eimear Ni Sheachnasaigh, Trinity College Dublin
- Marguerite Vaughan, Senior Pharmacist, Tallaght University Hospital.

Introduction

Anyone wishing to practise as a pharmacist in Ireland must first register with the PSI. The PSI must be satisfied that the requirements for a pharmacist to register are met. This registration must then be renewed on an annual basis. There are different routes of registration for pharmacists depending on where a person has graduated and trained as a pharmacist. Further information is available on the PSI website. Legislation governs the practice of pharmacy in Ireland, as well as what should be known by a practising registered pharmacist in Ireland to competently discharge their professional responsibilities and duties https://www.thepsi.ie/tns/about-psi/legislation.aspx. Pharmacists can work in different areas of practice looking after older people e.g. community or hospital practice. Hospital pharmacists are currently assigned to one of four grades: basic grade, senior grade, Chief 2, and Chief 1. The hospital pharmacy career structure has undergone review and the revised structure will be implemented.

Older people are particularly vulnerable to the harmful effects of medicines. As many as one in ten hospital admissions in over 65-year-olds are due to adverse drug events with approximately 70% of these being potentially avoidable (Cahir, 2020). Pharmacists, as medicines experts, play a significant role in optimising medication use and reducing the use of unnecessary, and potentially harmful, medicines in older people. They possess specialist knowledge about the impact of ageing on the pharmacokinetics and pharmacodynamics of medicines, and how this in turn affects safe prescribing of medicines in older adults. Through in-depth medication usage reviews and making deprescribing recommendations, pharmacists can lead to improved adherence to prescribed treatments, significant improvements in prescribing appropriateness, reduced healthcare resource usage, including a reduction in A&E presentations and improved patient satisfaction with care (McKee et al., 2016; Miller et al., 2017; Mair et al., 2020).

Polypharmacy is a particular concern in older adults, as it is linked to frailty. Addressing polypharmacy, has been cited by the World Health Organisation (WHO) as a major priority to reduce medication related harm (Donaldson et al., 2017). The complexity and heterogeneity of patients with multimorbidity and polypharmacy means that disease-specific guidelines are often inadequate, making clinical decision difficult. To address this challenge, guidelines have been developed on multimorbidity and tools to address polypharmacy (Kernick et al., 2017; Muth et al, 2018). Pharmacists, adopting a person centred approach, can identify the goals of treatment and work with the older adult to ensure that these are being achieved. For example, blood sugar control: Intensive glucose control is beneficial in preventing cardiovascular events in patients with a short duration of diabetes mellitus and no pre-existing cardiovascular disease (Turnbull et al., 2009). However, long follow-up (>10 years) is necessary to demonstrate a beneficial effect on macrovascular complications (Nathan et al, 2013). Less-stringent HbA1c goals [e.g. <8% (64 mmol/mol) or ≤9% (75 mmol/mol)] may be adequate for older patients with multiple comorbidities (Cosentino et al, 2020).

Through medicines reconciliation and medication review, pharmacists have been

shown to reduce medication-related harm e.g. medication errors and omissions, by supporting older patients when they transfer between care settings. Pharmacists are also a valuable resource for patients and other healthcare professionals, as they offer support and advice on all matters related to medicines use, and are a trusted source of evidence-based healthcare information. Pharmacists have unique expertise in the procurement, preparation, distribution, dispensing, disposal safe & secure storage, of medical products.

DOMAIN 3 - ROLES AND RESPONSIBILITIES

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day-to-day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge, and abilities. Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, seamless, appropriate, and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

As a Pharmacist you should:

Ref.	General practice: core knowledge and skills
P3.01	Adhere to the roles and responsibilities that are required to be registered as a Pharmacist with the Pharmaceutical Society of Ireland (PSI) and adhere to their ethical, legal and professional requirements that inform safe and ethical pharmacy practice. i.e. adherence to PSI Core Competency Framework (CCF) and Code of Conduct.
P3.02	Undertake appropriate learning and development activities to maintain and develop knowledge and skills and professional performance and maintain a record of CPD as per Irish Institute of Pharmacy (IIOP) recommendations .
P3.03	Conduct medication reviews, to optimise medication use in the older adult, with the aims of reducing the risk of medication-related harm and improving patient outcomes and quality of life.
P3.04	Access most up-to-date, reputable information and reference sources about medicines.
P3.05	Understand the pharmacokinetic and pharmacodynamic changes in older people as they relate to drug handling.
P3.06	Understand the potential for adverse drug reactions (ADRs) and takes steps to avoid, minimise, recognise and manage them.
P3.07	Check for drug-drug, drug-food and drug-disease interactions and take measures to minimize risks to the patient.
P3.08	Accurately complete and routinely check calculations relevant to prescribing and drug dosing.
P3.09	Know that potential for medication errors increases in those on multiple medicines, and the impact of errors, when they occur in older persons, can be more serious due to disease state and other factors. Systems should be in place to identify, report and learn from errors, including the reporting and investigation of near miss and error events when they occur.
P3.10	Consider the potential for misuse of medicines.

P3.11	Communicate information about medicines and what they are being used for when sharing or transferring responsibilities/ information either between healthcare professionals or across healthcare settings so as to ensure continuity of patient care at transitions of care
P3.12	Understand the principles of concordance and adherence to support self-management of medicines in older people, particularly in relation to physical and cognitive dysfunction.
P3.13	Has knowledge of the range of compliance aids available to support greater adherence and independence with medicines use, and identifies opportunities where their use may be beneficial
P3.14	Have a knowledge of non-prescribed (over-the-counter, complementary) medicines used by older people and implications for adverse effects, interactions and use with prescribed therapy
P3.15	Understand the risks associated with medication use in the older person considering the paucity of evidence available for older age groups, due to exclusion from clinical trials
P3.16	Understand the implications of sensory impairment and functional decline for medicines management of older people.

Ref.	Patient assessment: core knowledge and skills
P3.17	Take an accurate medication history and ensure medicines reconciliation, including recording allergies and intolerances, plus relevant medical, and social history.
P3.18	Understand how to optimise medicines management of the condition(s) being treated, and monitor response to treatment.
P3.19	Understand and recognise appropriate and inappropriate prescribing & polypharmacy and know how to address it.
P3.20	Assess medication adherence in a non-judgmental way and understand the different reasons non-adherence can occur (intentional or non-intentional) and how best to support patients/carers.

P3.21	Recognise potential adverse drug reactions (ADRs) affecting older people, including adverse drug reactions that may cause hospital admission, and potential prescribing cascades.
P3.22	Demonstrate ability in appropriate selection of formulation (e.g. liquid, modified release), dose frequency (once daily versus multiple doses) and devices (insulin pens, inhaler aids) to support medicines optimisation and adherence.
P3.23	Understand the medicines optimisation needs of special populations of older people e.g. housebound, institutionalised residents and frail patients, and those with intellectual disability and how care settings affect medicines management.
P3.24	Prioritise patients for medication review, depending on age, frailty, polypharmacy, high risk medicines, residential setting, life expectance etc, and also in line with HIQA requirement to conduct medicine use reviews in providing care to persons in residential care settings

Ref.	Providing information: core knowledge and skills
P3.25	Give the patient/carer clear, understandable and accessible information about their medicines (e.g. what it is for, how to use it, possible unwanted effects and how to report them, expected duration of treatment) tailored to the older person's needs, health literacy and acknowledging any limitations e.g. non-English speaking.
P3.26	Use patient decision aids where appropriate to assist the older person
P3.27	Check the patient/carer's understanding of the patient's medicines management, monitoring and follow-up. Ensure that the patient/carer knows what to do if their condition deteriorates or if there is no improvement in response to drug therapy within a specific time frame.
P3.28	Guide patients/carers on how to identify reliable sources of information about their medicines and treatments.
P3.29	When possible, encourage and support patients/carers to take responsibility for their medicines and self-manage their conditions.

P3.30	Optimise communication about medication therapy on transfer of care between settings.
P3.31	Be able to identify and actively respond to the medicines information needs of other health care professionals, accessing and interpreting specialized reference sources to ensure best practice, and to support the provision of evidence-based practice in a variety of care settings.

Ref.	Making prescribing/ deprescribing recommendations: Core knowledge and skills
P3.32	Work with the patient/carer in partnership to make informed choices, agreeing treatment goals that respect patient preferences including their right to refuse or limit treatment based on their individual values, beliefs and expectations about their health and treatment with medicines.
P3.33	Explain the rationale behind and the potential risks and benefits of drug management options in a way the patient/carer understands. Explore the patient/carers understanding of this information.
P3.34	Engage in evidence-based clinical reasoning using a logical and systematic approach to problem solving and decision making
P3.35	Consider both non-pharmacological (including no treatment &/or social prescribing) and pharmacological approaches to modifying disease and promoting health.
P3.36	Consider all pharmacological treatment options including optimising doses and de-prescribing.
P3.37	Apply understanding of the mode of action and pharmacokinetics of medicines and how these may be altered (e.g. age, weight, renal impairment, liver disease, genetics)
P3.38	Assess how co-morbidities, existing medication, allergies, contraindications, social circumstances and quality of life impact on management options.
P3.39	Take into account any relevant patient factors (e.g. ability to swallow) and the potential impact on route of administration and formulation of medicines.
P3.40	Make prescribing and deprescribing recommendations only within own scope of practice and recognize the limits of own knowledge and skill.

Ref.	Monitoring patients, review and safety: core knowledge and skills
P3.41	Establish and maintain a plan for reviewing the patient's treatment, ensures that the effectiveness of treatment is monitored and potential unwanted side-effects are identified.
P3.42	Ensure any necessary laboratory monitoring is carried out to ensure patent safety and optimization of medication.
P3.43	Detect and report suspected adverse drug reactions and medication incidents using appropriate reporting systems i.e. Health Products Regulatory Agency (HPRA)
P3.44	Recognise that frailty results in increased vulnerability to medication harm, and recognise the relationship between frailty and polypharmacy
P3.45	Recognise the inherent risks to patients when medicines are prescribed by multiple prescribers from various specialities.
P3.46	Make reasonable accommodations where required, when supporting people with additional needs e.g. intellectual disabilities, cognitive impairment.

Ref.	Enhanced skills
P3.47	Ability to carry out a comprehensive medication review in the older person which includes:
	1. Obtaining consent from patient.
	2. Collaboratively identify goals of medication therapy.
	3. Establish which medications are essential to achieve these goals.
	4. Identify potentially inappropriate prescriptions using appropriate implicit and explicit medication review tools.

	5. Suggest appropriate changes to the medication regime to help improve medication appropriateness and achieve collaborative goals and improve quality of life.
	6. Plan follow-up and evaluate outcomes in collaboration with the patient.
	7. Adapt the management plan in response to on-going monitoring and review of the patient's condition and preferences.
P3.48	Demonstrate an understanding of the risks associated with medicines use and the potential for adverse effects, including increased fall's risk.
P3.49	Lead, facilitate and engage in audit and research on medicines use in the older person in order to improve practice.
P3.50	Demonstrates leadership in the development and delivery of education on medicines optimisation in the care of the older person.
P3.51	Works to develop areas of advanced pharmacy practice in the care of the older adult, including subgroups with special needs e.g. intellectual disabilities.
P3.52	Develop processes that support safe prescribing particularly in areas of high risk (e.g. transfer of information about medicines, prescribing of repeat medicines).
P3.53	Analyses medication related incidents for trends, identifies and communicates risk and shares the learning from these incidents with relevant personnel.
P3.54	Influence change nationally through involvement with national clinical programmes that impact medicines management in the care of the older person
P3.55	Develop processes required to work with leaders of health and social care to develop new medicines optimisation services for older people.
P3.56	Demonstrate knowledge of the agencies involved in community care, their ability to support patients in taking their medicines and the effect of this on medicines management.
P3.57	Demonstrate awareness of assistive technologies that are available to support older people in optimising medicines use e.g. monitoring devices, compliance support.
P3.58	Identify current and future educational and professional development needs for pharmacists

Ref.	Gastrointestinal system: core knowledge and skills
P3.59	Demonstrates knowledge of the basic pathophysiology and risk factors for the development of constipation.
P3.60	Demonstrates knowledge of the mechanism of action, characteristics and clinical use of treatments for constipation, including faecal impaction.
P3.61	Demonstrates knowledge of the mechanism of action, characteristics and clinical use of treatments for medication-induced upper GI disease e.g. NSAIDs
P3.62	Demonstrates knowledge of the mechanisms of action, characteristics and clinical use of antiemetics, prokinetics, laxatives and antidiarrhoeals.
P3.63	Demonstrates knowledge of the basic pathophysiology and management options for dysphagia and its implications for medicines management including product formulation issues and mixing medicines with thickeners
P3.64	Demonstrates knowledge of the pharmacological support for malnutrition and anorexia/cachectic patients.
P3.65	Demonstrates knowledge of the pharmaceutical issues around administration of medication through nasogastric and percutaneous endoscopic gastrostomy (PEG) tubes.

Ref.	Respiratory system: core knowledge and skills
P3.79	Demonstrates knowledge of the treatment options for respiratory diseases including knowledge of relevant guidelines.
P3.80	Demonstrates knowledge of the impact of regular and frequent corticosteroid treatment on older people, particularly in relation to requirements for osteoporosis prevention
P3.81	Aware of the risks of respiratory depression associated with the use of anxiolytics, opioids and gabapentinoids.

P3.82	Demonstrates knowledge of inhaler types and what type is most suitable for the older adult
P3.83	Demonstrates ability to assess inhaler technique and demonstration of technique to support optimal use

Ref.	Central nervous system: core knowledge and skills
P3.84	Demonstrates understanding of the anatomy & physiology of the central and peripheral nervous system
P3.85	Demonstrates excellent understanding of the combined impact of frailty markers on a person with a neurological condition
P3.86	Demonstrates knowledge of the symptoms, basic pathophysiology and management options for the following mental health disorders: depression, Alzheimer's disease and other dementias, paranoid disorders, anxiety, insomnia, alcohol abuse, drug abuse and neuropathies.
P3.87	Demonstrates understanding of the mechanism of action, characteristics and clinical use of treatments for the following mental health conditions and takes account of the different characteristics of these medicines: depression, Alzheimer's disease and other dementias, paranoid disorders, anxiety, insomnia, alcohol abuse, drug abuse and neuropathies.
P3.88	Demonstrates understanding of the differences between acute confusional states (delirium) and dementia.
P3.89	Demonstrates knowledge of the pharmacological and non-pharmacological treatment options in dementia and delirium, including behavioural and psychological symptoms of dementia.
P3.90	Demonstrates knowledge of the pharmacological agents that can worsen dementia and management of patients with dementia and complex co-morbidities.
P3.91	Demonstrates knowledge of the medico-legal issues involved with covert medicines administration and consent.
P3.92	Demonstrates knowledge of the basic pathophysiology and common treatment of vestibular disorders.
P3.93	Demonstrates knowledge of the symptoms, basic pathophysiology and drug management options in Parkinson's Disease, and the interplay when presenting with a co-existing diagnosis of dementia.
P3.94	Demonstrates knowledge of the effect of Parkinson's disease and dementia on medicines use.
P3.95	Demonstrates an ability to identify and manage adverse effects from drugs which treat Parkinson's Disease and the medical conditions associated with the disease e.g. depression, hypotension, sleep disorders and bowel dysfunction.
P3.96	Demonstrates knowledge of the symptoms, basic pathophysiology and management options in epilepsy.
P3.97	Demonstrates knowledge of the interactions between psychiatric illness and epilepsy, psychotropic drugs and anticonvulsants.
P3.98	Demonstrates knowledge of the basic pathophysiology of pain.
P3.99	Demonstrates knowledge of the treatment options for acute pain.
P3.100	Demonstrates knowledge of the drug treatment options for chronic and neuropathic pain.
P3.101	Demonstrates knowledge of the complex issues around co-morbidities and selection of pain management options (drug and non-drug) in older people.
P3.102	Demonstrates understanding of psycho-social factors that can influence the experience of pain.

Ref.	Infections: core knowledge
P3.103	Demonstrates knowledge of the mechanism of action, characteristics and use of antibacterial agents in the management of bacterial infections (including spectrums of activity).
P3.104	Demonstrates knowledge of the management of the common infections seen in older people e.g.: Skin, Wound, UTI, URTI and LRTI.
P3.105	Demonstrates knowledge of the mechanism of action, characteristics and use of antiviral agents in the management of viral infections.

