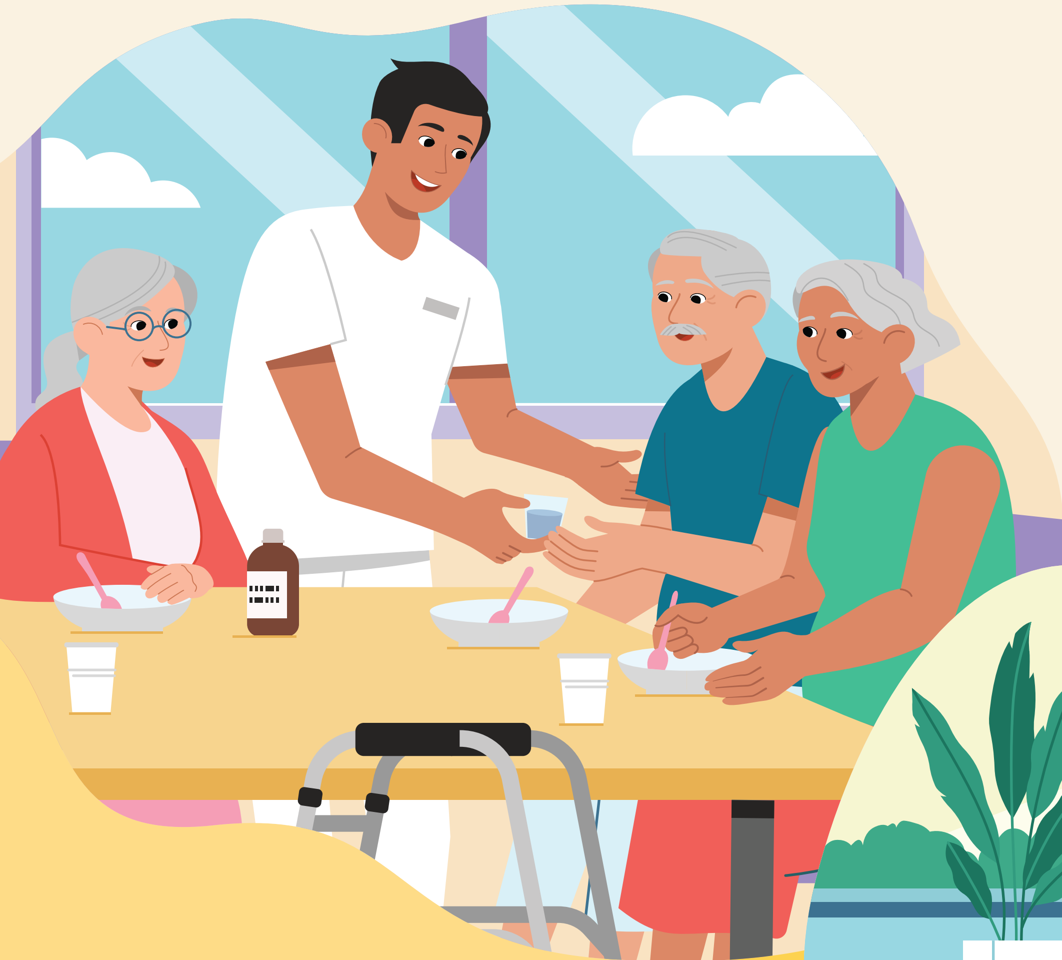
Geriatric Nursing Competency Framework



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FOREWORD

To meet the growing and diverse care needs of our ageing population, the Ministry of Health (MOH) has set up a Geriatric Nursing Competency Framework (GNCF) Development Workgroup. The Workgroup comprises nursing leaders, clinicians and educators to develop a national Framework that defines the roles and responsibilities of nurses in delivering care for older adults by clarifying the job roles, key activities and professional competencies.

The GNCF outlines the specific roles and competencies of nurses in care delivery for older adults in a broad spectrum of care settings ranging from primary care, acute and community hospitals to community care sectors. The Framework also serves as a guide to employers, training providers and academic institutions in developing and strengthening their training programmes.

I would like to thank the Workgroup and all who helped develop the GNCF. I hope that our nurses and stakeholders will find the GNCF a useful resource to develop a quality nursing workforce that meets the needs of our healthcare system and delivers safe, effective and quality care not just for the older individual but to their families and caregivers as well.

Ms Paulin Koh
Chief Nursing Officer
Ministry of Health

INTRODUCTION

GERIATRIC NURSING IN SINGAPORE

"Geriatric nursing" is broadly defined as the autonomous and holistic care of the older adult population, including the promotion of healthy ageing, prevention of illness, assessment and management of pathophysiological and psychosocial issues. Geriatric nursing in Singapore builds on a philosophy of care that is characterised by person-centredness, client and family empowerment, and care transition for continuity of care.

With Singapore's ageing demographics and complex client needs, the importance of geriatric nursing is magnified due to the need for more personalised and long-term care. The nurses should be empathetic and compassionate to the needs of older adults, families and / or caregivers and endeavour to provide holistic care in collaboration with various care partners. Nurses should possess a keen eye for detail to provide a holistic assessment of older adults to meet their care needs. They should advocate for the best interest of older adults to strengthen their autonomy and decision-making capabilities.

The nurses need to utilise all available resources and methods to empower clients, families and / or caregivers with the ability to self-manage their health and / or caregiving as well as remain resilient if challenges arise. Nurses need to be strong communicators to facilitate coordinated care with the relevant stakeholders. Apart from being adept in the clinical aspects of nursing, nurses should keep abreast of current technology and evidence-based practice, and adopt innovative approaches to improve the quality of care of older adults.

In essence, the key attributes of nurses caring for older adults are:

- **Patient, Empathetic and Compassionate**
- **Strong Attention to Details**
- **Resilient and Resourceful**
- **Collaborative**
- **Innovative**

OBJECTIVES OF THE FRAMEWORK

The Geriatric Nursing Competency Framework (GNCF) has been developed with the support of key stakeholders such as nursing professionals, employers and training providers. The GNCF was built on the foundation of the Community Nursing Competency Framework (CNCF) and it covers a wider spectrum of care settings ranging from primary care, and acute care to intermediate and long-term care. Similar to the CNCF, it is envisaged that the GNCF will serve as a repository that provides up-to-date and forward-looking information on existing and emerging job roles, skills and competencies specific to nurses caring for older adults. The Framework also provides a basis for sector-wide analysis of skills and manpower gaps as well as insights to support the design and review of training programmes to guide the contextualised planning and capability building of the nursing workforce.

Specifically, the Framework aims to support and benefit current and aspiring employees, employers, professional bodies and training providers as follows:

- Provide clarity of the roles and responsibilities and associated competencies.
- Provide a reference for the training and development for nurses in care delivery for older adults.

KEY COMPONENTS

The Framework consists of the following key components:

- **Job Role Profiles (JRPs)**
- **Professional Competencies (PCs)**

Each job role is detailed and defined using a JRP document. This document encompasses a job role description that summarises the key contributions and responsibilities, workplace context as well as necessary attributes for an incumbent to be able to perform the job. It also includes the Key Responsibility Areas (KRAs) and Key Activities (KAs) for each job role and the list of PCs at the required proficiency levels.

In addition, a glossary is included at the end of the document.