Ref.	Endocrine system: core knowledge
P3.106	Demonstrates knowledge of the mechanism of action, characteristics and use of treatments for thyroid disorders.
P3.107	Demonstrates knowledge of the basic pathophysiology, characteristics and treatment of SIADH.
P3.108	Demonstrates knowledge of the mechanism of action, characteristics and use of oral hypoglycaemic agents.
P3.109	Demonstrates knowledge of the mechanism of action, characteristics and use of injectable hypoglycaemic agents and the effect of diabetes on falls risk
P3.110	Demonstrates knowledge of the risk of hypercalcaemia associated with medication (e.g. Calcium and Vitamin D, thiazides) in older people.
P3.111	Demonstrates knowledge of the social, physical and cognitive issues around the use of hypoglycaemic medication in older people.
P3.112	Enhanced: Demonstrates an understanding of less intensive glycaemic control strategies in frailty/older people

Ref.	Gynaecology and urinary-tract disorders: core knowledge
P3.113	Basic pathophysiology of the different causes of urinary incontinence and the place of pharmacological and non-pharmacological management of these conditions.
P3.114	Drugs affecting urinary continence, including adverse effects of medicines causing urinary incontinence, and management of this condition in the presence of complex co-morbidities
P3.115	Basic pathophysiology of benign prostatic hypertrophy and management options for this condition.
P3.116	Basic pathophysiology and risk factors for the development of sexual dysfunction and mechanism of action, characteristics and clinical use of treatments for this condition.

Ref.	Malignant disease: enhanced knowledge
P3.117	Demonstrates the ability to identify, review, monitor and follow up medication issues for common malignancies found in older people e.g. prostate, breast, lung, skin and colon cancer, as well as haematological malignancies

Ref.	Nutrition and blood: core knowledge
P3.118	Demonstrates knowledge of the basic pathophysiology, monitoring and management options for neutropenia, as well as the adverse effects of medicines causing or contributing to neutropenia
P3.119	Demonstrates knowledge of the symptoms, basic pathophysiology and management options for malnutrition including electrolyte disturbances and the implications for medicines management.

Ref.	Musculoskeletal and joint diseases: core knowledge
P3.120	Demonstrates knowledge of the symptoms, basic pathophysiology and management options for osteoporosis (treatment & prevention) including its relationship with corticosteroid use.
P3.121	Demonstrates knowledge of the symptoms, basic pathophysiology and management options for osteoarthritis, gout, rheumatoid arthritis, polymyalgia rheumatica,
P3.122	Demonstrates knowledge of the basic pathophysiology of falls in older people., and the relationship between falls, fractures and osteoporosis
P3.123	Demonstrates understanding of the relationship between falls, fractures and osteoporosis.
P3.124	Demonstrates understanding of medical conditions that may increase a risk of falls.
P3.125	Demonstrates ability to identify medications that have a high risk for falls and to recommend safer alternatives where appropriate

P3.126	Demonstrates understanding of the importance of regular medication reviews in the older person to minimise the risks of falls.
P3.127	Demonstrates ability to work as part of the multidisciplinary team in contributing to the non-drug management of falls with multifactorial prevention strategies
Ref.	Enhanced
P3.128	Demonstrates knowledge of HSE guidance on preventing falls and fractures in Ireland's Aging Population
P3.129	Contributes development and updating of local policies on falls management

Ref.	Eyes: core knowledge
P3.130	Demonstrates knowledge of the basic pathophysiology, symptoms, and management options for glaucoma, macular degeneration, dry eyes and cataracts and the implications for medicines management in older people.

Ref.	Skin: core knowledge
P3.131	Demonstrates knowledge of the basic pathophysiology, symptoms, and management options for eczema, pruritus, dry skin, and fungal rashes.

	Enhanced
P3.132	Demonstrates knowledge of the basic pathophysiology, symptoms, and management options for leg ulcers and pressure sores.

Ref.	Immunological products and vaccines: core knowledge
P3.133	Demonstrates knowledge of the annual flu/pneumococcal/COVID vaccines and recommends their use when appropriate.

Ref.	Liver disease: core knowledge
P3.134	Demonstrates knowledge of the monitoring of liver function / dysfunction (acute or chronic).
P3.135	Demonstrates knowledge of the effect of medicines on liver function, particularly in relation to adverse effects.
P3.136	Demonstrates knowledge of dose adjustment of certain medicines in the setting of impaired liver function

Ref.	Renal disease: core knowledge
P3.137	Demonstrates basic understanding of the importance of fluid balance/Input & Output.
P3.138	Demonstrates understanding of the impact that derangement of urea and electrolytes can have on physical and cognitive functioning.
P3.139	Demonstrates ability to monitor renal function / dysfunction (acute/chronic) to ensure safe medication use
P3.140	Demonstrates knowledge of nephrotoxic medications and the impact that impaired renal function has on medication therapy; can make evidence-based drug/dose alteration recommendations in different stages of renal impairment.
P3.141	Demonstrates ability to calculate creatinine clearance (CrCl) using the Cockcroft and Gault equation and knowledge of clinical situations where CrCl and eGFR should be used in older people.
P3.142	Understands basic pathophysiology and risk factors for the development of renal failure (acute/chronic).
P3.143	Demonstrates knowledge of mechanism of action, characteristics and clinical use of treatments of renal failure, including clinical application of pharmacokinetic principles.
P3.144	Demonstrates an awareness that kidney function naturally declines with age
P3.145	Demonstrates an understanding of, and management treatments for renal bone disease, anaemia of chronic kidney disease

P3.146	Demonstrated an understanding of renal replacement therapies, and the requirement for dose adjustment/drug alterations in renal replacement therapies
Ref.	Enhanced
P3.147	Demonstrates awareness that CrCl and eGFR can be an unreliable assessment of kidney function in the older adult; particularly those at extremes of body weight and age

Ref.	Toxicology
P3.148	Demonstrates awareness of the possible toxic effects of medications in older people and the possible cumulative effect of taking multiple medicines
P3.149	Importance of identifying and managing high risk drugs and long-term medication in older people to reduce risk of toxicity.
P3.150	Utilisation of current information e.g. from the Health Products Regulatory Authority (HPRA) to reduce risk of medicines-related toxicity to older people.

Ref.	End of life care: core knowledge and skills
P3.151	Demonstrates an understanding of life-limiting conditions, the basic principles of palliative care and hospice care and management options for symptom control towards end of life
P3.152	Provides patient centred evidence-based advice on medication therapy with consideration of the physical, psychological, social and spiritual needs of a person with life-limiting conditions.
P3.153	Demonstrates understanding of how end stage chronic diseases may impact on treatment decisions e.g. ability to recognise when medications are no longer appropriate for the patient nearing end of life.
P3.154	Demonstrates an understanding of advance care planning and of complex legal and ethical issues affecting end of life care.
P3.155	Anticipate transitions of care e.g. progressing from aggressive treatment to comfort treatment with due consideration of potential supply chain issues
P3.156	Provide medication counselling to patients, caregivers and families, ensuring safe use of and disposal of medications e.g. opioids, with due consideration of risk, including potential for abuse.
P3.157	Demonstrates knowledge on the role of syringe drivers in palliative and hospice care including mixing of drugs in syringe drivers.
P3.158	Be able to identify and actively respond to medicines information needs of health care professionals and support the provision of evidence-based practice in a variety of care settings
P3.159	Demonstrate an in-depth knowledge of the use of specialist resources providing information about medicines used in palliative care and adapt this information for use in clinical settings
Ref.	Enhanced
P3.160	Active engagement in palliative care medicines education and training of students, pharmacists and patient care clinicians of various disciplines.
P3.161	Demonstrate leadership in the identification, development and delivery of medicines-related palliative care guidance and policy
P3.162	Be able to lead, facilitate and engage in medicines–related audit and research in the field of palliative care in order to improve practice.

PHYSIOTHERAPY

Discipline-Specific Knowledge and skills – PHYSIOTHERAPY

MEMBERSHIP OF PHYSIOTHERAPY WORKING GROUP

- Sinead Coleman, Clinical Specialist Physiotherapist, St James's Hospital
- Gillian Harte, Senior Physiotherapist, Tallaght University Hospital
- Siobhan Quinn, Senior Physiotherapist, Tallaght University Hospital
- Siobhán Magner, Clinical Specialist Physiotherapist, MMUH
- Lucinda Edge, Clinical Specialist Physiotherapist, SJH
- Paudie McQuinn, Project Lead Kerry ICPOP
- Ruth Wade, Senior Physiotherapist, Tallaght University Hospital
- Gráinne Gallagher, Senior Physiotherapist, St Luke's Kilkenny
- Gráinne Forde, Senior Physiotherapist, MMUH
- Eileen Moriarty, General Manager, Services for Older People, HSE

Introduction

In order to work as a physiotherapist in the Republic of Ireland, you must be registered with CORU and adhere to its code of professional conduct and ethics. Within the Irish setting, physiotherapists work within the following clinical grades:

Entry Level/Staff Grade Therapist

Upon entry into the workforce, entry level/Staff Grade therapists utilise knowledge, skills and abilities that have been attained from completion of a Bachelor of Science (Honors) or a Master of Science in Physiotherapy from a third level institution. Core skills will develop with time through experiential learning, supervision and continuous professional development within various clinical settings whilst operating at entry level/ staff grade.

Senior Therapist

At senior level, therapists build upon existing skills and possess a greater depth of specialist knowledge and complexity of responsibility which may include supervision of entry level/staff grade therapists and responsibilities for a clinical area/service.

Clinical Specialist Therapist

At clinical Specialist level, therapists are expected to demonstrate excellent clinical leadership in driving change, participate in post graduate research and operate with an expert level of proficiency. They consistently demonstrate excellence in a particular clinical area and often manage a greater depth and complexity of responsibility than at senior level.

Advanced Clinical Practice Therapist

At advanced clinical practice level, therapists demonstrate their ability to work autonomously at an expert level of clinical practice, possess advanced complex decision-making skills, be accountable, self-directed and deliver significant examples of quality improvements in terms of service redesign and delivery.

The Irish Society of Chartered Physiotherapists (ISCP) is the national, professional body representing chartered physiotherapists in Ireland. The ISCP describes physiotherapists as "health professionals who are responsible for developing, maintaining or restoring movement and functional ability throughout the lifespan across the health spectrum using evidence-based practice" (ISCP, 2021). This is

further emphasised by the World Confederation for Physical Therapy (WCPT) which highlights the holistic nature of physiotherapy in their statement that "physiotherapists help people maximise their quality of life, looking at physical, psychological, emotional and social wellbeing. They work in the spheres of promotion, prevention, treatment/ intervention, and rehabilitation" (WCPT, 2021).

The primary purpose of physiotherapists working with older people is to maintain and/or restore function, activity and independence. This requires a person-centred, collaborative, inter-professional approach to a wide range of conditions affecting this population across all health systems (International Association of Physiotherapists working with Older People (IPTOP)) (IPTOP, 2021). The unique knowledge, skills and experience of physiotherapists places them in a pivotal position to influence the health and function of maintain their health and wellbeing. This will ensure their contribution to the quality of life of older people and, where applicable, their support system or caregivers.

The ISCP have emphasised the unique role that physiotherapists hold within older person's services, some of which include:

- Advise the older person on a healthy lifestyle, including physical activity, aerobic and strengthening exercise, tailored to their lifestyle and goals
- Assist with recovery and rehabilitation after a heart attack, stroke, hip or knee replacement
- Provide expertise to manage conditions such as arthritis, diabetes, or Parkinson's Disease (PD)
- Provide exercises to promote strong bones, improve balance and muscle strength
- Holistic assessment and management of falls in older persons

Domain 3: Roles and Responsibilities

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day to day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge and abilities.

Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, appropriate and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

As a physiotherapist you should:

Ref	Core knowledge
PHY3.01	Have knowledge and understanding of the indications, contraindications and side effects to physiotherapy treatments
PHY3.02	Have knowledge and understanding of best practice guidelines in the identification and management of the more common conditions of older age including falls, sarcopenia, delirium, dementia, frailty, Parkinson's Disease (PD) and atypical parkinsonism, multimorbidity, stroke disease/chronic stroke, chronic inflammatory conditions, osteoarthritis.
PHY3.03	Understand the importance of activity and exercise in contributing to the health and wellbeing of the older person

Ref	Core skills
	Demonstrate the physiotherapy process including:

PHY3.04	Be able to carry out an accurate subjective assessment (detailing social history including baseline and current physical status)
PHY3.05	Be able to identify factors which may place the older person at risk of functional decline
PHY3.06	Demonstrate good observation and interviewing technique to build rapport with the older person and gather information.
PHY3.07	Be able to recognise indication for, and conduct, an accurate objective assessment including gait, balance and strength (including selection and use of standardised outcome measures as listed below)
PHY3.08	Be competent to carry out a risk assessment including transfers, outdoor and indoor mobility, stairs and seating
PHY3.09	Be able to recognise where more specialist assessment may be indicated (example: for orthotic or prosthetic devices, vestibular assessment, continence assessment)
PHY3.10	Be able to recognise an older person's ability to benefit from rehabilitation and have the ability to recommend the most appropriate rehabilitation setting for the patient
PHY3.11	Be able to recognise the impact of cognitive impairment on physical functional ability where relevant
PHY3.12	Be able to assess a person with cognitive impairment in a way that maximises their ability to participate and benefit from your intervention including collateral information from multidisciplinary team (MDT)/next of kin (NOK) as appropriate
PHY3.13	Be able to recognise when an older person's functional and social participation is being restricted by pain. Be able to consider appropriate non-pharmacological interventions for pain management.
PHY3.14	Prescribe and deliver exercise intervention to an older person with physical impairment that is impacting function
PHY3.15	Justify selection of treatment techniques using clinical reasoning skills
PHY3.16	Assess for suitability and provide mobility aids where appropriate
PHY3.17	Be able to deliver evidence based individually tailored intervention for falls reduction and prevention, sarcopenia reversal and prevention, frailty reduction and prevention
PHY3.18	Be able to delegate appropriate tasks to physiotherapy assistants and supervise ongoing intervention as needed
PHY3.19	Make recommendations and provide education to patients, carers and staff members on the means of mobility that is in the best interest of each individual
PHY3.20	Facilitate and deliver exercise classes
PHY3.21	Collaboratively identify SMART goals, with timescales and treatment plans including recommendations for longer hospital stay or transfer to rehabilitation facility where indicated in patient's best interest
PHY3.22	Plan, grade, implement and modify interventions that are outcome based and relevant to the older person's goals.
PHY3.23	Evaluate outcomes in collaboration with the older person and their families
PHY3.24	Is aware of and appropriately uses Standardised Outcome Measures validated in older persons care: · Balance: Berg Balance Scale, Timed Up and Go (TUG), Mini Best Test, Dynamic Gait Index, Falls Efficacy Scale. · Endurance: Six Minute Walk Test, Borg Breathlessness Scale, · Strength: 30 second Sit to Stand Test, 5 Times Sit to Stand Test, Grip Strength · Mobility: TUG, Elderly mobility scale, Gait Speed · Stroke: Motor Assessment Scale, Postural Assessment Scale for Stroke, 9 Hole Peg Test, Stroke Activity Scale · Parkinson's Disease: Unified Parkinson's Disease Rating Scale, Modified Parkinson's Activity Scale · Other: Visual Analogue Scale/Verbal Rating Scale for Pain
PHY3.25	Engage in clinical reasoning based on Physiotherapy practice and supporting evidence in the area of gerontology.
PHY3.26	Provide health promotion education on the importance of activity as we age, including most appropriate activity for each individual based on needs and previous experience

Ref	Enhanced knowledge
PHY3.27	Demonstrate an advanced understanding of the physiotherapy process and can identify older persons who may have a number of frailty markers with associated symptoms that impact on functional performance.
PHY3.28	Have knowledge of the signs of malnutrition in older persons care and the importance of adequate dietary intake to prevent secondary complications. In particular, have knowledge of adequate calorie and protein intake for muscle health in the context of muscle strengthening in a rehabilitation setting
PHY3.29	Identify current and future development needs for physiotherapy to meet the needs of the service user, community or population, including those in complex situations.
PHY3.30	Understand the effects of ageing, inactivity and chronic conditions on muscle strength and function, and the longer-term implications of this for the older person

Ref	Enhanced skills
PHY3.31	Demonstrate specialist clinical skills in areas such as continence and vestibular rehabilitation
PHY3.32	Plan strategically to drive change both within the physiotherapy profession and the broader health care context.
PHY3.33	Exercise a high degree of professional autonomy in the analysis of highly complex situations that contribute to the implementation of a treatment or management strategy for older persons.
PHY3.34	Create and develop standards of practice/care that positively impact on older persons care.
PHY3.35	Influence change nationally through involvement with national clinical programmes that impact on care of the older person_

Other Frailty Conditions/Syndromes and Considerations

(The below list is not exhaustive, but is a sample of common conditions/ syndromes encountered by Physiotherapists working with older persons)

FALLS	
Ref	Core knowledge
PHY3.36	Demonstrate understanding of the factors that may contribute to falls.
PHY3.37	Demonstrate understanding of medical conditions and medications that may increase a risk of falls.
PHY3.38	Demonstrate understanding of local falls pathways and local and national guidelines.
PHY3.39	Demonstrate understanding of falls services available locally
PHY3.40	Demonstrate understanding of equipment available to minimise or monitor falls.
PHY3.41	Demonstrate understanding of the benefits of bone protection.
Ref	Core skills
PHY3.42	Demonstrate ability to refer appropriately to specialist physiotherapy and MDT services
PHY3.43	Demonstrate ability to identify cause of falls and implement appropriate management plan when able.
PHY3.44	Be able to accurately detail falls history (including mechanism, frequency, risk factors, injuries obtained, ability to get up from the floor, fear of falling and perceived physical ability)
PHY3.45	Be able to assess balance and gait deficits using standardised outcome measures
PHY3.46	Be able to provide specialised balance and gait interventions to help reduce the risk of falls
PHY3.47	Demonstrate ability to effectively communicate with the MDT regarding patient falls risk and management plan.
PHY3.48	Demonstrate ability to recognise reduced confidence, self-limitation of activity and fear of falling during assessment.
PHY3.49	Demonstrate ability to provide advice and education to patients and families on falls management and equipment.

Ref	Enhanced knowledge
PHY3.50	Demonstrate understanding of medical conditions and medications that may increase a risk of falls.
PHY3.51	Have knowledge of how to carry out a comprehensive multifactorial falls risk assessment including knowledge of aggravating medications (including diuretics, beta blockers and sedative medication), and an understanding of indication for specialist referral for medication reconciliation, cardiovascular assessment, neurological assessment, vision assessment, home hazard assessment, bone health review, continence assessment.
PHY3.52	Have an understanding of assessments completed by other disciplines, and the implications for physiotherapy management.
PHY3.53	Demonstrate understanding of current thinking/research in the falls arena.
PHY3.54	Demonstrate understanding of the considerations needed when assessing a fall with suspected head injury or an unwitnessed fall.
Ref	Enhanced knowledge
PHY3.55	Demonstrate ability to assess for orthostatic hypotension and interpret the results.
PHY3.56	Demonstrate ability to complete a comprehensive falls assessment.
PHY3.57	Demonstrate ability to use synthesise information from various sources to assess and determine falls risk.
PHY3.58	Demonstrate ability to clinically reason whether fall could be syncopal or non-syncopal related.

Neurology Considerations for Older People	
Ref	Core knowledge
PHY3.59	Demonstrate understanding of the anatomy & physiology of the central and peripheral nervous system
PHY3.60	Demonstrate understanding of the components of a neurological assessment
PHY3.61	Demonstrate understanding of common neurological conditions and associated common symptoms
PHY3.62	Has basic understanding of the following conditions: a) Dementia b) Myopathy c) PD d) Stroke e) Transient Ischemic Attack (TIA)
PHY3.63	Demonstrate some understanding of the combined impact of frailty markers on a person with a neurological condition
Ref	Core skills
PHY3.64	Demonstrate ability to carry out a neurological assessment and problem list & treatment plan with understanding of frailty markers and their impact on the pre-existing neurological condition.
PHY3.65	Demonstrate ability to complete the physiotherapy process considering the cognitive, physical and functional impairments that may be present with the following conditions: a) Dementia b) Myopathy c) PD d) Stroke e) TIA
Ref	Enhanced knowledge
PHY3.66	Demonstrate understanding of local acute neurology pathways and how to access acute neurology services.
PHY3.67	Demonstrate understanding of common neurology medications
PHY3.68	Demonstrate excellent clinical knowledge of the following conditions: a) Dementia b) Myopathy c) PD d) Stroke e) TIA

PHY3.69	Demonstrate excellent understanding of the combined impact of frailty markers on a person with a neurological condition
Ref	Enhanced skills
PHY3.70	Demonstrate ability to carry out a detailed assessment of interaction between neurological, biomechanical and cognitive contributors to declining function, and develop an appropriate problem list and treatment plan"
PHY3.71	Demonstrate ability to use appropriate questions/outcome measure to assess older patients with a neurological condition
PHY3.72	Demonstrate excellent clinical knowledge and clinical skills when completing the physiotherapy process considering the cognitive, physical and functional impairments that may be present with the following conditions: a) Dementia b) Myopathy c) PD d) Stroke e) TIA

Orthopaedic Considerations for Older People	
Ref	Core knowledge
PHY3.73	Understand the anatomy and physiology of normal and ageing bone and skeleton
PHY3.74	Understand the signs and symptoms of a fracture and clinically reason whether physiotherapy intervention is appropriate.
PHY3.75	Understand the signs and symptoms of an infected wound, risk of infection and associated impact on function of an older person.
PHY3.76	Understand the most common types of fractures affecting older persons i.e. humeral, colles, vertebral, hip fractures, pubic ramus and the possible associated impact on functional performance.
PHY3.77	Understand different weight bearing status.
PHY3.78	Has a knowledge of the common surgical interventions for the above fractures
PHY3.79	Can identify factors which may affect prognosis and recovery after hip fracture
PHY3.80	Is aware of any local policies and procedures for the management of an older person after a fracture
PHY3.81	Has an awareness of delirium – how to detect delirium using standardised outcome measures (for example 4AT) and factors which may provoke or exacerbate delirium
PHY3.82	Have a knowledge of common pain medications
Ref	Core skills
PHY3.83	Demonstrate ability to assess a patient's functioning with consideration for their weight bearing status.
PHY3.84	Demonstrate the ability to incorporate both functional and formal exercise programmes, depending on the individual's needs and abilities
PHY3.85	Be able to identify where pain is affecting progress with physiotherapy and identify solutions to this
PHY3.86	Demonstrate the ability to set patient-centred goals and plan for discharge from services or cross-agency transfer
Ref	Enhanced knowledge
PHY3.87	Demonstrate understanding of local trauma pathways and inform specialist trauma teams for older persons.
PHY3.88	Demonstrate understanding of language used in results and reports for plain film x-ray, MRI and CT imaging.
PHY3.89	Has an understanding of the impact of a fracture on a person with frailty markers, and the implications of frailty markers for treatment planning and timeframes
PHY3.90	Understand modifiable risk factors for delirium (example: organisational, environmental, pharmacological)
Ref	Advanced skills

PHY3.91	Demonstrate ability to educate the patient in relation to a host of compensatory techniques to promote functional independence.
PHY3.92	Demonstrate the ability to appropriately adapt interventions in response to the presence of other conditions which may affect physical functioning (example: other fractures, Chronic Obstructive Pulmonary Disease, dementia)
PHY3.93	Be able to identify those patients at high risk for delirium and take appropriate steps to reduce its risk or minimise its impact
PHY3.94	Demonstrate the ability to recognise and assess pain in someone whose cognitive or language impairment limits their communication ability

PSYCHOLOGY

Discipline-Specific Knowledge and skills - PSYCHOLOGY

MEMBERSHIP OF PSYCHOLOGY WORKING GROUP

- Dr Niall Galligan – Principal Clinical Neuropsychologist, Our Lady's Hospice and Care Services
- Dr Niall Pender – Principal Clinical Neuropsychologist, Beaumont Hospital
- Dr Garret McDermott – Principal Clinical Neuropsychologist, Tallaght University Hospital
- Dr Sarah Casey – Senior Clinical Neuropsychologist, National Rehabilitation Hospital
- Dr Anna Marie Dowling – Senior Clinical Psychologist, Health Service Executive

Introduction

Psychology is the scientific study of the mind, encapsulating cognition, emotion and behaviour. Psychologists apply an advanced understanding of the above processes, and their relationship to brain functioning, to help assess, diagnose, and treat difficulties associated with physical and mental health. Psychologists complete extensive professional training, typically involving additional masters and doctoral level training subsequent to completion of an undergraduate degree. Within the Irish healthcare setting, Psychologists work within the clinical grades of Staff/Entry Grade, Senior Grade and Principal Grade, according to the level of experience, competency development, and responsibility required for each role. The objective of this document is to guide academic and continuous professional learning and to assist Psychologists in developing the necessary skills to provide effective services for older people.

The role of Psychologists, as part of an integrated care framework for older people, includes the following:

Assessment: Given the often-complex mental and physical health problems of older people, health care providers and families benefit from input from Psychologists because of their skills in psychological assessment. Psychologists have the necessary expertise to assess and differentiate between disorders such as dementia, depression, anxiety, psychosis, delirium, adjustment reactions, or combinations of these problems. Psychologists may also help to assess whether older people have the capacity to manage their own affairs and what specific supports are required to further enable the individual.

Intervention: As with younger people, a variety of mental health difficulties affect older people. Stressors common in late life also significantly affect the health and independence of older people. Such stressors include adapting to and coping with late-life transitions, grief, poverty, multiple medical conditions, functional limitations, cognitive changes, chronic pain, and care for a frail family member. Psychologists use psychological interventions, including various psychotherapies, to help the older person deal with mental health difficulties, adjustment to illness, and other late-life stressors.

Psychologists have expertise in a wide range of problems that affect older adults including the following:

- *Mental Health disorders.* Psychologists use psychological interventions to treat mental health disorders in older people. Psychologists have expert training in identifying emotional distress, assessing for suicide risk, and developing plans to alleviate distress.
- *Supported Decision-Making and Capacity assessment.* Families, health care providers, solicitors and judges concerned about an older person's capacity to make complex decisions (e.g., medical or legal) frequently avail of Psychologists' expertise in this domain. Psychologists work with an older person to support decision-making capacity, through gaining an understanding of the older person's will and preferences,

understanding what cognitive, emotional, and behavioural factors might influence decision-making, and by imparting strategies and skills to support the older person to make their own decision where possible.

- *Dementia and Acquired Brain Injury (ABI).* In addition to assessing cognitive impairment due dementia or ABI (e.g., stroke), Psychologists can help individuals recover cognitive function where possible, optimise remaining cognitive abilities, and build coping strategies to reduce distress and debilitation. Psychologists also teach behavioural and environmental strategies to caregivers to understand and manage behavioural and psychological symptoms associated with Dementia and ABI.
- *Health promotion.* As experts in human behaviour, Psychologists have been at the forefront in developing effective health promotion programs and strategies to enhance healthy behaviours.
- *Management of chronic diseases.* Psychologists help older people manage multiple chronic medical conditions that often accompany aging, such as heart disease, stroke, and arthritis. A major goal of such management is to prevent excess disability and hospitalisation through treatment adherence and behavioural interventions, including activity scheduling, biofeedback, and stress reduction techniques.
- *Insomnia.* Insomnia is prevalent among older adults, especially medically ill older people. Older people are especially vulnerable to the adverse effects of sleep medications, including memory impairment and impaired daytime performance. Psychologists have developed effective nonpharmacologic treatments for insomnia, including cognitive–behavioural techniques, and psychoeducation.

Education and Training: Psychologists play an important role in education and training. This occurs through direct provision of supervised specialist placements to trainee Psychologists. It also occurs through the provision of specialist teaching input into the main university-based programmes for doctoral training in Psychology in Ireland. Psychologists develop education and skills training events for staff in hospitals and other care facilities to specifically address the care of older adults. Educational input for other clinicians and the public is also provided by Psychologists.

Domain 3: Roles and responsibilities

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day to day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge and abilities.

Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, appropriate and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

As a Psychologist you should:

Ref	Core knowledge
PSY3.01	Have an understanding of models of aging: - Development as a life-long process encompassing early to late life, and encompassing both gains and losses over the lifespan - Different theories of late-life development and adaptation - Biopsychosocial perspective for understanding an individual's physical and psychological development within the sociocultural context - Concept of, and variables associated with, "positive" or "successful" aging
PSY 3.02	Understand typical aging-related changes in cognitive processes, including attention, memory, executive functioning, language, and global intellectual functions
PSY 3.03	Understand changing social networks in late life, and the value of meaningful roles and connections in later life
PSY 3.04	Have a basic understanding of frailty syndromes, common conditions and problems that will require the assessment and intervention from a Psychologist. These may include: a) Common Mental Health difficulties impacting older people such as depression and anxiety b) Dementia: Types and symptoms c) Delirium: Its most common causes and types encountered i.e. Hyper/ Hypoactive/Mixed d) Understand the difference between delirium, dementia and depression e) Understand the term 'cognitive impairment' and it's causes f) Understand the impact that Stroke/Transient Ischemic Attack (TIA) or other acquired brain injuries (ABI) may have on an older person g) Understand the impact that a new or previous neurological condition(s) may have on an older person
PSY 3.05	Demonstrate understanding of Psychology assessment methods, including: - Assessment measures or techniques which have been developed, normed, validated and determined to be psychometrically suitable for use with older people - Incorporating results from interdisciplinary assessment (e.g., including other health professionals' evaluations of presenting issues) - Multi-method approaches to assessing older people (including cognitive, emotional, behavioural and personality assessments, drawn from self-report, interviews, and observational methods) - Importance of integrating collateral information from family, friends, and caregivers, with appropriate consent, especially when potential cognitive impairment is being evaluated
PSY 3.06	Demonstrate understanding of contextual issues in Psychological assessment: - The range of potential individual factors that may affect assessment performance (e.g., cultural, educational, language background, medications, substance use, medical conditions) - The potential impact of neurodevelopmental difficulties, diagnosed or non-diagnosed, on cognitive, emotional, and behavioural functioning in later life (e.g., Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia). - The potential impact early life experiences on cognitive, emotional, and behavioural functioning in later life (e.g., attachment style, deprivation, trauma). - The potential impact of the assessment environment on test performance (e.g., noise, lighting, distractions) - The older person's current circumstances and available resources in deriving recommendations from assessment data
PSY 3.07	Demonstrate familiarity with the theory, research, and practice regarding various methods of intervention with older people, particularly with current research evidence about their efficacy with the relevant age group

PSY 3.08	Demonstrate understanding of diverse clients and contexts: - The diversity of the older adult population, and that age alone is a poor predictor of an individual's wellbeing and functioning - The unique experience of each individual - based on demographic, sociocultural, and life experiences - and that multiple factors interact over the lifespan to influence people's patterns of behaviour - Consideration of sexual and gender diversity as a contextual issue in both assessment and provision of care. - Historical influences affecting particular cohorts (e.g., experience of war and conflict, socio-political changes, prejudice and discrimination) - Multiple levels of psychological intervention/consultation, including individuals, families, healthcare professionals, organisations, and community leaders - Systems-based consultative and intervention models and their use with appropriate modifications in different geriatric settings
PSY 3.09	All Psychologists must have a detailed understanding of their code of professional conduct and ethics (see www.psychologicalsociety.ie/Code-of-Ethics)
PSY 3.10	Have a detailed understanding of relevant legislation (see appendices) pertaining to clinical services for older persons including the Mental Health Act 2001, Assisted Decision-Making (Capacity) Act (ADMA) 2015 and Children First Act 2015 (e.g., reporting of retrospective abuse)
PSY 3.11	Understand the steps that should be followed when informed consent may be compromised (e.g., due to being unconscious, or a judgement having been made in relation to the older person lacking decision-making capacity, or the older person being supported by a decision-making support under the ADMA (2015) or by means of an Enduring Power of Attorney, or an Advanced Healthcare Directive)
PSY 3.12	Understand the importance of identifying safeguarding issues with an awareness of the appropriate channels for reporting concerns regarding risks to older people
PSY 3.13	Demonstrate awareness of relevant national and local guidelines and policies relating to risk assessment and management of older people and people with dementia (See Appendices)

Ref	Core skills
PSY 3.14	Conduct clinical assessment and assist with differential diagnosis: - Evaluate older people's ability to provide informed consent for psychological assessment - Undertake psychological assessment to help differentiate between disorders such as dementia, depression, anxiety, delirium, adjustment reactions, or combinations of these problems - Assess older adult's motivation for treatment - Help determine whether older adults have the capacity to make specific complex decisions and recommend supportive interventions where possible
PSY 3.15	Develop psychological formulations for older people with complex problems based on clinical evaluation
PSY 3.16	Utilise assessment measures effectively: - Utilise screening tools for mood, cognition, substance abuse, neurodevelopmental difficulties, and other clinical issues to guide and inform comprehensive assessment - Evaluate age, educational, and cultural appropriateness of assessment instruments - Consider reliability and validity data in using standardised instruments with older people - Recognise sensory impairments and make environmental modifications accordingly - Consider the potential impact of medical conditions and medications on presenting difficulties and test performance

PSY 3.17	Communicate assessment results, formulations and recommendations - Provide clear and concise written and/or oral communication of psychological formulations - Use appropriate language and level of detail for the target audience - Communicate results within the confines of privacy and confidentiality considerations - Make specific and appropriate recommendations, based on assessment and formulation, to inform treatment planning - Translate assessment results into practical recommendations for patient, family, and team, providing relevant psychoeducational materials understandable to stakeholders
PSY 3.18	Provide effective, evidence-based interventions for particular issues affecting older people, including: a. Mental health disorders such as depression, anxiety and psychosis, including those of late onset b. Psychoeducation for patients and families regarding normal aging and common psychological difficulties associated with prevalent mental health and medical concerns c. Psychological difficulties associated with dementia, including support for both patients and family caregivers (e.g., inclusion of reminiscence and life review into psychotherapeutic interventions) d. Adjustment difficulties secondary to loss (e.g., bereavement, loss of valued roles and relationships) e. Group interventions for a range of aging-related health, mental health, and adjustment concerns f. Supporting patients and families facing advanced illness and death