THE GERIATRIC NURSING COMPETENCY FRAMEWORK

JOB ROLES AND CAREER MAP

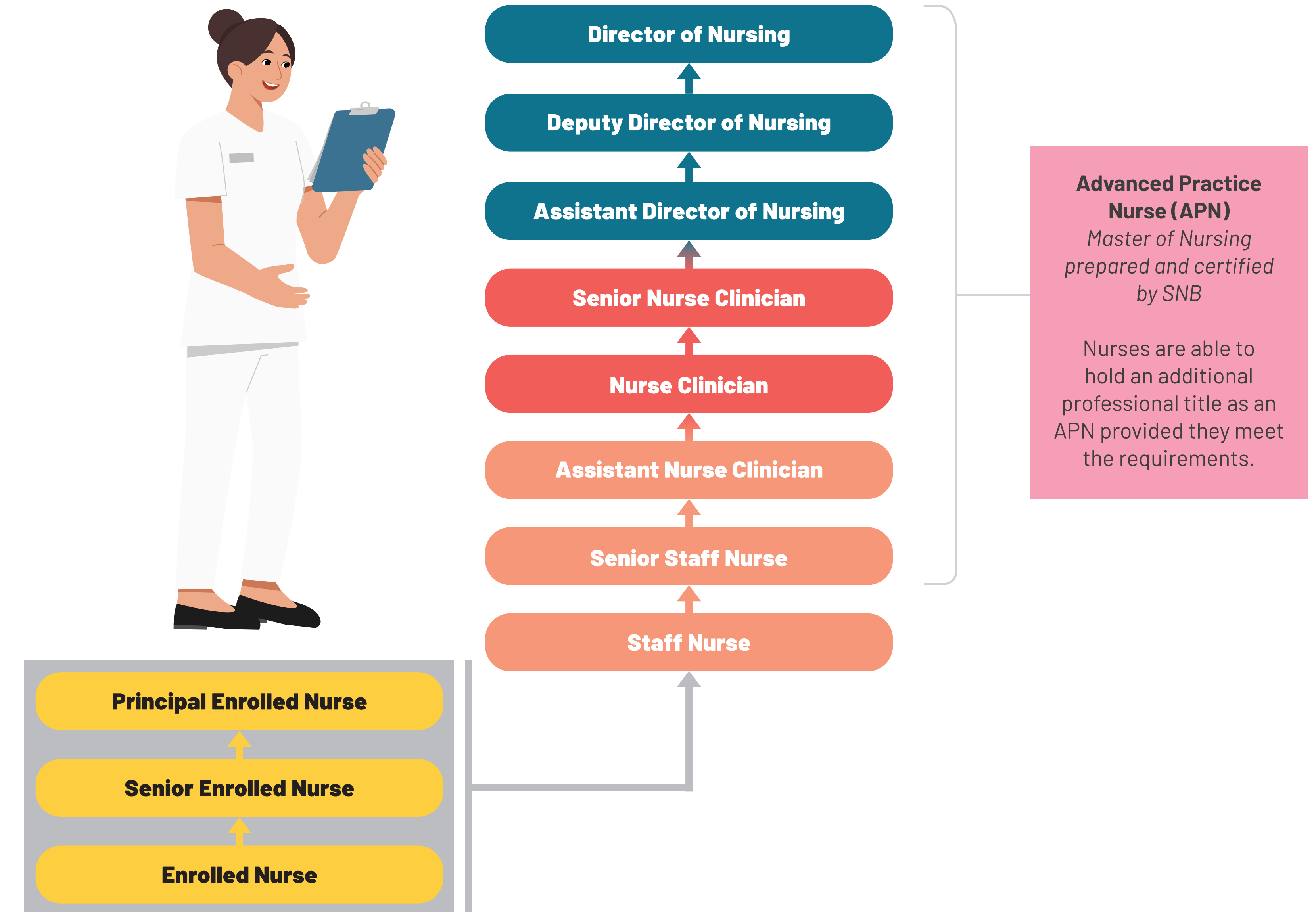
The Geriatric Nursing Competency Framework (GNCF) includes 12 Job Roles. These are:

- **Enrolled Nurse / Senior Enrolled Nurse / Principal Enrolled Nurse**
- **Staff Nurse / Senior Staff Nurse / Assistant Nurse Clinician**
- **Nurse Clinician / Senior Nurse Clinician**
- **Assistant Director of Nursing / Deputy Director of Nursing / Director of Nursing**
- **Advanced Practice Nurse (APN)***

The career map provides clear direction to nurses delivering care to older adults in achieving their career goals and higher nursing responsibilities. It also describes the development, implementation, and evaluation of the professional career map for nurses to support the achievement of the nursing strategic goals for succession planning and professional development. The career map for the nurses is shown on the next page:

*The term "Advanced Practice Nurse" (APN) is both a job role and professional title that is regulated by the Singapore Nursing Board (SNB). An APN is a Registered Nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for extended practice. APNs, who must have a Master's degree in Nursing and attain APN certification from SNB, are trained in the diagnosis and management of common medical conditions, including chronic illnesses. APNs provide a broad range of healthcare services. They work collaboratively with doctors and other healthcare professionals to provide nursing care to patients with complex needs. APNs may also be privileged to prescribe medications if they have completed the National Collaborative Prescribing Programme (NCPP) and have been credentialed by their employing institutions.

Nursing Clinical Career Path



**The clinical career path list is non-exhaustive. Variation is based on individual organisational policy.

JOB ROLE PROFILES

There are 5 Job Role Profiles (JRPs) for all 12 job roles identified in the care settings for older adults. Each JRP includes the following:

- ***Job Role Title***
- ***Job Role Description***
- ***Key Responsibility Areas***
- ***Key Activities***
- ***List of Professional Competencies (PCs) at required proficiency levels for each job role***

The job roles within each profile consist of key activities with incremental responsibilities as their job roles progress. For example, a Principal Enrolled Nurse will include the key activities of a Senior Enrolled Nurse and an Enrolled Nurse.

The JRPs developed for the Framework are shown below:

ENROLLED NURSE / SENIOR ENROLLED NURSE / PRINCIPAL ENROLLED NURSE

Job Role Description	The Enrolled Nurse provides person-centred care, promotes self-management, and facilitates activities in health promotion. S/He is involved in the comprehensive assessment of older adults. S/He assists in formulating care plans for older adults, caregivers, and family members and provides updates to the care team. S/He is the care advocator to older adults and families / caregivers. S/He assists in providing health education, caregiver training, health coaching and care coordination to help older adults achieve maximum quality of life and follow a holistic care plan. S/He consistently seeks to enhance his / her professional competency within the scope of practice.	The Senior Enrolled Nurse / Principal Enrolled Nurse assesses, plans, delivers and evaluates person-centred care. S/He ensures that basic care interventions and support are delivered and coordinated for older adults. In consultation with the Registered Nurse, s/he is expected to make relevant care decisions for older adults. S/He also supervises and assesses junior staff members and support care staff. The Principal Enrolled Nurse additionally participates in broader service development.

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities	Clinical Care Management	Enrolled Nurse	Assist in biological, psychological, social, spiritual, and environmental assessment of older adults
			Apply the principles of geriatric nursing when performing basic individualised nursing interventions for older adults
			Support conducive and safe environment for older adults' health
			Recognise care needs of older adults approaching end-of-life and provide them with relevant support
			Support older adults in activities of daily living in consideration of their abilities
			Assist in communicating care plans and report older adults', families' and / or caregivers' needs and goals to the care team
			Promote medication adherence and assist in administration of medication
			Monitor and report changes / abnormalities in older adults' health and social condition(s)

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Clinical Care Management (Cont'd)	Senior Enrolled Nurse	Perform comprehensive assessment of older adults
			Communicate care plans and address concerns from older adults, families and / or caregivers
			Administer medication, monitor medication adherence and provide relevant education in accordance with institutions' protocol and guidelines
			Escalate changes / abnormalities in older adults' health and social conditions in a timely manner and initiate appropriate interventions within his / her scope of practice
		Principal Enrolled Nurse	Evaluate individualised nursing interventions for older adults
			Plan individualised care plans for older adults using assessment of older adults' needs and communicate the care plan to the relevant stakeholders
			Evaluate older adults', families' and / or caregivers' understanding of the proposed care plans and goals
			Manage changes / abnormalities in older adults' health and social conditions and escalate appropriately
	Engagement and Empowerment	Enrolled Nurse	Build rapport with older adults, families and / or caregivers and stakeholders
			Maintain therapeutic relationships and professional boundaries when dealing with older adults, families and / or caregivers, and community partners
			Motivate older adults to adopt healthy ageing strategies and behavioural modifications
			Support self-management by assisting in providing education and health coaching to older adults, families and / or caregivers
			Support the implementation of teaching strategies to promote older adults' self-management
			Assist in health promotion and preventive health activities for individuals and the community
		Senior Enrolled Nurse	Provide training and health coaching to older adults, families and / or caregivers
			Assess individuals' learning needs and implement teaching strategies to promote self-management
			Participate in health promotion and preventive health activity within the scope of practice
		Principal Enrolled Nurse	Motivate older adults towards appropriate health-seeking behaviours and evaluate effectiveness of the approach
			Plan health promotion and preventive health activities within the scope of practice
	Care Transition and Integration	Enrolled Nurse	Assess older adults' care needs and support services and inform the care team for appropriate interventions
			Assist in referring and linking older adults, families and / or caregivers to other care providers
			Assist in the smooth transition of care for older adults in different care settings