PSY 3.19	Use Health-Enhancing Interventions: - Determine which aspects of physical, mental and behavioural health can be improved via psychological interventions - Prioritise health issues to be addressed when multiple targets are possible - Effectively intervene regarding mental health issues as part of overall treatment planing, and recognising close links between physical and mental health, and related disability in older people - Monitor the impact of intervention on health behaviours by evaluating outcomes
PSY 3.20	Intervene across settings: - Intervene in common geriatric settings (e.g., home, community centres, nursing homes, assisted living facilities, retirement communities, medical and mental health facilities) - Intervene at a level appropriate to the older adult person's needs, ranging from individual to family, systemic, and environmental contexts - Modify interventions to adapt to particular environmental and social characteristics
PSY 3.21	Recognise when psychological assessment or intervention is not appropriate (e.g., due to acute pain, fatigue, confusion)
PSY 3.22	Maintain a strong scientist-practitioner ethos: - Base interventions on empirical research, theory, and clinical judgment - Articulate case conceptualisations and relevant empirical evidence guiding choice of intervention strategies - Measure the effectiveness of interventions - Integrate or adapt various strategies to meet the needs of particular older people and make appropriate adjustments to treatment based on feedback and response to intervention
PSY 3.23	Assess risk where indicated: - Identify risk factors for harm to self or others - Screen and comprehensively assesses suicide risk - Screen and assesses risk of self-neglect due to cognitive, emotional or behavioural factors - Screen and assesses risk of elder abuse in emotional, physical, sexual, financial, and neglect domains

PSY 3.24	Recognise and manage boundary issues when working with older people in different settings (e.g. patients' homes, medical wards)
PSY 3.25	Practice self-reflection by: - Seeking out and engaging in regular clinical supervision - Demonstrating awareness of personal biases, assumptions, stereotypes, and potential discomfort in working with older people, particularly those of backgrounds divergent from the Psychologist - Monitoring internal thoughts and feelings that may influence professional behaviour, and adjust behaviour accordingly in order to focus on needs of the patient, family, and treatment team - Demonstrating accurate self-evaluation of knowledge and skill competencies related to work with older people presenting with diverse needs - Initiating consultation with or referral to appropriate providers when uncertain about one's own knowledge and skills
PSY 3.26	Help facilitate an older persons' will and preference in relation to returning to/ remaining at home, through supported positive risk taking, as far as is practicable. This may involve advocating for the right of an older person to make what might be considered by others to be an "unwise" decision (i.e., in the context of the individual having been assessed as having capacity to make that decision)
PSY 3.27	Follow the appropriate steps when informed consent may be compromised (e.g., due to being unconscious, or a judgement having been made in relation to the older person lacking decision-making capacity, or the older person being supported by a decision-making support under the ADMA (2015) or by means of an Enduring Power of Attorney, or an Advanced Healthcare Directive) based on national clinical, ethical and legal frameworks (see Appendices)
PSY 3.28	Demonstrate a high level of understanding in relation to safeguarding and child protection issues, including mandated reporting, with awareness of the appropriate channels for reporting concerns. This also involves providing support to others who may have concerns regarding potential safeguarding and child protection issues (see Appendices)
PSY 3.29	Demonstrate and articulate appropriate sections of the ADMA (2015) when a person whose capacity to make a decision is in question, including highlighting the appropriate level of decision-making support provided for in the legislation

Ref	Enhanced Knowledge
PSY 3.30	Have an advanced understanding of psychological difficulties affecting older people: - Biopsychosocial aetiological models, applied within a lifespan developmental and cohort relevant context, for major psychological disorders affecting older people - Differential presentations, associated features, age of onset, and course of common psychological disorders and syndromes in older people (e.g., anxiety, depression, psychosis, etc.) - Variations in presentations of psychological disorders in later life due to cohort, cognitive, medical and pharmacological issues, including lifelong mental health difficulties and late onset mental health difficulties - Under-recognised aspects of psychological disorders in late life which affect functional impairment and safety (e.g., suicide risk, substance use, complicated grief) - Interaction of common mental health difficulties with common medical illnesses and associated medications, and implications involved for assessment and treatment - Psychosocial, psychotherapeutic and psychopharmacological approaches to treating psychological disorders in older people, including health-related consequences of not treating and common side effects of treatments
PSY 3.31	Have an advanced understanding of the neuroscience of aging: - The parameters of cognitive changes in normal aging, including their basis in age-related changes in the brain - Factors that influence levels of cognitive performance in older adults (e.g., genetics, socioeconomic status, cohort effects, health status, mood, medications/ substances) - Characteristics and causes of mild cognitive impairment and reversible cognitive impairment, including depression and delirium, and the pathway to their management or reversal

PSY 3.32	Demonstrate understanding of common types of dementia and neurological conditions in terms of onset, aetiology, risk factors, clinical course, associated behavioural features, and evidenced-based management of these disorders, including: a) Dementia Alzheimer Type (DAT) b) Lewy Body Dementia (LBD) c) Stroke and Vascular Dementia d) Epilepsy e) Multiple Sclerosis (MS) f) Parkinson's Disease (PD) g) Traumatic Brain Injuries (TBI) h) Encephalopathy i) Motor Neuron Disease (MND) / Amyotrophic Lateral Sclerosis (ALS)
PSY 3.33	Have an advanced understanding of a wide spectrum of frailty syndromes, common conditions and problems of aging that will require assessment and intervention from a Psychologist. This may include: a) Understanding Delirium: including its presenting symptoms, causes and treatments b) Understanding red flags in relation to cognitive changes and the subsequent need for medical intervention (e.g., evidence of stroke, seizure activity) c) Understanding when it is not appropriate to complete formal cognitive assessments (e.g., due to acute pain, distress, delirium) d) Demonstrate understanding of the combined impact of frailty markers on a person with a neurological condition
PSY 3.34	Have an advanced understanding of the Person-Environment Interaction: - Interaction of an older person's abilities and needs with the demands and opportunities provided by various living and treatment environments (e.g., private homes, assisted living facilitates, nursing facilities) - Impact of aging stereotypes on an older person's perception of functional status and self-efficacy - Complexities around maintaining optimal independence and optimal safety, particularly when medical conditions and cognitive disorders impair the individual's functioning - Ethical and legal issues which arise in the context of markedly impaired functional status and decision making capacity
PSY 3.35	Demonstrate understanding of biological,psychological and social factors that can influence the experience of symptoms such as pain and fatigue
PSY 3.36	Demonstrate understanding of key considerations in balancing autonomy and protecting safety of at-risk older adults including: - Understanding the concept of, and processes underpinning Decision making capacity - Identifying and consulting relevant laws and policies covering abuse, assisted decision-making, advance directives, and confidentiality - Identifying appropriate recommendations for optimising older people's ability to decide upon issues around medical, residential, financial, and other life decisions
PSY 3.37	Demonstrate understanding of the variety of Service Delivery Models specific to the Older Person: - Differentiate goals and models of care in long-term, rehabilitation, acute, primary, home, assisted living, hospice, and other care settings - Appreciate a variety of models of geriatric mental health care, including integrated mental health services in primary care, specialty consultation, and home or community-based services - Demonstrate awareness of strengths and constraints of various care models

Ref	Enhanced skills
PSY 3.38	Complete specialist psychological assessment and formulation in relation a wide spectrum of frailty syndromes and common conditions affecting older people. This may include: a) Identifying specific patterns of change in the older persons' cognitive, emotional and behavioural presentation to help identify if presenting symptoms are neurodegenerative/neurological and/or psychological b) Collecting and interpreting information from family/Next of Kin/Caregivers in order to identify possible delirium (e.g., use of the 4AT tool) and to assist in placing the patient on the most appropriate care pathway c) Collecting and interpreting information from family and/or staff in order to help identify the underlying aetiology and ascertain rate of progression d) Assisting in transferring the patient to the correct care pathway based on accurate assessment
PSY 3.39	Demonstrate the ability to assess, identify and quantify the cognitive, emotional and behavioural difficulties associated with common types of dementia and neurological conditions including: a) Dementia Alzheimer Type (DAT) b) Lewy Body Dementia (LBD) c) Stroke and Vascular Dementia d) Epilepsy e) Multiple Sclerosis (MS) f) Parkinson's Disease (PD) g) Traumatic Brain Injuries (TBI) h) Encephalopathy i) Motor Neuron Disease (MND) / Amyotrophic Lateral Sclerosis (ALS)
PSY 3.40	Interpret psychological assessment results to inform bio-psycho-social formulations and treatment planning: - Interpret results of assessments and offer findings to clinicians to assist in identifying a new diagnosis based on clinical findings, the patient's presentation and data from psychometric and cognitive measures. - Identify disorder subtypes including differentiating between multiple types of dementia where possible and identifying associated implications for treatment - Consider normal age-related changes, base rates, risk factors, and distinct symptom presentations of psychological and neurological disorders in older adults when assisting with differential diagnoses - Identify the need for baseline and repeated-measures assessments in order to understand complex diagnostic problems
PSY 3.41	Evaluate older people's understanding, appreciation, reasoning, and communication abilities with regards to capacity for decision making: - Utilise clinically specific assessment tools designed to aid evaluation of decision making and other functional capacities - Integrate testing results with information from clinical interview with clients and collateral sources, including behavioural observations and interviews with family members, to formulate summaries and recommendations - Collaborate with professionals from other disciplines to assess specific functional capacities (e.g., independent living, driving) - Appreciate legal and clinical contexts of capacity/knowledge and skills evaluations (e.g., need for appropriate decision-making supports as set out in legislation)
PSY 3.42	Demonstrate ability to assess and formulate regarding psycho-social factors impacting symptoms associated with neurological conditions (e.g., pain, fatigue, sleep difficulties), and their impact on independent functioning and quality of life
PSY 3.43	Demonstrate ability to deliver evidenced-based psychological interventions to manage/alleviate the impact of symptoms associated with neurological conditions (e.g., pain, fatigue, sleep difficulties and functional impairment)
PSY 3.44	Demonstrate ability to use appropriate assessment methods and evidenced-based interventions with patients presenting with functional neurological symptoms

PSY 3.45	Provide Psychological Consultation: - Recognise situations in which psychological consultation is appropriate - Demonstrate ability to clarify and refine a referral question - Demonstrate ability to gather information necessary to answer a referral question - Advocate for quality care for older adults with their families, professionals, programs, health care facilities, legal systems, and other agencies or organisations
PSY 3.46	Participate in Interprofessional Teams: - Work with professionals in other disciplines to incorporate psychological information into team treatment planning and implementation - Appreciate and integrate feedback from interdisciplinary team members into case conceptualisations - Work to build consensus on treatment plans and goals of care, to invite various perspectives, and to negotiate conflict constructively - Demonstrate ability to work with diverse team structures (e.g., hierarchical, lateral) and team members - Apply an understanding of systemic theory, social psychology and organisational psychology to help facilitate effective team working and resolve conflict where possible
PSY 3.47	Lead, facilitate and engage in clinical research in older person cohorts, including designing research projects in line with older person service needs, and collaborating with all relevant stakeholders in respect of research issues
PSY 3.48	Provide expert resources, consultation, and teaching to undergraduate and postgraduate education on older person cohorts and Psychology of Aging / Geropsychology

PSY 3.49	Collaborate and Coordinate with Other Agencies and Professionals: - Work with team members to create efficient transitions across health care settings for older people and their families - Demonstrate respect for confidentiality and informed consent, as well as continuity of care, in coordinating with family members, other professionals, and agencies regarding care of an older client - Establish working relationships with local and national agencies and organisations, such as Alzheimer's Society, and Irish Hospice Foundation - Engage with national policy/clinical programmes to promote positive aging and encourage age friendly communities and hospitals

SOCIAL WORK

Discipline-Specific Knowledge and skills - SOCIAL WORK

MEMEMBERSHIP OF SOCIAL WORK WORKING GROUP

- Dr Sarah Donnelly, Assistant Professor in Social Work/Director of Graduate Studies, School of Social Policy, Social Work and Social Justice, UCD
- Patrice Reilly, Social Work Dublin North Integrated Care Team Older Persons aligned to Beaumont Hospital & Operational Lead Dublin North City Integrated Care Team Older Persons aligned to the Mater Hospital
- John Brennan, Independent Social Worker

CONTRIBUTORS

- Bernadette Casey, Principal Social Worker, National Safeguarding Manager
- Linda Curran
- Kerry Cuskelly
- Aoife Dunne, Senior Medical Social Worker, Integrated Care Team for Older Persons
- Liz Ferguson
- Conor Fitzpatrick
- Celine O'Connor, Principal Social Worker, Adult Safeguarding and Protection Office
- Aoife O'Neill, Principal Medical Social Worker
- Brendan Timon, Principal Social Worker, Adult Social Work Service

Introduction

"Social work is a practice-based profession and an academic discipline that facilitates social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing" (International Federation of Social Workers, 2014).

Gerontological social workers provide individual, family, group and community supports and services to older people, their families and carers. They focus on the whole system, adopting a social determinants to health approach. Adopting individual, community and coproduction approaches, social workers empower older persons to engage in assessment of needs, strengths and risks, individual care planning, service design and development. Social workers bring a psychosocial perspective to interdisciplinary teams and act as advocates for older people with a strong focus on human rights, autonomy, dignity, and the promotion of social justice (Burnette et al., 2003). Social workers are skilled in building trust, eliciting understanding of the older person's wishes, exploring options, and facilitating choice and control in order to ensure positive and sustainable decision making in later life (Milne et al., 2014: 13). They have core skills in interagency work, coordination and case management of services to ensure a holistic, joined up experience for the older person in navigating the wider health and social care, statutory and voluntary system. At macro level, social workers participate in the formulation and implementation of social policies and work to address wider marco economic and social issues.

Social workers work with older people, their families, and communities across a range of statutory and voluntary settings spanning institutional, acute and residential settings to community-based health and social care services, including primary care, social care, mental health, adult safeguarding and specialist services such as addiction and homeless services.

Within the Irish setting, social workers work within the following grades:

Professionally Qualified Grade

Upon entry into the workforce, Professionally Qualified Grade Social Workers utilise knowledge, skills and abilities that have been attained from completion of a Bachelor of Social Work or a Master of Social Work from an accredited third level institution. Core skills will develop with time through experiential learning, supervision and continuous professional development within various clinical settings whilst operating at this grade.

Senior Practitioner Grade

At Senior Practitioner level, social workers build upon existing skills and possess a greater depth of specialist knowledge and complexity of responsibility which includes supervision of main grade social workers and responsibilities for a clinical area/service.

Team Leader /Senior Grade

At Team Leader level, social workers are expected to demonstrate excellent clinical leadership in driving change, participate in post graduate research and operate with an expert level of proficiency. They consistently demonstrate excellence in a particular clinical area and often manage a greater depth and complexity of responsibility. They also have responsibility for the supervision of Main Grade Social Workers and Senior Practitioners.

Principal Social Worker Grade

A Principal Social Worker has achieved a high level of competence in the knowledge and skills associated with all other professional social work grades. Principal Social Workers are expected to demonstrate and advanced ability to lead and support a social work team, plan and manage resources, provide supervision. They must be able to demonstrate the ability to critically evaluate information and make sound judgements when making decisions. They must support continuing professional development and build effective working relationships with management within and across care sectors.

The Irish Association of Social Workers is the national professional body for social workers in the Republic of Ireland: www.iasw.ie .

Please Note! This section should be read in conjunction with the Common Competences' Domains section in this Framework document.

DOMAIN 3 - ROLES AND RESPONSIBILITIES

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day-to-day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge, and abilities. Each discipline should be able and willing to articulate their own roles and responsibilities in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, seamless, appropriate, and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

As a social work professional, you should:

Ref	Core knowledge
SW3.1	Demonstrate knowledge and understanding of ageism and its impact on older people and their quality of life
SW3.2	Demonstrate a knowledge of and commitment to anti-oppressive practice with the older person giving due consideration to an individual's age, race, gender, religion, culture, language, disability, sexuality, and capacity
SW3.3	Demonstrate an understanding of issues of intersectionality for example, older people and poverty, LGBTQI, race and ethnicity, suicide, substance misuse issues
SW3.4	Demonstrate knowledge and understanding of human rights, social justice and the need for micro and macro level advocacy on issues concerning the care of older people and their family carers
SW3.5	Understand social work theories, methods and approaches that social workers utilize to offer older persons with complex functional, clinical and mobility needs a support system to help them live as actively as possible with optimal quality of life
SW3.6	Understand attachment, separation, resilience, grief and loss/bereavement in later life and the impact of change on an older person and their family system
SW3.7	Understand that social workers have a key role in navigating family and power dynamics and adopting a systems approach working with the whole family/their ecosystem.
SW3.8	Demonstrate a theoretical understanding and knowledge of conflict and solution-focused processes in order to assist older people and their families experiencing relationship difficulties
SW3.9	Demonstrate a knowledge and understanding of groupwork practice and facilitation skills, and its potential benefit to working with older person's and/or their carers
SW3.10	Demonstrate knowledge and understanding of the value of community development in order to empower and promote social inclusion of older persons and their relative, friend or carer at individual and service development level through community development and capacity building approaches
SW3.11	Understand the meaning of 'cultural competence' in the care of older persons **(see Appendix 2)**
SW3.12	Understand frailty in later life, including the social factors that contribute to and can prevent frailty
SW3.13	Demonstrate an understanding the role of family carer(s) with older persons, the potential impact of caring and of the changing roles within the family structure when providing care as well as social work interventions to assist and support carers to adjust to and cope with fluctuating and changing care needs.
SW3.14	Demonstrate a knowledge and understanding of working with older persons and self-neglect
SW3.15	Demonstrate knowledge and understanding of abuse and prevention of abuse of older adults who are vulnerable including the principles of adult safeguarding, reporting processes and relevant legislation
SW3.16	Demonstrate a critical understanding of social policy, its evolution, implementation and impact on older people, social work, other professions, and inter-agency working including entitlements specific to older persons and/or their carers
SW3.17	Demonstrate a working knowledge of core counselling skills and methods and their application when working with older persons and/or their carers
SW3.18	Have a working knowledge of all relevant legislation **(see Appendix 3)**
SW3.19	Demonstrate a working knowledge of models of supervision used in social work practice with older people
SW3.20	Demonstrate a high level of commitment to developing self-care strategies and to attending to any psychological or emotional impact that working with older persons and their families may have on you

Ref	Core skills
SW3.21	Demonstrate skills in engaging the older persons and other relevant parties in psychosocial assessment of needs, wishes, strengths, supports and risks
SW3.22	Demonstrate care planning, care coordination and complex case management skills
SW3.23	Demonstrate an ability to assist older persons to identify decision-supporters/co-decision makers and to navigate the socio-legal issues related to the Assisted Decision-Making (Capacity) Act 2015
SW3.24	Demonstrate an ability to support older people and their families with planning for future care needs and preferences, including an understanding of the legislation and processes of applying for additional homecare, the NHSS, EPOA, Advance Care Planning, emergency care planning
SW3.25	Demonstrate knowledge of, and ability to interpret legislation and policy, and educate and/or advise older persons/ their carers / family and colleagues re same
SW3.26	Demonstrate engagement and motivational interviewing skills in working with difficult to engage persons
SW3.27	Demonstrate an ability to engage and adapt counselling styles and approaches according to the individual needs of older persons and their families
SW3.28	Demonstrate report writing skills for court hearings for example EPA or Ward of Court applications
SW3.29	Demonstrate the ability to share professional knowledge and expertise regarding psychosocial issues in ageing, with the older person, their family, the multidisciplinary team and/or other relevant colleagues
SW3.30	Demonstrate strong networking skills and an ability to facilitate co-production, groupwork and community development approaches in working with older persons, their communities and/or their carers
SW3.31	Educate colleagues regarding anti-oppressive practice and raise awareness of wider or MDT factors or practices that may be considered oppressive to older persons and/or their carers
SW3.32	Educate colleagues regarding abuse practices and raise awareness of wider or MDT factors or practices that may be considered abusive to older persons and/or their carers
SW3.33	Demonstrate the ability to conduct an initial safeguarding screening and safety plan and review and assess effectiveness
SW3.34	Demonstrate an ability to take a lead role within teams in safeguarding adults at risk of abuse
SW3.35	Demonstrate the ability to support colleagues to identify and report safeguarding concerns and guide them through screening any ongoing safeguarding investigations and safety planning

Ref	Enhanced knowledge
SW3.34	Demonstrate advanced knowledge of policy analysis at micro and macro level and development of policies, procedures, protocols and guidelines relating to older people in general and specifically in relation to social work
SW3.35	Demonstrate an advanced knowledge, understanding and skill base in providing socio-legal information in relation to assisted decision-making and advance care planning and signpost for appropriate professional / legal advice.
SW3.36	Demonstrate an advanced ability to mentor, offer peer support and provide supervision to students and social work staff
SW3.37	Demonstrate an advanced knowledge and understanding in supporting older persons and their carers and their supporters, with issues of self-neglect and/or hoarding
SW3.38	Demonstrate an advanced knowledge and understanding of social work theoretical frameworks for practice
SW3.39	Demonstrate an advanced knowledge and understanding of the social work role in facilitating integrated care
SW3.40	Demonstrate excellent knowledge of counselling and interviewing skills as relevant to social work

SW3.41	Demonstrate an advanced ability to understand ethics and values and to analyse ethical dilemmas and make decisions about them accordingly, for e.g., ability to analyse and act on ethical dilemmas at individual, group and organisational level
SW3.42	Demonstrate an advanced awareness of the structural issues in society that negatively impact older people and their families, for example, poverty and advocate to ameliorate_as necessary

Ref	Enhanced skills
SW3.43	Demonstrate advanced networking and coordination skills and a strong ability to facilitate co-production, groupwork and community development approaches in working with older persons, their communities and/or their carers
SW3.44	Demonstrate an advanced ability to resolve conflict and excellent mediation skills in supporting families with complex relationships, including where abuse is present, in order to facilitate the on-going care plan, as agreed by the older person
SW3.45	Demonstrate advanced report writing skills for court
SW3.46	Demonstrate advanced written and verbal presentation skills in relation to court attendance or completion of risk assessment reports as above
SW3.48	Demonstrate an ability to promote a positive safeguarding ethos and 'zero tolerance' of abuse culture as per Adult Safeguarding Policy
SW3.47	Promote a 'Positive Risk-Taking' approach to working with older people
SW3.49	Demonstrate advanced skills in critically analyzing and contributing to social policy development at macro and micro level
SW3.50	Demonstrate an ability to conduct risk assessments as specific to the person's situation and support the older persons, their family and/or team to 'manage risk' in keeping with the person's capacity, will and preference
SW3.51	Demonstrate an advanced ability to coordinate communication across services and sectors so that the older persons and their family's experience of care is one that is person centred, planned, anticipatory, empowering, well-coordinated and efficient
SW3.52	Demonstrate advanced complex case management skills
SW3.53	Demonstrate an ability to advocate alongside older people and their families at individual, group and community level, supporting them to overcome barriers and access and mobilize resources to address identified needs

SPEECH AND LANGUAGE THERAPY

Discipline-Specific Knowledge and skills - SPEECH AND LANGUAGE THERAPY

MEMBERSHIP OF SPEECH AND LANGUAGE THERAPY WORKING GROUP

The following CORU registered Speech and Language Therapist, who are members of the Speech and Language Therapy Provision for Older People living with Frailty working group from the IASLT (Irish Association of Speech and Language Therapists) prepared the following document:

- Orla Boyle, Senior Speech and Language Therapist, Gerontological Emergency Department Intervention (GEDI) Team, Tallaght University Hospital
- Aine Murphy, Clinical Specialist Speech and Language Therapist, Frailty Intervention Therapy Team (FITT), Mater Misericordiae University Hospital
- Anne Claffey, Senior Speech and Language Therapist Mullingar Frailty Intervention Team (MFIT), Regional Hospital, Mullingar
- Anne Dolan, Senior Speech and Language Therapist, Frailty Intervention Therapy Team and Reablement Team, Cavan General Hospital
- Aifric Conway, Senior Speech and Language Therapist, FITT team, Beaumont Hospital
- Jennifer Maher, Clinical Specialist Speech and Language Therapist, STEP South Tipperary
- Maria Cremin, Senior Speech and Language Therapist FITT, University Hospital Kerry
- Vanessa Gilleran, RFIT, Senior Speech and Language Therapist, Roscommon University Hospital

Contributors:

- Danielle McConnell, Speech and Language Therapist, Regional Hospital Mullingar
- Ciara Moran, Speech and Language Therapist, St. James' Hospital
- Helena Walsh, Speech and Language Therapist, University Hospital Limerick

Introduction

In order to work as a Speech and Language Therapist (SLT) in the Republic of Ireland, you must be registered with CORU and adhere to its code of professional conduct and ethics. The Irish Association of Speech & Language Therapists (IASLT) is the professional body serving, promoting and representing SLTs in Ireland. IASLT (2016) defines SLT's scope of practice as the screening, assessment, diagnosis, management and prevention of communication disorders and feeding, eating, drinking and swallowing (FEDS) difficulties, also known as dysphagia. SLTs work with people across the lifespan and the objective of services is to improve service users' quality of life by optimising their ability to communicate and/or swallow in their natural environments (IASLT, 2016). A better understanding and awareness of the prevalence of communication difficulties and challenges that older people experience, as well as the impact of presbyphagia (normal ageing of swallow), multiple clinical conditions and frailty on swallow function in older people continues to emerge as more in-depth and focused research is carried out internationally. With this, comes the recognition of the fundamental role SLT has in various clinical contexts in working with older people. Correspondingly, the contexts and breadth of the SLT profession's role in working with older people are continually expanding and progressing in Ireland to meet the needs of this heterogeneous client group.

The Code of Professional Conduct and Ethics for Speech and Language Therapists (CORU, 2019) supports the position that, in working with older people, SLTs are uniquely qualified to:

- Optimise older people's ability to communicate in all environments. Given that communication involves the transfer of information between individuals, and can incorporates multiple modalities and forms (e.g. speaking, reading, writing, gestures), SLTs work with both the individual and a broad and varied range of communication partners as required.
- Improve quality of life for older people through facilitation of communication and facilitation of feeding, eating, drinking and swallowing. Given the centrality of communication to all aspects of everyday living, and the core, life sustaining function of eating and drinking, this role can take many different forms and approaches, depending on the needs and priorities of the individual
- Undertake appropriate assessment, diagnosis and management of communication disorders and feeding, eating, drinking and swallowing disorders in line with evidence informed practice
- Advocate for older people, and support older to people to advocate for themselves, in the context of communication difficulties, and/or feeding, eating, drinking and swallow disorders. This encompasses facilitation of older people, through communication assessment and support, to be actively involved in decision making and consent relating to their care in keeping with the principles and legislation outlined in the Assisted Decision Making (Capacity) Act, 2015.

Within the Irish setting, SLTs work within the following clinical grades:

Entry Level/Staff Grade Therapist

Upon entry into the workforce, Entry level/Staff Grade therapists utilise knowledge, skills and abilities that have been attained from completion of a Bachelor of Science (Honors) or a Master of Science in Speech and Language Therapy from a third level institution. Core skills will develop with time through experiential learning, supervision and continuous professional development within various clinical settings whilst operating at entry level/staff grade.

Senior Therapist

At Senior level, therapists build upon existing skills and possess a greater depth of specialist knowledge and complexity of responsibility which may include supervision of entry level/staff grade therapists and responsibilities for a clinical area/service.

Clinical Specialist Therapist

At Clinical Specialist level, therapists are expected to demonstrate excellent clinical leadership in driving change, participate in post graduate research and operate with an expert level of proficiency. They consistently demonstrate excellence in a particular clinical area and often manage a greater depth and complexity of responsibility than at senior level.

Advanced Clinical Practice Therapist

At Advanced Clinical Practice level, therapists operate within an extended scope of practice, and may engage in activities that are traditionally a function of other professions. In order to practice at this professional level, therapists demonstrate high levels of analysis and critical thinking which has been developed through a distinct blend of further education and practical expertise (National Health & Social Care Professions Office, 2016). Advanced practice roles for SLTs are not currently well developed in Ireland, however, given the recognised benefits to service users and service providers, it is an area of priority identified in HSE national strategy and planning documents, in order to meet the evolving needs of the Irish healthcare system.

Domain 3: Roles and responsibilities

Roles and responsibilities incorporate the knowledge and skills required within each discipline on a day to day basis to provide high quality care to older persons. Roles and responsibilities will, therefore, differ between disciplines, and team members should recognise their own limitations in skills, knowledge and abilities.

Each discipline should be able and willing to articulate their own roles and responsibilities

in a meaningful way to colleagues from the other disciplines so as:

- to ensure the delivery of high-quality person centred care
- to enhance collaboration and
- to ensure that there is a clear understanding amongst team members of each other's roles.

Such clarity about each discipline's roles and responsibilities helps to ensure that the services offered to the older person are coordinated, appropriate and timely. Each discipline should seek to instill in service users and other professional members the value of their professional role, as this is fundamental to effective collaboration and leads to a respect for the expertise of all professionals (Suter, et al; 2009).

As a Speech & Language Therapist you should:

Ref	Core knowledge
SLT3.01	Understand that all Speech & Language Therapists must be registered with CORU and adhere to code of professional conduct and ethics
SLT3.02	Have an awareness of the subtypes of dementia and the common communication and cognitive linguistic features associated with each subtype
SLT3.03	Understand the impact of dementia and/or delirium on the communication and cognitive linguistic ability of the older person
SLT3.04	Understand the impact of dementia and/or delirium on the communication interactions experienced by the older person
SLT3.05	Understand the features and subtypes of Primary Progressive Aphasia (PPA)
SLT3.06	Understand that onward referral to a Memory Clinic or specialist service may be indicated if changes in communication are the first recognizable indicator of a possible neurological condition or disease
SLT3.07	Understand how communication impairments associated with age-related conditions and progressive neurological conditions can impact on the social, mental and physical well being of the older person and their carer and/or family
SLT3.08	Understand how communication assessment and individualized communication support strategies and tools are central to the accurate implementation of the Assisted Decision Making (Capacity) Act 2015
SLT3.09	Understand the impact of ageing on feeding, eating, drinking and swallowing (FEDS) and the changes in swallowing associated with normal ageing (presbyphagia)
SLT3.10	Understand the signs and symptoms of dysphagia (swallowing difficulties) in older people
SLT3.11	Understand the impact of frailty and sarcopenia on FEDS in older people
SLT3.12	Understand that frailty and/or acute illness can exacerbate the features of presbyphagia, increasing risk for dysphagia in older people. Understand that this dysphagia may also improve with treatment or interventions targeting frailty and/or acute illness
SLT3.13	Understand the physical consequences of dysphagia for older people including weight loss, respiratory illness, dehydration and malnutrition
SLT3.14	Understand the psycho-social consequences of dysphagia for older people including impact on quality of life, effect on participation and social activities, and anxiety or concern relating to FEDS
SLT3.15	Understand the impact of FEDS difficulties for carers and/or family of the older person
SLT3.16	Understand and apply knowledge of clinical bedside evaluation of swallow with older people
SLT3.17	Understand and apply knowledge of evidence based therapies, compensations and modifications for older people experiencing dysphagia
SLT3.18	Have an awareness of objective assessments of swallow such as videofluoroscopy, fibreoptic endoscopic evaluation of swallow, or ultrasonography of swallow, and when to refer an older person for these objective assessments

SLT3.19	Have an awareness of interventions which address the clinical sequelae of dysphagia and/or aspiration including alternative feeding (e.g. nasogastric tube, PEG tube, TPN), and Eating and drinking for comfort (or with acknowledged risk). Understand the benefits and risks of these interventions and apply this knowledge to support person-centred decision making for the older person
SLT3.20	Understand the ethical considerations relating to dysphagia, aspiration risk and decisions regarding alternative feeding for older people with progressive age-related and neurological conditions
SLT3.21	Understand that ethical decision making relating to dysphagia, aspiration risk and decisions regarding alternative feeding for older people is an on-going collaborative process and not a single event. Priorities, preferences and health factors can change over time and may introduce new considerations which will influence or alter decision making
SLT3.22	Understand common respiratory conditions which affect older people and how they impact on communication and FEDS
SLT3.23	Understand the role of Respiratory Physiotherapy, Respiratory Clinical Nurse Specialist or Advanced Nurse Practitioner in working with older people and when/how to refer as appropriate
SLT3.24	Understand the common neurological conditions which affect older people, including dementia, Parkinson's Disease (PD), Stroke and ministroke/ TIA, and Traumatic brain injury (TBI). Understand the impact that these conditions have on communication and EDS for older people
SLT3.25	Understand the combined impact of frailty markers on an older person with a neurological condition
SLT3.26	Understand that older people who have difficulty communicating due to receptive or expressive language impairment, or cognitive linguistic difficulties require in depth communication assessment, including liaison with their regular communication partners and those who know them best, in order to ensure that behaviours indicating pain, distress or well-being are recognised and responded to in an appropriate way

Ref	Core skills
SLT3.27	Recognise and identify indicators for carrying out assessment of communication with the older person and their communication partners
SLT3.28	Select and use standardized and non-standardised assessment tools to profile the communication abilities and needs of the older person where assessment of communication is indicated. Also able to clinically reason why/why not to use these tools.
SLT3.29	Collaboratively identify goals for intervention in relation to communication with the older person and their communication partners
SLT.3.30	Plan, grade, implement and modify interventions that are outcome based and relevant to the older person's communication related goals
SLT3.31	Evaluate outcomes in collaboration with the older person and their communication partners
SLT3.32	Contribute to differential diagnosis of conditions such as Mild Cognitive Impairment (MCI), dementia, Primary Progressive Aphasia (PPA) through profiling of communication ability
SLT3.33	Facilitate communication partner training with older people and their communication partners
SLT3.34	Facilitate conversation training programmes for individuals and groups
SLT3.35	Support clinical colleagues in the identification of relevant strategies and communication supports that will help to facilitate the inclusion of the older person in assessments, therapies and conversations relating to their care and management
SLT3.36	Identify when and how the inclusion of alternative and augmentative communication (AAC) tools, devices and assistive technology may help to support effective communication with an older person
SLT3.37	Support and train the communication partners of older people in the effective use of AAC tools and devices
SLT3.38	Advocate for the inclusion of older people with communication impairments in conversations and decision making related to their care, through the use of appropriate and person specific strategies