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Care Transition and Integration (Cont'd)	Senior Enrolled Nurse	Provide information to older adults and families on available resources, services and programmes
			Suggest referrals for care and support according to needs and / or preferences
			Facilitate follow-up care for older adults with an interdisciplinary care team
		Principal Enrolled Nurse	Recommend appropriate community resources, services and programmes required by older adults with care needs
			Provide feedback on the effectiveness of recommended care referrals and suggest improvements
			Promote interdisciplinary care delivery in collaboration with relevant care partners
			Coordinate follow-up care for older adults in collaboration with the interdisciplinary care team
	Health Promotion, Wellness and Disease Prevention	Enrolled Nurse	Adopt positive perspectives in health promotion, wellness and disease prevention interventions
			Participate in health promotions, wellness and disease prevention activities, taking social and economic factors into consideration
			Develop and improve personal skills required for health promotion, wellness and disease prevention
			Maintain cultural awareness and sensitivity by recognising that older adults are individuals with specific needs
			Assist in developing health promotion and training materials
			Assist in research projects and raise health awareness
		Senior Enrolled Nurse	Conduct health promotion, wellness and disease prevention interventions
			Support older adults and / or families to understand their conditions and diagnoses
		Principal Enrolled Nurse	Provide feedback on the effectiveness of recommended health promotion, wellness, and disease prevention strategies
			Coordinate follow-up care for older adults in collaboration with health promotion, wellness, and disease prevention strategies
			Supervise junior nurses in the implementation of health promotion, wellness, and disease prevention programmes
			Participate in developing learning materials for health promotion, wellness and disease prevention strategies

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Nursing Practice Management, Innovation and Research	Enrolled Nurse	Participate in quality assurance activities
			Participate in peer-sharing sessions on nursing-related issues
			Comply with personal safety measures in clinical practice
			Identify and report risks or hazards in care settings to ensure safety of self and other team members
			Practise infection-control precautionary measures
			Assist in responsibilities as per emergency protocols in the event of public health threat or emergency
			Comply with guidelines and policies to ensure older adults' confidentiality and personal data protection
			Assist in quality improvement, evidence-based practice or research projects
		Senior Enrolled Nurse	Conduct peer-sharing sessions on nursing related issues
			Monitor compliance with infection control and precautionary measures
			Initiate appropriate measures to minimise actual or potential risks and barriers to the safety of older adults
		Principal Enrolled Nurse	Monitor compliance with infection control precautionary measures
			Provide guidance to junior nurses on measures to prevent actual or potential risks and barriers to the safety of older adults
			Participate in quality improvement, evidence-based practice or research projects
			Participate in collaborative practice with RN and other healthcare team members
			Demonstrate clinical reasoning / judgement in the provision of safe and quality nursing care within the scope of practice
	Professional Development and Leadership	Enrolled Nurse	Attend continuing professional development courses based on learning needs
			Identify learning needs for personal and career development
			Determine personal and career development goals
			Supervise and teach support care staff and / or students
		Senior Enrolled Nurse	Contribute to the development of goals and career progression plans of junior nurses
			Provide supervision, teaching, and assessment of junior staff in the care team and / or students
		Principal Enrolled Nurse	Participate in formulating career progressions of junior nurses
			Participate proactively and / or make suggestions for improvement of care
			Advocate for safe and quality patient care

	Competency Domain	Competency Element	Expected Proficiency Level		
			Enrolled Nurse	Senior Enrolled Nurse	Principal Enrolled Nurse
Professional Competencies	D1. Person-centred Care	E1. Comprehensive Assessment and Management	Level 1	Level 1	Level 1
		E2. Client, Family and Caregiver Education and Empowerment	Level 1	Level 2	Level 2
		E3. Communication, Collaboration and Teamwork	Level 1	Level 2	Level 2
		E4. Discharge Planning and Care Transition Across Care Continuum	Level 1	Level 1	Level 2
	D2. Health Promotion, Wellness and Disease Prevention	E5. Health Promotion, Wellness and Disease Prevention	Level 1	Level 1	Level 1
	D3. Professional Development and Leadership	E6. Develop and Lead Self	Level 1	Level 1	Level 2
		E7. Develop and Lead Others	Level 1	Level 1	Level 1
	D4. Improvement, Innovation and Research	E8. Quality Improvement, Innovation and Research	Level 1	Level 1	Level 1

STAFF NURSE / SENIOR STAFF NURSE / ASSISTANT NURSE CLINICIAN

Job Role Description

The Staff Nurse / Senior Staff Nurse / Assistant Nurse Clinician is responsible for performing care assessments, planning and management in accordance with established geriatric nursing standards and evidence-based practices. S/He collaborates with the interdisciplinary team to achieve quality person-centred care. S/He facilitates the care transition of older adults and coordinates with various stakeholders and community resources. S/He participates in service development, research and quality improvement projects.

The Staff Nurse provides older adults, families and / or caregivers education as well as promotes health and wellbeing. S/He guides, supervises and / or precepts the support care team, junior staff and students. S/He recommends initiatives and implements evidence-based practice.

The Senior Staff Nurse contributes to the planning of older adult / caregiver education and health promotion programmes. S/He precepts junior nurses and contributes to continuing professional development activities.

The Assistant Nurse Clinician is responsible for leading her / his team and ensuring the delivery of safe and quality care. S/He contributes to the development of geriatric nursing policies, standards and evidence-based practices. S/He assesses outcomes of quality improvement, evidence-based practice and / or research projects. S/He supports the quality audits within the team. S/He provides clinical supervision, precepts the junior nurses, and contributes to geriatric nursing training.

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities	Clinical Care Management	Staff Nurse	Perform comprehensive geriatric assessments to identify strengths and needs of older adults, families and / or caregivers
			Communicate with and / or engage interdisciplinary teams, families and / or caregivers to understand older adults' needs and / or align care goals
			Develop person-centred nursing care plans with consideration of older adult's needs and preferences
			Explain care plans and address concerns from older adults, families and / or caregivers
			Perform evidence-based nursing interventions
			Perform medication administration and / or titration in accordance with organisational guidelines and protocols
			Support older adult's ability for self-medication and medication adherence and escalate to relevant care team members for medication reconciliation and optimisation
			Manage and escalate appropriately in the event of unexpected and / or abnormal changes
			Advocate and / or facilitate Advance Care Planning (ACP) discussions
		Senior Staff Nurse	Analyse comprehensive geriatric assessment to identify strengths and needs of older adults, families and / or caregivers
			Review person-centred nursing care plans with consideration of older adults' needs and preferences
		Assistant Nurse Clinician	Evaluate person-centred care plans and prioritise care goals
			Address factors related to medication adherence in collaboration with the interdisciplinary team

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Engagement and Empowerment	Staff Nurse	Engage older adults, families, caregivers and / or relevant others as active partners to identify needs, preferences and expectations of older adults
			Build therapeutic relationships and maintain professional boundaries when dealing with older adults, families, caregivers and / or community partners
			Provide individualised training and geriatric-specific education to older adults, families and / or caregivers according to self-management needs
			Identify older adults, families and / or caregivers who are suitable to adopt technologies, and support relevant training
			Engage relevant stakeholders to educate and / or empower older adults, families and / or caregivers for self-management
			Utilise various motivational techniques to engage older adults, families and / or caregivers in health improvement and disease management
			Implement and coordinate health promotion and preventive care activities for older adults
		Senior Staff Nurse	Evaluate effectiveness of caregiver training and / or geriatric-specific education and recommend follow-up actions for older adults, families and / or caregivers
			Introduce appropriate technologies for older adults, families and / or caregivers to support self-management and caregiving
		Assistant Nurse Clinician	Collaborate with care team to evaluate barriers to self-care management
	Care Transition and Integration	Staff Nurse	Assist older adults in navigating care systems based on needs, resources and preferences of older adults, families and / or caregivers
			Initiate and / or prioritise care referrals based on older adult's needs, readiness, preferences and care goals in consultation with the interdisciplinary team
			Coordinate care among the interdisciplinary health and social care team with the involvement of older adults, families and caregivers
			Assist older adults, families and / or caregivers in transitioning between care settings according to the available framework
		Senior Staff Nurse	Empower older adults, families and / or caregivers to encourage independence in managing care transitions
		Assistant Nurse Clinician	Address gaps in care transitions encountered by older adults, families and caregivers, or the junior nurses

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Health Promotion, Wellness and Disease Prevention	Staff Nurse	Provide, resources, and education on healthy ageing as appropriate according to the needs of older adults
			Advocate evidence-based screening, immunisations, and health promotion services
			Respond therapeutically to age-related changes in the psychosocial context of older adults, including sensory loss, isolation, and social determinants of health
			Collaborate with older adults, their families, and health care teams to implement a plan of care to manage age-related changes, risk factors and / or changes affecting wellbeing
			Identify older adults with needs for pre-frailty and frailty prevention
		Senior Staff Nurse	Empower older adults to make healthy choices by providing evidence-based information, resources, and education
		Assistant Nurse Clinician	Implement strategies to prevent pre-frailty and frailty
	Nursing Practice Management, Innovation and Research	Staff Nurse	Assess his / her practice against established organisational guidelines, standards and clinical protocols to improve self-efficiency
			Support quality audits to maintain and improve standards of care
			Recommend initiatives and implement quality improvement, evidence-based practice or research project(s)
			Identify risks / hazards and take appropriate measures as per established policies and procedures to ensure his / her safety at the workplace
			Practise safety and infection-control precautionary measures
			Support early identification of health threat risks to older adults and / or workplace through information and / or data gathered
			Identify and report risks and barriers to the safety of older adults in accordance with organisational protocols
			Execute responsibilities as per emergency protocols in the event of a public health threat or emergency
			Comply with guidelines and policies to ensure confidentiality and personal data protection for older adults
		Senior Staff Nurse	Assess the practices of junior nurses against established organisational guidelines and standards to improve efficiency and cost-effectiveness
			Perform and / or facilitate quality audits within the organisation
			Supervise other team members on safety and infection-control precautionary measures to reduce the risk of errors, complications and infections
			Provide guidance to junior staff to ensure confidentiality and personal data protection for older adults
		Assistant Nurse Clinician	Evaluate quality improvement, evidence-based practice or research projects for follow-up / implementation
			Execute corrective actions to improve safety and infection-control practices

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Professional Development and Leadership	Staff Nurse	Attend continuing professional development activities based on learning needs
			Acquire practice-based learning through applying and reflecting on his / her knowledge and practice
			Identify and highlight actual and / or potential non-adherence to standards of nursing practices
			Provide feedback on the effectiveness of training programmes implemented
			Participate in the development of training roadmaps for career progression
			Precept junior nurses and nursing students
		Senior Staff Nurse	Supervise the nursing team to ensure that approved standards of nursing practices are adhered to
			Provide feedback on performance to junior members of the care team
			Promote a positive learning culture within the nursing team
			Support and / or provide in-service education to healthcare team
		Assistant Nurse Clinician	Co-facilitate a training programme for skill development
			Align practice with institutional and professional policies, guidelines and legislations
			Recommend appropriate strategies to improve care team's performance
			Manage conflicts and propose resolutions, and escalate when necessary

	Competency Domain	Competency Element	Expected Proficiency Level		
			Staff Nurse	Senior Staff Nurse	Assistant Nurse Clinician
Professional Competencies	D1. Person-centred Care	E1. Comprehensive Assessment and Management	Level 2	Level 2	Level 3
		E2. Client, Family and Caregiver Education and Empowerment	Level 2	Level 3	Level 3
		E3. Communication, Collaboration and Teamwork	Level 2	Level 2	Level 2
		E4. Discharge Planning and Care Transition Across Care Continuum	Level 2	Level 2	Level 2
	D2. Health Promotion, Wellness and Disease Prevention	E5. Health Promotion, Wellness and Disease Prevention	Level 2	Level 2	Level 2
	D3. Professional Development and Leadership	E6. Develop and Lead Self	Level 2	Level 2	Level 3
		E7. Develop and Lead Others	Level 1	Level 2	Level 2
	D4. Improvement, Innovation and Research	E8. Quality Improvement, Innovation and Research	Level 2	Level 2	Level 2

NURSE CLINICIAN / SENIOR NURSE CLINICIAN

Job Role Description

The Nurse Clinician / Senior Nurse Clinician is responsible for assessing, planning, developing and evaluating the overall geriatric nursing clinical practice to provide the best quality care for older adults. S/He participates in the development of evidence-based practice guidelines and policies, and defines care standards in collaboration with multidisciplinary teams. S/He supports the development of new service models and / or strategies to improve care delivery and integration, incorporating interprofessional collaborative approaches.

The Senior Nurse Clinician is highly experienced in her / his areas of geriatric practice, and manages older adults through direct care or by providing consultations to the geriatric nursing team. S/He reviews, identifies and addresses care and service gaps. S/He advocates and develops innovative care interventions to meet the changing needs of individual older adults and / or population groups. S/He assumes management responsibilities and oversees the training and development of geriatric nursing teams.

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities	Clinical Care Management	Nurse Clinician	Conduct comprehensive geriatric assessment by obtaining relevant history, performing cognitive assessment, assessing other geriatric syndromes as well as functional and psychosocial status
			Facilitate interdisciplinary team discussions to align and prioritise care goals
			Evaluate person-centred care plans, incorporating anticipatory care needs, in consultation with the interdisciplinary team, older adults, families and / or caregivers
			Serve as resource person and provide clinical guidance for geriatric care
			Manage older adults with complex care needs in collaboration with the interdisciplinary team, older adults, families and / or caregivers
			Provide consultations on the escalated care management of older adults' health, behavioural and social conditions
			Review medications of older adults, including medication reconciliation, side-effects, effects of polypharmacy, and provide education in collaboration with primary care team and pharmacist, in accordance with organisational protocols
			Assess older adult's capability in self-administration of medication and render support as required
			Advocate and / or facilitate Advanced Care Planning with older adults and families
			Provide end-of-life symptom management and psycho-spiritual support for the older adult and his / her family
			Ensure timely and accurate documentation is performed by the care team as per organisational standards and guidelines
		Senior Nurse Clinician	Provide insights to interdisciplinary care team on the management of older adults with complex care issues
			Provide consultation on the escalated care management of older adults' health, behavioural and social conditions
			Develop strategies to involve older adults, families and caregivers in setting goals for care and preferences

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Engagement and Empowerment	Nurse Clinician	Tailor education and training activities for older adults, families and caregivers to empower self-management
			Develop education materials to facilitate self-management for older adults, families and / or caregivers
			Develop plans to raise awareness and adoption of new technologies to promote self-monitoring and management of health conditions
			Maintain therapeutic relationships and professional boundaries when dealing with older adults, families, caregivers and / or community partners
		Senior Nurse Clinician	Evaluate education materials to facilitate self-management for older adults, families and / or caregivers
	Care Transition and Integration	Nurse Clinician	Anticipate and recommend initiatives to address transitional care needs of older adults
			Oversee the coordination of care across the continuum including conducting discharge planning
			Prioritise referrals based on older adults' needs, preferences and care goals with consideration of resource availability and efficiency
			Engage with community partners and ensure smooth transition of care to the community team / long-term care facilities
			Build strong relationships with community partners, particularly for older adults receiving shared care, to ensure an effective flow of care information
		Senior Nurse Clinician	Develop and implement frameworks to address common transitional care needs of older adults, families and / or caregivers
			Develop measures for the interdisciplinary team to work collaboratively to support individual older adults, families and / or caregivers
	Health Promotion, Wellness and Disease Prevention	Nurse Clinician	Plan, implement and evaluate health promotion and preventive health activities for the older adult population
			Promote frailty prevention and increase functional capacity for older adults in collaboration with interdisciplinary teams and community partners
			Provide support and connect the health system to support the older adult to self-care
			Promote disease screening and vaccinations that are relevant to the older adult
			Stimulate and provide opportunities for social networking for older adults so as to promote psychosocial wellbeing
		Senior Nurse Clinician	Develop strategies to involve and encourage older adults, families and caregivers in health promotion, wellness and disease prevention