SLT3.39	Where relevant, provide communication training to the older person in order to help to build their capacity for decision making
SLT3.40	Collaborate with capacity assessors to support effective, person-centred communication with the older person during capacity assessment
SLT3.41	Demonstrate an ability to complete a comprehensive clinical bedside evaluation of swallow with an older person, making appropriate adjustments for person-specific factors such as reduced vision, impaired hearing, difficulties with communication and/or cognition, confusion or delirium
SLT3.42	Plan, grade, implement and modify interventions that are outcome based and relevant to the older person's goals for eating, drinking and swallowing
SLT3.43	Provide education on FEDS to older people and their carers and/or family
SLT3.44	Provide training to staff with regard to FEDS and the older person
SLT3.45	Apply knowledge of common respiratory conditions and their impact on communication and FEDS to modify SLT assessment and intervention as appropriate
SLT3.46	Apply knowledge of the combined impact of frailty markers on an older person with a neurological condition to modify SLT assessment and intervention as appropriate
SLT3.47	Complete relevant person-centred SLT assessment and intervention, considering the communication, cognitive, physical and functional impairments that may be present with common neurological conditions in older people including dementia, Parkinson's Disease (PD), Stroke and ministroke/TIA, and Traumatic brain injury (TBI).
SLT3.48	Support and facilitate the older person to effectively engage with pain assessment through implementation of relevant communication supports and person-specific strategies
SLT3.49	Modify an SLT assessment and/or intervention plan to focus on comfort and supportive care for an older person who is approaching end of life
SLT3.50	Support ethical decision making in relation dysphagia, aspiration risk and decisions relating to alternative feeding for older adults, which takes account of the preferences and priorities of the older person and their family or carers

Ref	Enhanced knowledge
SLT3.51	Have an advanced understanding of dementia, dementia subtypes and patterns of progression across the course of the disease
SLT3.52	Understand the importance of communication profiling in order to help support the recognition and monitoring of changes in the condition of the older person such as delirium, progression of MCI to dementia, progression of dementia, or differential diagnosis of acute events in older people presenting with non-specific symptoms
SLT3.53	Have an advanced understanding of health literacy and knowledge of tools and methods that services and clinicians can use to evaluate the ways in which they communicate with older people
SLT3.54	Demonstrate an advanced understanding of the Assisted Decision-Making (Capacity) Act 2015, capacity evaluation, and triggers for capacity evaluation.
SLT3.55	Understand and apply knowledge of objective assessment of swallow such as videofluoroscopy, fibreoptic endoscopic evaluation of swallow, or ultrasonography of swallow in line with your own professional training and scope of practice
SLT3.56	Have an advanced knowledge of common aetiologies, presentations and prognosis of FEDS impairments in older people. Have an understanding of sarcopenic dysphagia and the specific considerations associated with management
SLT3.57	Understand the reasons for oxygen therapy, contra-indications of oxygen therapy and the impact of oxygen use on communication and FEDS for older people
SLT3.58	Have an advanced clinical knowledge of the common neurological conditions which affect older people, including dementia, Parkinson's Disease (PD), Parkinson's Plus syndromes, Stroke and ministroke/TIA, and Traumatic brain injury (TBI). Have an advanced understanding of the impact that these conditions have on communication and FEDS for older people
SLT3.59	Have an advanced understanding of the combined impact of frailty markers on an older person with a neurological condition

SLT3.60	Understand the contra-indications and side effects experienced by older people with common analgesics, and how these relate to communication and FEDS
SLT3.61	Have an advanced knowledge of interventions and strategies which can support comfort, oral hygiene, communication and FEDS for the older person and their carer/family at end of life

Ref	Enhanced Skills
SLT3.62	Advocate for the evaluation of facilitators and barriers to effective communication with older people. Promote methods and practices which help to support communication access, inclusion and health literacy for older people
SLT3.63	Demonstrate an advanced ability to promote and develop practice relating to communication access within services and care settings
SLT3.64	Participate in the completion of objective assessment of swallow such as such as videofluoroscopy, fibreoptic endoscopic evaluation of swallow, or ultrasonography of swallow, in line with your own professional training and scope of practice
SLT3.65	Plan, grade, implement and modify SLT assessments and interventions for the older person considering the communication, cognitive, physical and functional impairments that may be present with the neurological conditions that commonly affect older people including dementia, Parkinson's Disease (PD), Parkinson's Plus syndromes, Stroke and ministroke/TIA, and Traumatic Brain Injury (TBI)
SLT3.66	Collaborate with and support MDT colleagues to implement care pathways that facilitate the effective identification and monitoring of pain and well-being for older people who may have difficulty communicating verbally
SLT3.67	Provide SLT assessment and intervention for older people and their carer/family with complex needs at end of life

Appendices

Appendix 1 - Knowledge and skills Framework CPD Record

This sample template has been designed to support the professional to rate their current level of professional development (CPD) and identify learning needs in a structured fashion. This tool can be used by an individual or a team to support CPD planning.

Please identify areas of strength and areas for improvement to inform your CPD plan.

Professional Name:

Supervisor/Manager Name:

Name/ Role of Staff Member or Team:					Date:
Ref	Knowledge and skills area	Self-Rating: Areas of strength & further development	Self-Rating: Areas for Improvement	Learning Needs Identified/ Actions	Signed by: Professional Manager/Supervisor

Appendix 2 - Glossary

Acquired Brain Injury (ABI): is any injury to a person's brain that happens during their lifetime. The injury can be caused by a stroke, a bleed in the brain, an infection, a tumour, a lack of oxygen or a fall, for example.

Activities of Daily Living: (ADLs): Everyday routines generally involving functional mobility and personal care, such as bathing, dressing, toileting, and meal preparation; basic self-care tasks.

Activity Analysis: Process of systematically appraising what behaviours and skills are required for participation in a given activity.

Adaptive Equipment: Equipment that enables a person with a disability to function independently; the term is being replaced by the term, assistive devices.

Advocacy: Advocacy is about giving advice and support to the older person to make choices that are right for them when it comes to decisions on their health and social care. Advocacy in healthcare aims to support older people who are vulnerable, to ensure that their rights are being upheld in a health and social care context. This may include individuals who are physically disabled or wheelchair-bound, or those with age-associated degenerative diseases such as dementia. Activities include ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change.

Assistive Device: Any technology that enables a person with a disability to improve his or her functional level.

Capacity Building: The process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive in a fast-changing world.

Cognitive Skills: Skills required for all aspects of thinking including the processes of perception, memory, reasoning, language and some types of learning.

Community Development: A holistic approach grounded in principles of empowerment, human rights, inclusion, social justice, self-determination and collective action (Kenny, 2007).

Contraindication: A specific situation in which a drug, procedure, or surgery should not be used because it may be harmful to the person.

Co-production: When an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.

CORU: CORU is Ireland's multi-profession health regulator. The role of CORU is to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration of health and social care professionals. CORU was set up under the Health and Social Care Professionals Act 2005. It is made up of the Health and Social Care Professionals Council and the Registration Boards, one for each profession named in our Act. CORU currently regulates the following professions: Dietitians, Dispensing Opticians, Medical Scientists, Occupational Therapists, Optometrists, Physical Therapists, , Physiotherapists, Podiatrists, Radiographers, Radiation Therapists, Social Workers and Speech and Language Therapists.

Cultural Knowledge and skills: Implies a heightened consciousness of how culturally diverse populations experience their uniqueness and deal with their differences and similarities within a larger social context (NASW, 2015). Cultural knowledge and skills requires all healthcare professionals to examine their own cultural backgrounds and identities to increase awareness of personal assumptions, values, stereotypes, and biases. This awareness of personal values, beliefs, stereotypes, and biases informs their practice and influences relationships with clients (Web). Diversity is multi-dimensional and includes race, disability, class, economic status, age, sexuality, gender (including transgender), faith and belief, and the intersection of these and other characteristics.

Delirium: Delirium is a serious disturbance in mental abilities that results in confused

thinking and reduced awareness of the environment. The start of delirium is usually rapid — within hours or a few days.

Dementia: Nonspecific but lasting deterioration of intellectual functioning characterized by failing memory, distractibility, impairment in judgment and abstraction, reduced language facility, alterations in mood and affect, and disturbance of orientation. Accompanied by changes in personality and ways of relating to others.

Deprescribing: A systematic process of identifying and discontinuing drugs in instances in which exu which existing or potential harm outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values and preferences. It is a positive patient-centred intervention, which requires shared decision making, informed patient consent, and close monitoring of effects.

Dysphagia: Any impairment of eating, drinking and swallowing.

Enteral tube feeding: Use of a tube to deliver a feed directly into the stomach or gut.

Fine Motor Skills: The ability to move the hands and fingers in a smooth, precise and controlled manner. Fine motor control is essential for efficient handling of classroom tools and materials. It may also be referred to as dexterity.

Gross Motor Skills: Coordinated body movements involving the large muscle groups. A few activities requiring this skill include running, walking, hopping, climbing, throwing and jumping.

Instrumental Activities of Daily Living (IADLs): Complex skills needed to successfully live independently. These skills are usually learned during the teenage years such as managing finances, handling transportation (driving or navigating public transit), shopping, preparing meals, using the telephone and other communication devices, managing medications, housework and basic home maintenance.

Interdisciplinary Teams (IDT) are organised to work on a common set of complex problems and each contributes their skill set in order to augment and support others in the team whilst taking account of that person's contribution. Members retain specialised roles and functions whilst communicating actively with one another.

Malnutrition: Malnutrition (undernutrition form) is a state of nutrition in which a deficiency of energy, protein and other nutrients causes measurable adverse effects on body structure and function and clinical outcome. Reduced food intake or reduced nutrient absorption, combined with acute or chronic inflammation, leading to altered body composition and diminished function, characterises malnutrition associated with disease or injury.

Medicines optimisation: The entire way medicines are selected, procured, delivered, prescribed, administered and reviewed, to optimise the contribution that medicines make to enabling informed patient choice and delivering desired outcomes for patients.

Medicines reconciliation: The process of creating and maintaining the most accurate list possible of all medications a person is taking – including drug name, dosage, frequency and route – in order to identify any discrepancies and to ensure any changes are documented and communicated, thus resulting in a complete list of medications. It aims to provide patients and service users with the correct medications at all points of transfer within and between health and social care services.

Medication review: A structured evaluation of a patient's medicines with the aim of optimising medicines use and improving health outcomes. This entails detecting drug-related problems and recommending interventions.

Mild cognitive impairment (MCI): An early stage of memory loss or other cognitive ability loss (such as language or visual/spatial perception) in individuals who maintain the ability to independently perform most activities of daily living.

Modified Consistency Diet: Foods that have been physically altered to change their texture/ consistency. Altering food texture has demonstrated a therapeutic benefit for reducing the risk of choking. Within the International Dysphagia Diet Standardisation Initiative framework, there are 5 levels of food textures (Levels 3-7) which include Regular diet (Level 7), Soft Diet (Level 6), Minced & Moist Diet (Level 5), Pureed Diet (Level 4) and Liquidised Diet (Level 3).

Multi-disciplinary Teams (MDT) allow for each discipline to independently contribute its expertise to a patients care. Typically the Consultant Physician prescribes the contribution of others in the team and team members work in parallel.

Myopathy: Abnormal condition of skeletal muscle characterized by muscle weakness and wasting.

Neuropathic Pain: Pain caused by a lesion or disease of the somatosensory nervous system.

Nociceptive Pain: Pain caused by potentially harmful stimuli being detected by nociceptors around the body.

Nutrition assessment: Nutrition assessment should be performed in all subjects identified as being at risk by nutrition screening for risk of malnutrition, and will give the basis for the diagnosis decision, as well as for further actions including nutritional treatment. It is a comprehensive approach to diagnosing nutritional problems that uses a combination of medical, nutritional and medication histories; physical examination; anthropometric measurements; and laboratory data.

Nutrition: The process of providing or obtaining the food and hydration necessary for health and growth.

Nutritional care: Nutritional care is an overarching term to describe the form of nutrition, nutrient delivery and the system of education that is required for meal service or to treat any nutrition-related condition in both preventive nutrition and clinical nutrition (Cederholm et al., 2017).

Nutrition support: The provision of nutrients and any necessary adjunctive therapeutic agents to patients orally and/or enterally by administration into the stomach or intestine and/or by intravenous infusion (parenterally) for the purpose of improving or maintaining a patient's nutrition status.

Occupation: To be engaged in the action of performing of daily life tasks. Thus, occupation pertains to the person being engaged in doing something (e.g., getting dressed, playing cards, reading a book). Thus, occupation should not be confused with or referred to as the task the person will have done or plans to do

Occupational Therapy Process: Client-centred delivery of occupational therapy services. The process includes evaluation and intervention to achieve targeted outcomes. The stages of the process and the dynamic interactions among the different aspects of the process are emphasised

Parenteral nutrition: Nutrition provided intravenously, typically involving an infusion of amino acids, glucose, fat, vitamins, trace elements and electrolytes.

Perception: Process of becoming aware of, attending to, or interpreting stimuli, usually by visual, auditory, or kinaesthetic senses

Person-centred: A way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs.

Physical disability: Physical degeneration or loss to an individual caused by either congenital or adventitious factors

Polypharmacy: Concurrent use of multiple medications. Although there is no standard definition, polypharmacy is often defined as the routine use of five or more medications. This includes over-the-counter, prescription and/or traditional and complementary medicines used by a patient (WHO, 2019).

Pressure Sore: Breakdown in the skin due to pressure that results in tissue death and sometimes infection; also known as skin sore or decubitus ulcer.

Quality Improvement (QI): Process whereby the quality of healthcare is evaluated in terms of predefined standards; formally termed quality assurance; sometimes termed continued improvement or performance improvement.

Rehabilitation: the action of restoring someone to health or normal life through training and therapy after imprisonment, addiction, or illness.

Sarcopenia: Sarcopenia is a syndrome of its own characterized by the progressive and generalised loss of skeletal muscle mass, strength and function (performance) with a consequent risk of adverse outcomes

Skin Integrity: refers to skin health. A skin integrity issue might mean the skin is damaged, vulnerable to injury or unable to heal normally.

Therapeutic diet: Modified from a 'normal' diet and is prescribed to meet a medical or special nutritional need. It is part of a clinical treatment and in some cases can be the principle treatment of a condition

Traumatic brain injury (TBI): a form of acquired brain injury occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object or when an object pierces the skull and enters brain tissue.

Treatment burden: is the effort and resources required by a patient or caregiver to manage the patient's medical conditions and the impact that this has on their lives

Treatment plan: Interdisciplinary plan to address the client's assessed needs; the expression care plan is common in long-term care; other settings may employ the term rehabilitation plan or individualized education plan.

Visual Acuity: refers to the ability of the visual system to discern fine distinctions in the environment as measured with printed or projected visual stimuli.

Visual Attention: A process that addresses this problem by directing a tiny fraction of the information arriving at primary visual cortex to high-level centres involved in visual working memory and pattern recognition.

Visual field: The entire area that can be seen when the eye is directed forward, including that which is seen with peripheral vision.

Visual Perception: Perception is the ability to receive, interpret and organise information from an external source into useable information. Visual perception is not related to eyesight as such, but is the ability to interpret and understand what we are able to see. Visual perception is made up of the following components:

- Visual discrimination
- Visual memory/sequential memory
- Visual special relations
- Visual form constancy
- Visual closure
- Visual figure ground
- Position in space

Visual Scanning: refers to the ocular strategies employed for exploring various classes of visual stimuli including faces, objects, and scenery. Scanning patterns reflect the viewer's strategy for acquiring visual information. Therefore, visual scanning precedes visual information processing

Visual-Spatial Processing Skills: Perceptions based on sensory information received through the eyes and body as one interacts with the environment and moves one's body through space. Including: Depth perception, directionality, form constancy, position in space, spatial awareness, visual discrimination, visual figure-ground.