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Nursing Practice Management, Innovation and Research	Nurse Clinician	Assist in developing healthcare policies, legislation and professional regulatory frameworks
			Participate in the development of evidence-based guidelines and protocols for geriatric nursing practice within the appropriate governance framework
			Monitor the geriatric care nursing team's practice on resource management and recommend strategies to reduce waste in service delivery, care and treatment
			Ensure the appropriateness and cost-effectiveness of practices, equipment and products used for older adults
			Lead quality audits, quality improvement and evidence-based projects
			Identify and report potential ethical and legal implications in geriatric care nursing service delivery
			Conduct risk assessment to identify risks and safety hazards of geriatric care nursing practice and implement measures to mitigate risks identified
		Senior Nurse Clinician	Assess health priorities, needs and changing demographics of the population to proactively ensure service alignment
			Implement healthcare policies, legislation and professional regulatory frameworks
			Develop evidence-based guidelines and protocols for geriatric nursing practice within the appropriate governance framework
			Managing budgeting, acquisition and utilisation of resources by the geriatric nursing team
			Evaluate outcomes and develop outcome indicators for geriatric nursing practice
			Appraise current evidence, disseminate outcomes and provide appropriate recommendations
			Develop clinical care management and escalation framework for geriatric nursing for his / her area of geriatric nursing practice
	Professional Development and Leadership	Nurse Clinician	Support staff development through continuing nursing education
			Develop and conduct structured geriatric-related induction programmes, clinical teaching rounds, in-service and training programmes
			Provide clinical supervision and coaching for nurses in the clinical area for geriatric nursing care
			Participate in the development of competency assessments and training roadmap for nursing staff caring for older adults
			Define and communicate team's purpose and goals for his / her team and align the development of roles and responsibilities across levels
			Conduct or contribute to performance appraisal for staff working in the geriatric area
			Attend formal and informal continuing education and training based on his / her learning and professional development needs
			Participate in research and promote evidence-based practice to improve older adult outcomes and render cost-effective care for them

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Professional Development and Leadership (Cont'd)	Nurse Clinician (Cont'd)	Participate in quality improvement projects to improve workflow / processes related to geriatric nursing care
			Implement strategies to improve welfare and wellbeing of nurses caring for older adults
		Senior Nurse Clinician	Provide mentorship for nurses in the clinical area of geriatric nursing care
			Develop effective team systems for ongoing supervision and preceptorship
			Participate in staff interview / selection / planning or geriatric nursing talent development
			Lead the development of competency assessments and training roadmap for nursing staff caring for older adults
			Strategise purpose and goals for his / her team and align the development of roles and responsibilities across levels
			Implement and evaluate policies and nursing standards for older adult care delivery

	Competency Domain	Competency Element	Expected Proficiency Level	
			Nurse Clinician	Senior Nurse Clinician
Professional Competencies	D1. Person-centred Care	E1. Comprehensive Assessment and Management	Level 3	Level 4
		E2. Client, Family and Caregiver Education and Empowerment	Level 3	Level 4
		E3. Communication, Collaboration and Teamwork	Level 3	Level 4
		E4. Discharge Planning and Care Transition Across Care Continuum	Level 3	Level 3
	D2. Health Promotion, Wellness and Disease Prevention	E5. Health Promotion, Wellness and Disease Prevention	Level 3	Level 3
	D3. Professional Development and Leadership	E6. Develop and Lead Self	Level 3	Level 4
		E7. Develop and Lead Others	Level 3	Level 4
	D4. Improvement, Innovation and Research	E8. Quality Improvement, Innovation and Research	Level 3	Level 3

ADVANCED PRACTICE NURSE

Job Role Description	The Advanced Practice Nurse (APN) is responsible for providing complex and extended nursing practice to older adults. S/He demonstrates expert knowledge, advanced clinical and decision-making skills to assess and manage older adults' health and social care issues in collaboration with the interdisciplinary team. S/He provides a broad range of healthcare services to older adults, including managing medical conditions and geriatric syndromes. S/He provides education and training in both clinical and academic settings to promote the advancement of nursing and healthcare. S/He drives the development of evidence-based practice, integrating theoretical and practice-based knowledge to influence the development of geriatric nursing practices and policies at local and / or national levels.	

	Key Responsibility Areas	Key Activities
Responsibilities and Activities	Clinical Care Management	Perform advanced health assessment incorporating comprehensive geriatric assessment, physical examination, diagnostic tests, diagnosis formulation and management plans in collaboration with the interdisciplinary team
		Provide clinical consultation and recommendation to the interdisciplinary care team on the management of older adults with complex care needs
		Perform medication review and reconciliation to address issues with polypharmacy
		Prescribe medication to older adults based on identified health conditions in adherence to collaborative prescribing guidelines*
		Perform procedures in accordance with collaborative agreements, guidelines and protocols
		Evaluate and monitor the health maintenance of chronic diseases in older adults and provide management of geriatric syndromes
	Engagement and Empowerment	Provide health and disease-related education to older adults and their families / caregivers and promote self-management
		Identify the older adults' primary concerns, priorities, and preferences to promote person-centred goal setting and shared decision-making
	Care Transition and Integration	Conduct interdisciplinary team discussions to determine the goals of care and ensure smooth transition and continuity of care
		Communicate effectively with multiple stakeholders and interdisciplinary team to facilitate effective discharge planning to ensure the continuity of care and smooth transition to community for older adults
		Initiate referrals that promote continuity of care according to older adult's needs and care goals within the available clinical privileging framework
	Health Promotion, Wellness and Disease Prevention	Evaluate learning plans to address health-related needs of older adults with consideration of their cognitive and sensory changes
		Advocate for health promotion and preventive health with appropriate interventions such as health screening, immunisation and risk assessment
		Apply evidence-based practice in advocating for health-promotion activities

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Nursing Practice Management, Innovation and Research		Develop innovative models and services to improve healthcare delivery and outcomes to meet the ongoing needs of older adults
			Provide clinical leadership in the delivery of care for older adults
			Develop, review and update clinical policies, guidelines and protocols based on contemporary evidence
			Provide consultation on clinical outcome evaluations and develop clinical outcome indicators for geriatric nursing practice
			Lead or participate in research and the development and implementation of evidence-based practice related to geriatric nursing
			Contribute to national and local policies and strategies related to geriatric nursing practice
	Professional Development and Leadership		Develop and deliver geriatric care training programmes for interdisciplinary learning
			Keep abreast with updated evidence in geriatric care practice through continuous learning and reflection on practices
			Provide clinical supervision, coaching and assessment of novice Advanced Practice Nurses, students and interns

	Competency Domain	Competency Element	Expected Proficiency Level
			Advanced Practice Nurse
Professional Competencies	D1. Person-centred Care	E1. Comprehensive Assessment and Management	Level 4
		E2. Client, Family and Caregiver Education and Empowerment	Level 4
		E3. Communication, Collaboration and Teamwork	Level 4
		E4. Discharge Planning and Care Transition Across Care Continuum	Follow JRP
	D2. Health Promotion, Wellness and Disease Prevention	E5. Health Promotion, Wellness and Disease-Prevention	Follow JRP
	D3. Professional Development and Leadership	E6. Develop and Lead Self	Follow JRP
		E7. Develop and Lead Others	Follow JRP
	D4. Improvement, Innovation and Research	E8. Quality Improvement, Innovation and Research	Follow JRP

NOTE: *Only applicable for APNs with a National Collaborative Prescribing Programme certificate and credentialed by their employing institutions.