Appendix 3 - List of Relevant Legislation

General Legislation

- Assisted Decision-Making (Capacity) Act 2015
- Children First Act 2015
- Equal Status Acts 2000 to 2015
- European Communities (Amendment of the Irish Medicines Board Act 1995) Regulations 2007
- Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2021
- National Vetting Bureau (Children and Vulnerable Persons) Act 2012
- Pharmacy Act 2007
- The Lunacy Act,1871
- The Disability Act 2005
- The Domestic Violence Act 2018
- The Health Act 2007
- The Health Act 2007 Regulations
- The Mental Health Acts 2001 to 2009
- The Mental Health Act 2001 (Approved Centres) Regulations 2006
- The Nursing Home Support Scheme Act 2009
- The Protected Disclosures Act 2014

Criminal Legislation (relevant to Safeguarding Work)

- Criminal Damage Act 1991
- Criminal Law Rape Act 1990
- Criminal Law Sexual Offences Act 1993
- Criminal Justice (Victims of Crime) Act 2017
- Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012
- Firearms/Offensive Weapons Act 1991
- Non-Fatal Offences Against the Person Act 1997
- Misuse of Drugs Act 1977, Misuse of Drugs Act 1985, Misuse of Drugs Act 2015
- Mental Treatment Act 1945
- Public Order Act 1994
- Theft Act 2001

Appendix 4 - Further Resources: Guidelines, Standards

CORU (2005). Registered dietitian. Definition available at https://coru.ie/health-and-social-care-professionals/education/approved-qualifications/dietitians/.Accessed 7/12//21.

CORU (2019) Physiotherapists registration board code of professional conduct and ethics. Available at: https://coru.ie/files-codes-of-conduct/prb-code-of-professional-conduct-and-ethics-for-physiotherapists.pdf. Accessed 7/12/21.

CORU (2019) Social Worker Registration Board Standards of Proficiency for Social Workers. Available at: https://www.coru.ie/files-education/swrb-standards-of-proficiency-for-social-workers.pdf. Accessed 7/12/21.

CORU (2019) Speech and Language Therapists Registration Board Code of Professional Conduct and Ethics. Available at: https://www.coru.ie/files-codes-of-conduct/sltrb-code-of-professional-conduct-and-ethics-for-speech-and-language-therapists.pdf. Accessed 7/12/2021.

Dahlgren G & Whitehead M (1991) Policies and strategies to promote social equity in health. Institute for Future Studies, Stockholm (Mimeo)

Department of Health (2019) The Irish National Dementia Strategy. Available at: https://assets.gov.ie/10870/3276adf5273f4a9aa67e7f3a970d9cb1.pdf (Accessed 31/08/21)

Department of Health (2013) National Positive Ageing Strategy

Department of Health (2021) Slaintecare Implementation Strategy and Action Plan 2021 – 2023

Department of Health (2013), 'National Positive Ageing Strategy', Available at: https://www.gov.ie/en/publication/737780-national-positive-ageing-strategy/ (Accessed 30/8/21)

Department of Health (2021). Sláintecare Implementation Strategy and Action Plan 2021-2023. Available at: https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/

HIQA (2019) Guidance on a Human Rights-based Approach in Health and Social Care Services

HIQA (2019) National Standards for Adult Safeguarding

HIQA (2016) National Standards for Residential Care Settings for Older People in Ireland

HIQA (2016) Supporting People's Autonomy: A Guidance Document

HIQA (2015) Communicating in plain English, Adults

HIQA (2012) A Guide to the National Standards for Safer Better Healthcare

ICPOP (2021) Practice Guidance for Community Based Older Persons Multidisciplinary Teams.

ICPOP (2020) ICPOP Enhanced Community Care Implementation Guidance: Older Persons Service Model Implementation Guide.

ICPOP (2018) Implementing Integrated Care for Older Persons in Ireland: Early stage insights and lessons for scale up

ICPOP (2018) Case Management Approaches to Support Integrated Care for Older Adults.

ICPOP (2017) Making a Start in Integrated Care for Older Persons - A practical guide to the local implementation of Integrated Care Programmes for Older Persons, Health Service Executive.

ICPOP (2016) Integrated Care Programme 10 Step Integrated Care Framework, Health Service Executive.

Irish Association of Social Workers (2020) Code of Ethics.

Irish Association of Social Workers (2020) Code of Practice.

Irish Association of Speech and Language Therapists (2016) Scope of Practice

Health Service Executive (2018) People's Needs Defining Change: Health Services Change Guide. HSE: 2018.

National Clinical Programme for Older People (NCPOP) (2017) 'Urgent Care Needs for Older People-Frailty at the Front Door'.

National Clinical Programme for Older People (NCPOP) (2012) Specialist Geriatric Services Model of Care, Health service Executive.

National Clinical Programme for Older People (NCPOP) (2016) Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment

NICE (2013) Falls Prevention Guidelines. Available at: https://www.nice.org.uk/guidance/cg161

NICE (2017) Falls in Older People Quality Standards. Available at: Overview | Falls in older people | Quality standards | NICE

Psychological Society of Ireland (2019) *Code of Professional Ethics*. Available at: www.psychologicalsociety.ie/Code-of-Ethics. Accessed 08/12/2021.

Reed, J. Ackermann, P., Benton, E., Fitzpatrick, S., Poole, C., Regan, I., Swanton, S., Conneely, F. (2016) Progressing Advanced Practice: Advanced Practice tool-kit for the health and social care professions. Health Service Executive: 2016.

Tusla (2017). Children First: National Guidance for the Protection and Welfare of Children

Websites:

Affinity Project: About AFFINITY National Falls and bone health project 2018-2023 - HSE.ie

CORU HSCP Standards & Regulations: www.coru.ie

International Foundation for Integrated Care (IFIC) International Foundation for Integrated Care Website & Publications: www.intergratedcarefoundation.org

Irish Association of Occupational Therapists: www.aoti.ie

Irish Association of Social Workers: www.iasw.ie

Irish Gerontological Society: https://www.irishgerontology.com/

Irish Nutrition and Dietetic Institute: www.indi.ie

Irish Society of Chartered Physiotherapy: www.iscp.ie

Irish Society of Physicians in Geriatric Medicine: http://ispgm.ie/

National Integrated Care Programme for Older Persons: www.icpop.org

The Irish Association of Speech and Language Therapists: www.iaslt.ie

The Irish Longitudinal Study on Ageing (TILDA): https://tilda.tcd.ie/

The Irish Nurses and Midwives Organisation: www.inmo.ie

The Pharmaceutical Society of Ireland: www.thepsi.ie

The Psychological Society of Ireland: www.psychologicalsociety.ie

References and Further Reading

Advanced Practice (Nursing) Standards and Requirements, NMBI, (2017)

ADVANTAGE JA (2019) Policy Brief: Prevention and management of frailty in the EU, A health policy priority. Available at: https://www.advantageja.eu/images/Layman_report_final.pdf (accessed 30/08/21)

Afezolli, D. et al. (2021), 'Silver book II quality urgent care for older people', Available at: https://www.bgs.org.uk/resources/resource-series/silver-book-ii (Accessed 30/8/21)

American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012. Patient-centered care for older adults with multiple chronic conditions: a stepwise approach from the American Geriatrics Society. *Journal of the American Geriatrics Society*, *60*(10), pp.1957-1968.

American Heart Association/American Stroke Association Guideline 2016 Guidelines for Adult Stroke Rehabilitation and Recovery (ahajournals.org) (Accessed 20/08/21)

American Psychological Association, 2014. Guidelines for psychological practice with older adults. *The American Psychologist*, *69*(1), pp.34-65.

Anderson, G. and Horvath, J., 2002. Chronic conditions: making the case for ongoing care. *Baltimore, MD: The Johns Hopkins University*.

Annerieke Stoop MSc,Manon Lette MSc,Paul F. van Gils PhD,Giel Nijpels PhD,Caroline A. Baan PhD,Simone R. de Bruin PhD, (2019) Comprehensive geriatric assessments in integrated care programs for older people living at home: A scoping review. Accessed: https://doi.org/10.1111/hsc.12793

Barry, M.J., 2012. Shared decision making: informing and involving patients to do the right thing in health care. *The Journal of ambulatory care management*, *35*(2), pp.90-98.

BASW & Department of Health and Social Care England (2018) Capabilities Statement for social workers in England who work with older people https://www.basw.co.uk/resources/capabilities-statement-social-workers-england-who-work-older-people

BASW (2019) The Role of SW in palliative, end of life care and bereavement care: https://www.basw.co.uk/system/files/resources/basw_33710-4_0.pdf

Berloviene, D., Beta, G., Role, D., Deimante, D. and Samusevica, A., 2019, May. COMPETENCY DEVELOPMENT IN EDUCATING HEALTH CARE SPECIALISTS AT WORK WITH OLDER PEOPLE. In *SOCIETY. INTEGRATION. EDUCATION. Proceedings of the International Scientific Conference* (Vol. 4, pp. 56-64).

Biestek (1967) *The Casework Relationship*. Loyola University Press,

Britannica (1998). The Editors of Encyclopaedia. "Gerontology and geriatrics". *Encyclopedia Britannica*, 20 Jul. 1998, https://www.britannica.com/science/gerontology. [Accessed 27 April 2021].

British Geriatric Society. (2014). *Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings.* British Geriatric Society: London.

British Geriatrics Society. (2012) Silver Book: quality care for older people with urgent and emergency care needs. Available from: https://www.bgs.org.uk/sites/default/files/content/attachment/2018-05-01/Silver%20Book%202012%20Complete.pdf

Burnette, D., Morrow-Howell, N., Li-Mei Chen, L-M. (2003) 'Setting Priorities for Gerontological Social Work Research: A National Delphi Study', *The Gerontologist*, 43(6), pp. 828-838.

Cahir, C., Curran, C., and Walsh, C. (2020). The prevalence and characteristics of adverse drug reaction-related hospital admissions in older patients. Journal of Epidemiology and Community Health, 74: A36-A37.

CGNA (2020) *Gerontological Nursing Standards of Practice and Competencies* (4th Edition) Toronto, Canada: CGNA.

Clegg, Dr. A., (2013) *Frailty in Elderly People*. The Lancet, Volume 381 (9882); 8-14

Clyne, McCoubrey & Hamilton, 2008. Therapy Project Office Occupational Therapy Competencies. Dublin: Health Service Executive

Clyne, McCoubrey & Hamilton, 2008. Therapy Project Office Physiotherapy Competencies. Dublin: Health Service Executive

Clyne, McCoubrey & Hamilton, 2008. Therapy Project Office Speech & Language Therapy Competencies. Dublin: Health Service Executive

Coffey, A., Savage, E., Leahy-Warren, P., Mulcahy, H., Wills, T., McCarthy, V., Fehin, P., Ó Doibhlin, D., McLoughlin, K., Benefield, L. E., O'Sullivan, B. and Hegarty, J. (2017). Systematic literature review and national focus groups to support the development of a strategic vision and educational framework for Gerontological Nursing. Dublin: Health Service Executive.

Conroy, S.P. and Turpin, S., 2016. New horizons: urgent care for older people with frailty. *Age and ageing*, *45*(5).577-584.

Cooper, P; Tempest, S. (2018) Spotlight on Advanced Clinical Practice. OT News (6) 24-26

Cosentino, F., Grant, P. J., Aboyans, V., Bailey, C. J., Ceriello, A., Delgado, V., Federici, M., Filippatos, G., Grobbee, D. E., Hansen, T. B., Huikuri, H. V., Johansson, I., Jüni, P., Lettino, M., Marx, N., Mellbin, L. G., Östgren, C. J., Rocca, B., Roffi, M., Sattar, N., … ESC Scientific Document Group (2020). 2019 ESC Guidelines on diabetes, pre-diabetes, and cardiovascular diseases developed in collaboration with the EASD. European heart journal, 41(2), 255–323.

Cruz-Jentoft, A. et al. (2019), 'Sarcopenia: revised European consensus on definition and diagnosis', Age and ageing, 48(1):16-31

CSWE Canadian Social Work Education Gero Ed Center & Social Work Leadership Institute (No Year) Geriatric Social Work Competency Scale II with Life-long Leadership Skills: Social Work Practice Behaviors in the Field of Aging. Accessed via: https://pogoe.org/sites/default/files/GeriatricSocialWorkCompetencyScaleII%26LifelongLeadershipSkills.pdf 13/08/21

Deacon (2011) Integrated career and competency framework for dietitians and front line staff. Diabetes UK. Available at https://www.diabetes.org.uk/professionals/training--competencies/competencies .

Denise Burnette, MSSW, PhD, Nancy Morrow-Howell, MSW, PhD, Li-Mei Chen, MSW, PhD

Dent,. Et al. (2018), 'International clinical practice guidelines for sarcopenia (ICFSR): screening, diagnosis and management', Journal of Nutrition, Health and Aging, 22(10): pp 1148-1161

Department of Health & PA Consulting (2018) Health Service Capacity Review 2018 – review of health demand and capacity requirements in Ireland to 2031. Dublin, Ireland. Available at: https://www.gov.ie/en/publication/26df2d-health-service-capacity-review-2018/

Department of Health & Social Care (2019) Strengths Based Approach - Practice Framework and Handbook for Social Work with Adults:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778134/stengths-based-approach-practice-framework-and-handbook.pdf

Dijkman, B., Roodbol, P., Aho, J., Achtschin-Stieger, S., Andruszkiewicz, A., Coffey, A., Felsmann, M., Klein, R., Mikkonen, I., Oleksiw, K., Schoofs, G., Soares, C. & Sourtzi, P. 2016. *European Core Knowledge and skills Framework for Health and Social Care Professionals Working with Older People*. Available from: http://ellan.savonia.fi/

Donaldson, L.J., Kelley, E.T., Dhingra-Kumar, N., Kieny, M. and Sheikh, A. (2017) 'Medication without harm: WHO's third global patient safety challenge', The Lancet, 389(10080), pp. 1680-1681.

EFAD (2015) Briefing Paper on the Role of the Dietitian in the Prevention and Management of Nutrition-related Disorders in Older Adults European Federation of Associations of Dietitians.. http://www.efad.org/media/1333/position-paper-on-the-role-of-the-dietitian-in-the-prevention-and-management-of-nutrition-related-diaseas-in-the-elderly.pdf. Accessed September 2019.

EFAD (2017) Statement on the Role of the Dietitian in the Prevention and Management of Nutrition-related Disorders in Older Adults . European Federation of Associations of Dietitians. Available at: http://www.efad.org/en-us/specialists-networks/older-adults/role-statement/ . Accessed September 2021.

Ellan (2016). European Core Knowledge and skills Framework for Health and Social Care Professionals Working With Older People.

Ellis, G., & Sevdalis, N. (2019). Understanding and improving multidisciplinary team working in geriatric medicine. *Age and Ageing*, *48*(4), 498–505. https://doi.org/10.1093/ageing/afz021

Ellis, G., Whitehead, M A., O'Neill, D., Langhorne, P., Robinson, D. (2011) *Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials*. BMJ, 343: d6553. Cochrane Database System Rev 6(7)

7th ed. Lippincott, Williams & Wilkins: Philadelphia. Eton, D.T., et al., Building a measurement framework of burden of treatment in complex patients with chronic conditions: a qualitative study. Patient Relat Outcome Meas, 2012. 3: p. 39-49.

Frank JR, Snell L, Sherbino J, editors. *CanMEDS 2015 Physician Competency Framework*. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015.

Health and Social Care Professionals Council, 2021 *Continuing Professional Development* Available at:[https://coru.ie/health-and-social-care-professionals/education/continuing-professional-development/cpd-for-registrants/]. Accessed 7th December 2021

Health Service Executive (2018) Food nutrition and hydration policy for adult patients in the acute setting. Available at https://www.hse.ie/eng/about/who/acute-hospitals-division/food-nutrition-and-hydration-policy-for-adult-patients/

Health Service Executive. (2008). *Therapy Project Office: Occupational Therapy Competencies.* Health Service Executive. Available from: https://ipmn.ie/wp-content/uploads/2017/11/Senior-Competencies.pdf

Henderson, V. (1966). *The Nature of Nursing: A Definition and its Implications for Practice, Research, and Education*. New York: Macmillan Publishing.

Hernández, B., Reilly, R.B. and Kenny, R.A., 2019. Investigation of multimorbidity and prevalent disease combinations in older Irish adults using network analysis and association rules. *Scientific reports*, *9*(1), pp.1-12.

Hopewell, S., Copsey, B., Nicolson, P., Adedire, B., Boniface, G. and Lamb, S. 2019.Multifactorial interventions for preventing falls in older people living in the community: a systematic review and meta-analysis of 41 trials and almost 20 000 participants.

Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report, May 2017. Houses of the Oireachtas, Dublin. Available at: https://www.gov.ie/en/publication/0d2d60-slaintecare-publications/#the-slaintecare-report

IDDSI (2021) International Dysphagia Diet Standardization Initiative Framework. Available at www.iddsi.org. Accessed September 2021.

IASW Head Medical Social Work Group (2014) Social Work in a Medical Setting: Competencies Framework

ICDA (2016) International Competency Standards for Dietitians. International Confederations of Dietetic Associations. Available at https://www.internationaldietetics.org/Downloads/ICDA-Intl-Competencies-for-Dietitian-Nutritionists.aspx. Accessed September 2021.