ASSISTANT DIRECTOR OF NURSING / DEPUTY DIRECTOR OF NURSING / DIRECTOR OF NURSING

Job Role Description

The Assistant Director of Nursing / Deputy Director of Nursing / Director of Nursing is responsible for the development and advancement of Geriatric Nursing practice, in alignment with the organisational strategic direction and national healthcare priorities. S/He oversees the development and implementation of evidence-based nursing in the care of older adults and evaluates geriatric nursing standards and competencies in response to the evolving healthcare landscape.

S/He endorses the geriatric nursing care model and ensures the availability of resources for safe, quality, person-centred and value-based care delivery.

S/He advocates for the needs and wellbeing of geriatric-trained nurses and motivates them to pursue personal and professional development. S/He provides feedback on national policies and strategies related to geriatric nursing practice.

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities	Engagement and Empowerment	Assistant Director of Nursing / Deputy Director of Nursing	Implement best practices to enhance engagement and promote self-management for older adults
			Facilitate and lead engagement with various stakeholders and synergise services to enhance care delivery and build collaboration
			Develop strategies to empower older adults through enhancing health literacy, enabling informed choices in relation to their healthcare needs
			Partner with various stakeholders to expand older adult care services
			Evaluate the effectiveness of strategies for older adults' engagement to promote self-management of health and wellbeing
		Director of Nursing	Set strategic directions to strengthen and extend networking to enhance wellbeing, health promotion and care delivery for the older adult population
	Care Transition and Integration	Assistant Director of Nursing / Deputy Director of Nursing	Implement strategies for care integration to meet the health and social needs of older adults
			Promote and implement a systems-approach to ensure smooth care transition and coordination
			Develop and evaluate the effectiveness of systems-approach to care transition and coordination
			Lead and spread collaborative improvement efforts to redesign and improve care coordination and transition
		Director of Nursing	Drive multi-dimensional care integration to improve quality and cost-effectiveness of care for older adults
	Health Promotion, Wellness and Disease Prevention	Assistant Director of Nursing / Deputy Director of Nursing	Advocate interventions and behaviours to promote healthy ageing, including functional independence, social engagement, physical and mental wellness
			Implement and evaluate strategies to enhance the uptake of evidence-based immunisation and age-appropriate screening for diseases and identification of geriatric syndromes
		Director of Nursing	Set direction for health promotion activities in line with evolving needs of the ageing population

	Key Responsibility Areas	Job Role Profile	Key Activities
Responsibilities and Activities (Cont'd)	Nursing Practice Management, Innovation and Research	Assistant Director of Nursing / Deputy Director of Nursing	Lead and review geriatric nursing care model, care processes and practices
			Evaluate and drive the adoption of best practices and innovation in geriatric care delivery
			Lead and facilitate evidence-based initiatives and health services research to ascertain clinical and cost-effectiveness
		Director of Nursing	Drive a culture of quality and safety in person-centred geriatric care
	Professional Development and Leadership	Assistant Director of Nursing / Deputy Director of Nursing	Provide clinical leadership in geriatric nursing
			Develop and review geriatric training and development programmes and provide recommendations in alignment with organisational goals
			Oversee the development and lead the implementation of evidence-based geriatric nursing care practices and innovative care delivery
			Evaluate the effectiveness of geriatric nursing care practices, and provide recommendations to enhance the quality of geriatric nursing standards
			Develop and evaluate talent development and performance management strategies within the organisation to build geriatric nursing capability
		Director of Nursing	Seek opportunities to influence local and national policy on geriatric care management and capability-building

	Competency Domain	Competency Element	Expected Proficiency Level		
			Assistant Director of Nursing	Deputy Director of Nursing	Director of Nursing
Professional Competencies	D1. Person-centred Care*	E2. Client, Family and Caregiver Education and Empowerment	Level 4	Level 4	Level 4
		E3. Communication, Collaboration and Teamwork	Level 4	Level 4	Level 4
		E4. Discharge Planning and Care Transition Across Care Continuum	Level 4	Level 4	Level 4
	D2. Health Promotion, Wellness and Disease Prevention	E5. Health Promotion, Wellness and Disease Prevention	Level 3	Level 4	Level 4
	D3. Professional Development and Leadership	E6. Develop and Lead Self	Level 4	Level 4	Level 4
		E7. Develop and Lead Others	Level 4	Level 4	Level 4
	D4. Improvement, Innovation and Research	E8. Quality Improvement, Innovation and Research	Level 3	Level 4	Level 4

NOTE: *The incumbent is expected to have the capabilities reflected in PCs, E1. Comprehensive Assessment and Management at Level 4 in order to be able to guide and step in as required, even though the current JRP does not include active participation in direct Person-centred Care.

PROFESSIONAL COMPETENCIES

A total of eight Professional Competencies (PCs) have been developed for nurses delivering care to older adults and the PCs developed have been further organised into four competency domains. The Person-centred Care competency domain is further organised into four competency sub-domains.

Overview of the Geriatric Nursing Competency Framework (GNCF)

COMPETENCY DOMAIN		COMPETENCY ELEMENT	DEFINITION OF COMPETENCY ELEMENT
D1. Person-centred Care			
D1.1 Clinical Care Management	E1	Comprehensive Assessment and Management	Perform comprehensive assessment of older adults to identify geriatric syndromes, common geriatric conditions, and psychosocial and functional issues in order to develop and implement an individualised care plan using a person-centred approach to promote function, mental wellness, and quality of life
D1.2 Engagement and Empowerment	E2	Client, Family and Caregiver Education and Empowerment	Engage and empower older adults, families and / or caregivers in self-management of health and wellbeing
D1.3 Communication and Collaboration	E3	Communication, Collaboration and Teamwork	Utilise engagement strategies to work together with older adults, caregivers, other professionals and community partners on a common goal towards the health and wellbeing of older adults
D1.4 Care Transition and Integration	E4	Discharge Planning and Care Transition Across Care Continuum	Facilitate and manage discharge planning and care transition of older adults across different settings and / or levels of care to ensure optimal care continuum and coordination
D2. Health and Wellness	E5	Health Promotion, Wellness and Disease Prevention	Promote healthy ageing through advocating interventions and behaviours that promote functional independence, social engagement, and physical and mental wellness. Advocate evidence-based immunisation and screening for diseases
D3. Professional Development and Leadership	E6	Develop and Lead Self	Develop awareness of one's role and abilities, enhance capabilities and manage behaviours and practises to achieve professional and / or organisational goals
	E7	Develop and Lead Others	Drive change, foster a collaborative culture, cultivate dynamic and competent care teams and network to shape population health for the older adults
D4. Improvement, Innovation and Research	E8	Quality Improvement, Innovation and Research	Develop and implement quality improvement and innovation to drive evidenced-based practice care for older adults to achieve optimal outcomes

Definition of the 4 Proficiency Levels

Within each competency domain are specific competency elements that are expressed in ascending levels of expertise where Level 1 marks the most basic level of proficiency and Level 4, advanced level of proficiency.