ICN (2002): Nursing Definitions. Retrieved from: https://www.icn.ch/nursing-policy/nursing-definitions

INDI (2021) Role of the dietitian. Irish Nutrition and Dietetics Institute. Available at www.indi.ie. Accessed September 2021

INDI Nutrition support Reference Guide (2021 in press) . Chapter on Nutrition for Older Persons. Available to members from the Irish Nutrition & Dietetics Institute. www.indi.ie

International Association of Physiotherapists working with Older People (IPTOP) https://world.physio/subgroups/older-people (Accessed 22/08/2021)

International Federation of Social workers. (2019) Global Social Work Statement of Ethical Principles

Interprofessional Education Collaborative Expert Panel (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative.

Irish Society of Chartered Physiotherapists (ISCP) https://askthephysio.ie/ageing-well/ (Accessed 15/08/2021)

Jivraj, S., Nazroo, J. and Barnes, M. (2012) 'Change in social detachment in older age in England', in J. Banks, J. Nazroo, and A. Steptoe (eds) *The Dynamics of Ageing: Evidence from the English Longitudinal Study of Ageing 2002–2010 (Wave 5),* London, UK: Institute for Fiscal Studies, pp 49–97.

Keeping, C. (2014) 'The Processes Required for Effective Interprofessional Working' in Thomas, J. et al (eds) 'Interprofessional Working in Health and Social Care: Professional Perspectives' 2nd Ed. Houndmills: Palgrave Macmillan

Kenny, R.A., Hernández, B., O'Halloran, A., Moriarty, F. and McGarrigle, C., 2020. TILDA report to inform demographics for over 50s in Ireland for COVID-19 crisis. *TILDA, Dublin*.

Kernick, D., Chew-Graham, C.A. and O'Flynn, N. (2017) 'Clinical assessment and management of multimorbidity: NICE guideline', The British Journal of General Practice : The Journal of the Royal College of General Practitioners, 67(658), pp. 235-236.

Kerr, B., Gordon, J. MacDonald, C. and Stalker, K. (2005) Effective Social Work with Older People. Scottish Executive Social Research: 2005

Laffoy, M., Health Service Executive (HSE) Strategic Health Planning, National Council on Ageing and Older People (NCAOP), Department of Health and Children (DOHC) (2008) HSE Strategy to Prevent Falls and Fractures in Ireland's Ageing Population. Available at: https://www.lenus.ie/handle/10147/51533

Li, Z., Zhang, Z., Ren, Y. *et al.* (2021) Aging and age-related diseases: from mechanisms to therapeutic strategies. *Biogerontology* **22,** 165–187.

Lowenstein, A. (2004) Gerontology Coming Of Age: The Tan Academic Discipline, *Educational Gerontology*, 30:2, 129-141, DOI: 10.1080/03601270490266293

Mair, A., Wilson, M. and Dreischulte, T. (2020) 'Addressing the Challenge of Polypharmacy', Annual Review Pharmacology and Toxicology, (60), pp. 661-681.

Major Trauma Audit (MTA) (2018) Major Trauma Audit National Repot. Available at: https://www.noca.ie/documents/major-trauma-audit-national-report-2018

McGarry, S., Cuskelly, K., Reilly, P., Coffey, A., Finucane, N., O'Loughlin, A., Casey, L., (2020), The Liaison Social Work Role in Nursing Homes and Residential Settings: A Model for Practice. Dublin: Irish Association of Social Workers.

McKee, H., Miller, R., Cuthbertson, J., Scullin, C., Scott, M. (2016) 'Nursing home outreach clinics show an improvement in patient safety and reduction in hospital admissions in residents with chronic conditions'. European Journal for Person Centered Healthcare. 4. pp. 650-655.

McNicholas T, Laird E., 2018. Change in chronic disease prevalence and health behaviors over the first four waves of TILDA. In: N Turner, O Donoghue, RA Kenny, eds. *Wellbeing and Health in Ireland's Over 50s 2009-2016*. The Irish Longitudinal Study on Aging; 2018: 90-106. https://doi.org/10.13140/RG.2.2.17312.64002

McNicholas T, Laird E., 2018. Change in chronic disease prevalence and health behaviors over the first four waves of TILDA. In: N Turner, O Donoghue, RA Kenny, eds. *Wellbeing and Health in Ireland's Over 50s 2009-2016*. The Irish Longitudinal Study on Aging; 2018: 90- 106. https://doi.org/10.13140/RG.2.2.17312.64002

Mezey, M., Mitty, E., Burger, S.G. and McCallion, P., 2008. Healthcare professional training: A comparison of geriatric competencies. *Journal of the American Geriatrics Society*, *56*(9), pp.1724-1729.

Miller. R., McClean, M., Frie,l A. (2017) 'An Independent Service User Evaluation of a Consultant Pharmacist Led. Medicines Optimisation in Older People's Project', International Journal of Integrated Care, 17(5) pp.A122.

Milne, A. (2020) *Mental Health in Later Life: Taking a Life Course Approach*, Bristol; Policy Press.

Milne, A., Sullivan, M.S, Tanner, D., Richards, S., Ray, M., Lloyd, L., Beech, C., Phillips, J. 2014. Social work with older people: a vision for the future. The College of Social Work (TCSW).

Mitchell, L. and Boak, G., 2009. Developing knowledge and skills frameworks in UK healthcare: lessons from practice. *Journal of European industrial training*.

Muth, C., Blom, J.W., Smith, S.M., Johnell, K., Gonzalez-Gonzalez, A.I., Nguyen, T.S., Brueckle, M.S., Cesari, M., Tinetti, M.E. and Valderas, J.M., 2019. Evidence supporting the best clinical management of patients with multimorbidity and polypharmacy: a systematic guideline review and expert consensus. *Journal of internal medicine*, *285*(3), pp.272-288.

Muth C, Uhlmann L, Haefeli WE, et al. Effectiveness of a complex intervention on Prioritising Multimedication in Multimorbidity (PRIMUM) in primary care: results of a pragmatic cluster randomised controlled trial. BMJ Open 2018;8:e017740

Nathan DM, Bayless M, Cleary P, Genuth S, Gubitosi-Klug R, Lachin JM, Lorenzi G, Zinman B; DCCT/EDIC Research Group. Diabetes control and complications trial/epidemiology of diabetes interventions and complications study at 30 years: advances and contributions. Diabetes 2013;62:3976–3986.

National Council for the Professional Development of Nursing and Midwifery (2008) Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts, 4th edition

National Health & Social Care Professions Office (2016) Health and social care professions education and development strategy 2016 – 2019. Dublin: Health Service Executive

National Institute for Health and Care Excellence [NICE], (2017), Parkinson's Disease in Adults (NG71) https://www.nice.org.uk/guidance/ng71 (Accessed 31/08/21)

National Institute for Health and Care Excellence, 2016. Multimorbidity: clinical assessment and management. NG56. London: NICE.

National Institute for Health and Clinical Excellence. (2010). Delirium: Prevention, Diagnosis and Management. London. Available from: https://www.nice.org.uk/guidance/cg103/resources/delirium-prevention-diagnosis-and-management-pdf-35109327290821

National Institute for Health and Clinical Excellence [NICE]. (2013). Falls in Older people: Assessing Risk and Prevention. London. Available from: https://www.nice.org.uk/guidance/cg161/resources/falls-in-older-people-assessing-risk-and-prevention-pdf-35109686728645. Accessed 30/8/21.

National Association Social Workers, (2015) Standards and Indicators for Cultural Knowledge and skills in Social Work Practice. Washington, DC: Author.

NCPRO (2021) the nutrition process care model. American Academy of Nutrition & Dietetics. Available at https://www.ncpro.org/about. Accessed September 2021.

NHS (2014) Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. NHS England, South

Nursing and Midwifery Board of Ireland (2015) Working with Older People (Professional Guidance). Dublin: NMBI

Nursing and Midwifery Board of Ireland (2015). *Scope of Nursing and Midwifery Practice Framework.* Dublin, Nursing and Midwifery Board of Ireland.

Nursing and Midwifery Board of Ireland (2017) Advanced Practice Nursing Standards and Requirements. Dublin, Nursing and Midwifery Board of Ireland.

Nursing and Midwifery Board of Ireland (2019) Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority, 4th edition. Dublin, Nursing and Midwifery Board of Ireland.

Nursing and Midwifery Board of Ireland (2021) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.* Dublin, Nursing and Midwifery Board of Ireland.

O'Shea, E. & Keogh, F. (2017) 'Post-diagnostic support for people with dementia' in O'Shea, E., Cahill, S., Pierce, M., Rees, G., Irving, K., Keogh, F., Carney, P., Pierse, T. and Hennelly, N. *Developing and implementing dementia policy in Ireland.* NUI Galway and Centre for Economic and Social Research on Dementia, pp.89-95.

Office of the Nursing and Midwifery Services Director, Health Service Executive (2018) National Summary Guidance for Nursing and Midwifery Care-Metrics Data Measurement in Older Person Services 2018.

Oliver, D., Foot, C., Humphries, R. (2014) *Making our health and care systems fit for an ageing population.* Kings Fund

Palliative Care Competence Framework Steering Group. (2014). Palliative Care Competence Framework. Dublin: Health Service Executive

Palliative Care Knowledge and skills Framework Steering Group (2014). Palliative Care Knowledge and skills Framework. Dublin: Health Service Executive

Panel, I.E.C.E., 2011. *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Interprofessional Education Collaborative Expert Panel.

Panel, I.E.C.E., 2011. *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Interprofessional Education Collaborative Expert Panel.

Payne, S., Kerr, C., Hawker, S., Hardey, M. and Powell, J., 2002. The communication of information about older people between health and social care practitioners. *Age and ageing*, *31*(2), pp.107-117.

Pierce, M. & Pierse, T (2017) 'Prevalence of Dementia in Ireland' in O'Shea, E., Cahill, S., Pierce, M., Rees, G., Irving, K., Keogh, F., Carney, P., Pierse, T. and Hennelly, N. *Developing and implementing dementia policy in Ireland.* NUI Galway and Centre for Economic and Social Research on Dementia, pp. 29-39.

Pikes Peak Geropsychology Knowledge and Skill Assessment Tool. 2012

Psychological Society of Ireland. 2019. *Code of professional ethics*

RGP Ontario (2017) Competency Framework for Interprofessional Comprehensive Geriatric Assessment

Rijken, M., Van Kerkhof, M., Dekker, J. and Schellevis, F.G., 2005. Comorbidity of chronic diseases. *Quality of Life Research*, *14*(1), pp.45-55.

Romero-Ortuno, R., Hartley, P., Kenny, R.A. *et al.* (2021). Frail by different measures: a comparison of 8-year mortality in The Irish Longitudinal Study on Ageing (TILDA). *Eur Geriatr Med.* https://doi.org/10.1007/s41999-021-00570-9

Ross, K. and Dexter-Smith, S. eds., 2017. Psychological best practice in inpatient services for older people. British Psychological Society.

Ross, K. and Dexter-Smith, S. eds., 2017. Psychological best practice in inpatient services for older people. British Psychological Society.

Rubenstein LZ, Stuck AE, Siu AL, Wieland D. 1991). Impact of geriatric evaluation and management programs on defined outcomes: overview of the evidence. Journal of the American Geriatrics Society. 1991; Vol. 39:8S-16S.

Ryan K, Connolly M, Charnley K, Ainscough A, Crinion J, Hayden C, Keegan O, Larkin P, Lynch M,

McEvoy D, McQuillan R, O'Donoghue L, O'Hanlon M, Reaper-Reynolds S, Regan J, Rowe D, Wynne M; Palliative Care Knowledge and skills Framework Steering Group. (2014). Palliative Care Knowledge and skills Framework. Dublin: Health Service Executive

Salive, M.E., 2013. Multimorbidity in older adults. *Epidemiologic reviews*, *35*(1), pp.75-83.

Setting Priorities for Gerontological Social Work Research: A National Delphi Study

Scope of Nursing and Midwifery Practice Framework (2015)

Scottish Government Polypharmacy Model of Care Group. Polypharmacy Guidance, Realistic Prescribing. 3rd edn. Edinburgh: Scottish Government 2018. Available at: https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/09/Polypharmacy-Guidance-2018.pdf.

Shay, L.A. and Lafata, J.E., 2015. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Medical Decision Making*, *35*(1), pp.114-131.

Shay, L.A. and Lafata, J.E., 2015. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Medical Decision Making*, *35*(1), pp.114-131.

Seals, D. R., et al, 2016. Physiological geroscience: targeting function to increase healthspan and achieve optimal longevity. J Physiol 594(8): 2001-2024.

Sheehan, A. and O'Sullivan, R, 2020. Ageing and Public Health – an overview of key statistics in Ireland and Northern Ireland. Dublin: Institute of Public Health.

Sheehan, O.C., et al., A systematic literature review of the assessment of treatment burden experienced by patients and their caregivers. BMC Geriatr, 2019. 19(1): p. 262.

Sherrington C, Fairhall NJ, Wallbank GK, Tiedemann A, Michaleff ZA, Howard K, et al. (2019) Exercise for preventing falls in older people living in the community. Cochrane Database Syst Rev. 2019; 1:Cd012424.

Sláintecare Implementation Strategy and Action Plan 2021-2023 gov.ie - Sláintecare Implementation Strategy and Action Plan 2021-2023 (www.gov.ie) (Accessed 25/08/21)

Social Work Leadership Institute Geriatric Social Work Knowledge and skills (Year unknown). Available at: http://epadgec.jefferson.edu/pdfs/SW%20Gero%20Compt.pdf . Accessed 13/08/2021.

Society for Acute Medicine Allied Health professional Working Group. (2017) *SAM AHP Competencies.* Availablefrom: *https://www.acutefrailtynetwork.org.uk/uploads/files/1/SAM%20AHP-Competencies-V4.0.pdf*

The Aging Readiness and Competitiveness Report-Third Edition. Driving Innovation in Healthcare and Wellness. October 2021

The Irish Association of Social Workers' (IASW) Special Interest Group on Ageing (SIGA) (2011) The Role of the Social Worker with Older Persons

The Motor Neurone Disease Association, Parkinson's UK, Therapists in Multiple Sclerosis & The Multiple Sclerosis Trust, 2020. Allied Health Professionals' competency framework for progressive neurological conditions. Available at: [https://mstrust.org.uk/sites/default/files/competencies-all-july-30-2020-FINAL.pdf]. Accessed 7th December 2021

TILDA (2016). The impact of frailty on public health nurse service utilisation. Findings from The Irish Longitudinal Study on Ageing.

TILDA (2017), *The Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing 2017,* Available from : https://www.tcd.ie/tcaid/assets/pdf/wave3report.pdf

Turnbull FM, Abraira C, Anderson RJ, Byington RP, Chalmers JP, Duckworth WC, Evans GW, Gerstein HC, Holman RR, Moritz TE, Neal BC, Ninomiya T, Patel AA, Paul SK, Travert F, Woodward M. Intensive glucose control and macrovascular outcomes in type 2 diabetes. Diabetologia 2009;52:2288–2298.

UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). Lancet 1998;352:854–865.

United Kingdom Clinical Pharmacy Association. Care of Older People Expert Professional Practice Curriculum, 2014. Accessed via www.rps.com 07.03.22.

US Department of Health and Human Services, 2010. Multiple chronic conditions—a strategic framework: optimum health and quality of life for individuals with multiple chronic conditions. Washington, DC: US Department of Health and Human Services, 2.

Volkert et al (2019) ESPEN guideline on clinical nutrition and hydration in geriatrics. Volkert D, Beck AM, Cederholm T, Cruz-Jentoft A, Goisser S, Hooper L, Kiesswetter E, Maggio M, Raynaud-Simon A, Sieber CC, Sobotka L, van Asselt D, Wirth R, Bischoff SC. Clin Nutr. 2019 Feb;38(1):10-47. doi: 10.1016/j.clnu.2018.05.024. Epub 2018 Jun 18. PMID: 30005900.

WHO Regional Office for Europe (2015). Strengthening a competent health workforce for the provision of coordinated/ integrated health services.Available at:https://www.euro.who.int/en/health-topics/Health-systems/health-workforce/publications/2015/strengthening-a-competent-health-workforce-for-the-provision-of-coordinated-integrated-health-services-2015

Wilkinson R & Marmot M (Eds.) (2003) *Social determinants of health: the solid facts.* 2nd Edn. Copenhagen, WHO Regional Office for Europe.

World Confederation for Physical Therapy (WCPT) https://world.physio/resources/what-is-physiotherapy (Accessed 22/08/2021)

World Health Organization. (2010) Framework for action on interprofessional education and collaborative practice. Geneva, Switzerland: WHO

Wren, M. A., Keegan, C., Walsh, B., Bergin, A., Eighan, J., Brick, A., Connolly, S., Watson, D., & Banks, J. (2017). Projections of demand for healthcare in Ireland, 2015-2030. First report from the HIPPOCRATES model. Economic and Social Research Institute.

Wyman, M.F., Shiovitz-Ezra, S. and Bengel, J., 2018. Ageism in the health care system: Providers, patients, and systems. In *Contemporary perspectives on ageism* (pp. 193-212). Springer, Cham.