LEVEL	RESPONSIBILITY (Degree of supervision and accountability)	AUTONOMY (Degree of decision-making)	COMPLEXITY (Degree of difficulty of situation and tasks)	KNOWLEDGE AND ABILITIES (Required to support work as described under Responsibility, Autonomy and Complexity)
4	Accountable for significant area of work, strategy or overall direction	Empowered to chart direction and practices within and outside of work (including professional field / community), to achieve / exceed work results	Highly Complex	• Synthesise knowledge in a field of work and the interface between different fields, and create new forms of knowledge • Employ advanced skills to solve critical problems and formulate new structures, and / or redefine existing knowledge or professional practice • Demonstrate exemplary ability to innovate and formulate ideas and structures • Demonstrate ability to lead both individuals and teams in promoting best practice • Lead research to inform evidence in clinical care and quality management
3	Accountable for achieving assigned objectives, decisions made by self and others	Provide leadership to achieve desired work results; manage resources, set milestones and drive work	Complex	• Evaluate factual and advanced conceptual knowledge within a field of work, involving a critical understanding of theories and principles • Select and apply an advanced range of cognitive and technical skills, demonstrating mastery and innovation, to devise solutions for complex and unpredictable problems in a specialised field of work • Manage and drive complex work activities
2	Work under broad direction May hold some accountability for the performance of others, in addition to self	Use discretion in identifying and responding to issues, work with others and contribute to work performance	Non-routine (may not have precedence)	• Select and apply a range of cognitive and technical skills to solve non-routine / abstract problems • Apply relevant procedural and conceptual knowledge and skills to perform differentiated work activities and manage changes • Able to collaborate with others to identify value-adding opportunities
1	Work with some supervision Accountable for tasks assigned	Use limited discretion in resolving issues or enquiries. Requires occasional to frequent guidance	Routine (has precedence)	• Understand and apply factual and procedural knowledge in a field of work • Apply basic skills to carry out defined tasks • Identify opportunities for minor adjustments to work tasks

Each PC document includes the following:

- **Competency Domain**
- **Competency Element**
- **Definition of Competency Element**
- **Proficiency Level Description of Competency Element**
- **Knowledge**
- **Abilities**
- **Sources of Information**

The 8 PCs developed for the GNCF are shown in the following pages.

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.1 Clinical Care Management	E1 Comprehensive Assessment and Management	Perform comprehensive assessment of older adults to identify geriatric syndromes, common geriatric conditions, and psychosocial and functional issues in order to develop and implement an individualised care plan using a person-centred approach to promote function, mental wellness, and quality of life

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Assist in performing comprehensive assessments of older adults and implementing nursing interventions according to the individualised care plan	Formulate and implement individualised care plans by conducting comprehensive assessment to manage geriatric syndromes	Evaluate and review individualised care plans by conducting comprehensive assessment for older adults with complex care needs	Develop and review evidence-based clinical practice; review comprehensive assessment, outcomes and revise care plans appropriately
Knowledge	• Principles of geriatric nursing • Basic knowledge of physiology and pathophysiology of ageing • Concepts of person-centred care • Principles of clinical reasoning • Fundamental understanding of ethical principles • Basic knowledge of geriatric assessment • Basic understanding of geriatric syndromes • Prevention and basic management of geriatric syndromes • Basic knowledge of age-related conditions and common chronic diseases • Basic understanding of pharmacology in older adults • Understanding of interdisciplinary approach to care management • Principles of palliative care • Advance Care Planning (ACP) • Common signs and symptoms of end of life and management • Types of community resources	• Principles of geriatric nursing • Physiology and pathophysiology of ageing • Concepts of person-centred care • Clinical reasoning • Legal and ethical principles • Comprehensive Geriatric Assessment (CGA) • Risk factors for geriatric syndromes • Prevention and management of geriatric syndromes • Age-related conditions and common chronic diseases • Pharmacology in older adults • Interdisciplinary team roles and responsibilities • Principles of palliative care • Advance Care Planning (ACP) • Common signs and symptoms of end-of-life and management • Types of community resources	• Principles of geriatric nursing • Physiology and pathophysiology of ageing • Concepts of person-centred care • Clinical reasoning • Legal and ethical principles • Comprehensive Geriatric Assessment (CGA) • Contributing factors to geriatric syndromes • Prevention and management of geriatric syndromes • Age-related conditions and common chronic diseases • Pharmacology in older adults • Interdisciplinary collaboration • Principles of palliative care • Advance Care Planning (ACP) • Common signs and symptoms of end-of-life and management • Types of community resources	• Principles of geriatric nursing • Advanced pathophysiology of ageing* • Concepts of person-centred care • Advanced clinical reasoning • Legal and ethical principles • Comprehensive Geriatric Assessment (CGA) • Contributing factors to geriatric syndromes • Prevention and management of geriatric syndromes • Age-related conditions and common chronic diseases • Diagnosis and management of common geriatric conditions* • Clinical pharmacology in older adults* • Collaborative practice agreement on medication prescription* • Interdisciplinary collaboration • Principles of palliative care • Advance Care Planning (ACP) • Common signs and symptoms of end-of-life and management • Types of community resources

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.1** Clinical Care Management	**E1** Comprehensive Assessment and Management	Perform comprehensive assessment of older adults to identify geriatric syndromes, common geriatric conditions, and psychosocial and functional issues in order to develop and implement an individualised care plan using a person-centred approach to promote function, mental wellness, and quality of life

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Perform basic geriatric assessment and recognise signs and symptoms of geriatric syndromes • Support diverse needs • Advocate for older adults to promote their right to dignity, respect and safety • Assist in formulation of person-centred care plan • Identify and report abnormalities • Assist in implementation of non-pharmacological nursing interventions for geriatric syndromes and common geriatric conditions • Assess medication adherence • Participate in discussions with interdisciplinary teams to ensure care plans are appropriately implemented • Assist in the management of end of life care. including grief and bereavement support • Provide relevant information on community resources to facilitate discharge planning	• Perform Comprehensive Geriatric Assessment and identify geriatric syndromes • Identify and support diverse needs • Advocate for older adults to promote their right to dignity, respect and safety • Formulate and prioritise person-centred care plan based on individualised care needs, preferences and goals • Recognise signs and symptoms of complications related to geriatric syndromes and escalate accordingly • Implement care plans for geriatric syndromes and common geriatric conditions • Assist medication reconciliation and monitor medication effectiveness • Advocate for medication safety and deprescribing • Facilitate discussions with the interdisciplinary teams to ensure care plans are appropriately implemented • Manage common signs and symptoms of end of life care • Advocate appropriate older adults for (ACP) discussion	• Perform Comprehensive Geriatric Assessment and identify geriatric syndromes and common geriatric conditions • Advocate for older adults to promote their right to dignity, respect and safety • Evaluate person-centred care plans based on individualised care needs, preferences and goals • Manage complications related to geriatric syndromes and common geriatric conditions • Review the implementation of non-pharmacological nursing interventions for the prevention of complications related to geriatric syndromes • Assess medication effectiveness and safety • Review polypharmacy and recommend deprescribing • Collaborate with interdisciplinary teams, community partners, older adults and their families / caregivers to incorporate discussions to promote person-centred care • Manage common signs and symptoms of end-of-life care • Advocate or facilitate ACP discussions	• Conduct advanced comprehensive health assessments, apply clinical reasoning and generate differential diagnoses* • Develop person-centred treatment plans based on best evidence, older adults' preferences and goals of care • Evaluate clinical situations where modification should be catered based on older adults' preferences, life expectancies, functional statuses and comorbidities • Develop evidence-based clinical guidelines, protocols and standards in collaboration with the interdisciplinary team to promote quality care for older adults • Develop and review the systematic implementation of non-pharmacological nursing interventions for the prevention of complications related to geriatric syndromes and common geriatric conditions • Prescribe medication based on collaborative practice agreement* • Develop strategies for safe, appropriate and effective medication management in older adults, including medication reconciliation and deprescribing

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	**D1.1** Clinical Care Management	**E1** Comprehensive Assessment and Management	Perform comprehensive assessment of older adults to identify geriatric syndromes, common geriatric conditions, and psychosocial and functional issues in order to develop and implement an individualised care plan using a person-centred approach to promote function, mental wellness, and quality of life

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities (Cont'd)		• Advocate appropriate referrals to interdisciplinary team • Recommend referrals to appropriate community services	• Facilitate appropriate referrals to interdisciplinary teams for older adults with complex needs • Initiate referrals to appropriate community services	• Develop strategies to promote older adults' right to dignity, respect and safety • Lead discussions with interdisciplinary teams to ensure care plans are appropriately implemented* • Develop and evaluate palliative care planning, including symptoms management, Advance Care Planning (ACP) discussion, and support family to promote quality end of life care# • Initiate appropriate referrals to the interdisciplinary team • Implement strategies to bridge the gaps in care transitions to community services

Sources of Information

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*Ability only relevant for APNs.

For detailed information, please refer to the Palliative Nursing Competency Framework (PNCF).

NOTE: *For APN roles, special / privileged abilities and specific knowledge have been marked with an asterisk "*" and placed under Proficiency Level 4 across the Framework. Thus, if a Geriatric nurse is a SSN, APN, s/he would refer to the Competency Level assigned to the SSN role in addition to the items marked with an asterisk "*" under Proficiency Level.

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.2 Engagement and Empowerment	E2 Client, Family and Caregiver Education and Empowerment	Engage and empower older adults, families and / or caregivers in self-management of health and wellbeing

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Provide caregiver training and encourage self-management	Provide education and training to facilitate self-management and promote shared decision-making	Plan, develop and implement education and training programmes, and enable self-management and self-advocacy	Develop strategies, guidelines and protocols to reinforce self-management and improve health literacy
Knowledge	• Older adult engagement and motivation strategies • Concepts of self-management • Factors in facilitating self-management • Health coaching • Therapeutic relationships • Concept of health literacy • Basic principles and methods of patient education • Training resources • Basic understanding of methods to evaluate learning outcomes	• Older adult engagement and motivation strategies • Concepts of self-management • Effective strategies in facilitating self-management • Health coaching • Techniques of motivational interviewing • Therapeutic relationships • Concept of health literacy • Principles and methods of education and training • Training resources • Methods to evaluate understanding and learning outcomes	• Older adult engagement and motivation strategies • Concepts of self-management • Effective strategies in facilitating self-management • Health coaching • Techniques of motivational interviewing • Therapeutic relationships • Principles of health literacy • Principles and methods of education and training • Education and training design • Training resources • Evaluation of training effectiveness and efficiency	• Older adult engagement and motivation strategies • Emerging trends in self-management • Effective strategies in facilitating self-management • Health coaching • Techniques of motivational interviewing • Therapeutic relationships • Strategies to improve health literacy • Best practices in education and training design and delivery • Education and training design • Training resources • Evaluation of training effectiveness and efficiency • Relevant stakeholders for patient education and training

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.2 Engagement and Empowerment	E2 Client, Family and Caregiver Education and Empowerment	Engage and empower older adults, families and / or caregivers in self-management of health and wellbeing

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Establish rapport and trust with older adults, families and / or caregivers • Assess older adults and their caregivers' ability for self-management • Motivate older adults and their caregivers to be involved in daily care and decision-making • Recommend resources for self-care and maintenance of wellbeing • Assist in identification of the preferences, health literacy, cultural and learning needs of older adults and / or their caregivers • Deliver patient education and caregiver training • Provide feedback to care team on education and training outcomes for older adults, families and / or caregivers • Evaluate effectiveness of education and training sessions and address gaps • Encourage older adults, families and / or caregivers to access appropriate community resources according to care plan	• Facilitate therapeutic relationships with older adults, families and / or caregivers to encourage older adults to take ownership of care decisions • Recommend strategies to facilitate self-management • Implement strategies to motivate older adults and their caregivers to be involved in daily care and decision-making • Recommend resources for self-care and maintenance of wellbeing • Identify the preferences, health literacy, cultural and learning needs of older adults and / or their caregivers • Provide self-management education and caregiver training and evaluate its effectiveness • Recommend care and support options to address identified gaps and reduce caregiver burden • Empower older adults, families and / or caregivers to actively seek available support options for their complex needs	• Maintain therapeutic relationships with older adults, families and / or caregivers • Recognise barriers and develop strategies to facilitate self-management • Review provision of resources for self-care and maintenance of wellbeing • Develop, implement and evaluate education programmes to address identified gaps in older adults in consideration of their health literacy, preferences and culture • Promote empowerment of older adults, families and / or caregivers to actively seek available support options for their complex needs	• Develop strategies to promote therapeutic relationships with older adults, families and / or caregivers • Drive a culture to support older adults and their caregivers to be involved in daily care and decision-making • Drive development and implementation of resources for self-care and maintenance of wellbeing • Evaluate education programmes for specific care needs in older adults and recommend strategies for improvement • Evaluate motivation strategies to enhance self-care and decision-making • Incorporate best practices to drive and improve health literacy of older adults, families and / or caregivers • Identify and collaborate with appropriate stakeholders on the education and training of older adults, families and / or caregivers

Sources of Information

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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.3 Communication and Collaboration	E3 Communication, Collaboration and Teamwork	Utilise engagement strategies to work together with older adults, caregivers, other professionals and community partners on a common goal towards the health and wellbeing of older adults

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Communicate and engage with older adults, families, caregivers and / or team members	Engage with older adults, families and / or caregivers and collaborate with team members and relevant stakeholders	Manage challenging relationships with older adults, families, and caregivers and collaborate with community partners / relevant stakeholders	Foster collaboration and synergise services to enhance older adult care and develop nursing capabilities
Knowledge	• Basic communication skills with older adults • Therapeutic communication techniques • Interprofessional collaboration framework • Principles of mental capacity	• Communication skills and strategies with older adults • Therapeutic communication techniques • Basic counselling skills • Interprofessional collaboration framework • Principles of mental capacity • Informed consent	• Communication skills and strategies with older adults • Therapeutic communication techniques • Basic counselling skills • Interprofessional collaboration framework • Conflict resolution • Negotiation skills • Principles of mental capacity • Informed consent	• Communication skills and strategies with older adults • Therapeutic communication techniques • Counselling skills • Relevant healthcare communication models • Inter-professional collaboration framework • Conflict resolution • Negotiation strategies • Collaborative leadership • Principles of mental capacity • Informed consent

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.3 Communication and Collaboration	E3 Communication, Collaboration and Teamwork	Utilise engagement strategies to work together with older adults, caregivers, other professionals and community partners on a common goal towards the health and wellbeing of older adults

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Build trust and rapport with older adults, families and / or caregivers to cultivate a therapeutic relationship • Recognise older adults' communication abilities (verbal and non-verbal) may be impacted by their health conditions, medication, sensory loss and cultures • Use appropriate communication skills and adaptive aids to elicit information from older adults, families and / or caregivers • Work with interprofessional healthcare team members to meet the needs of older adults	• Build trust and rapport with older adults, families and / or caregivers and interprofessional healthcare team to cultivate therapeutic relationships • Identify older adults' barriers in communication • Implement effective communication strategies to meet the intended outcomes for older adults • Provide guidance and / or counselling to older adults, and / or caregivers on their care needs and preferences • Present relevant information on older adults and participate in interdisciplinary discussions • Advocate for the best interest of older adults with consideration of their capacity and informed consent for person-centred decision-making • Collaborate with interprofessional healthcare team members and relevant stakeholders to support individual older adults' needs and preferences	• Foster a professional partnership with older adults and their family / caregivers and interprofessional healthcare team to cultivate a therapeutic relationship • Identify older adults' barriers in communication • Evaluate communication strategies to meet intended outcomes for older adults • Identify alternative counselling strategies for challenging situations • Facilitate interdisciplinary case discussions • Promote decision-making through discussions with various stakeholders with consideration of their capacity and informed consent to meet older adults' needs and preferences • Resolve conflicts within teams and other stakeholders • Establish networks and collaborative partnerships with relevant stakeholders to manage older adults' needs and preferences	• Build a culture of trust and openness within the organisation and with the broader stakeholders • Identify best practices to enhance communication strategies • Develop strategies to improve communication channels within the healthcare system to meet intended outcomes for the older adults • Establish communication channels and define organisational policies and protocols • Lead interdisciplinary case discussions • Support the assessment of mental capacity* • Facilitate decision-making through discussions with various stakeholders with consideration of their capacity and informed consent to meet older adults' needs and preferences • Synergise collaborative efforts provided by various stakeholders to facilitate continuity of care

Sources of Information

1. Canadian Gerontological Nursing Association. (2020). *Gerontological Nursing Standards of Practice and Competencies 2020 (4th ed.).* Toronto, Canada: CGNA. Retrieved December 5, 2021, from https://img1.wsimg.com/blobby/go/036d4df6-e252-4a6f-9603-35d9db22fbf0/CGNA_Standards-Competencies_2020.pdf
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*Ability only relevant for APNs

NOTE: *For APN roles, special / privileged abilities and specific knowledge have been marked with an asterisk "*" and placed under Proficiency Level 4 across the Framework. Thus, if a Geriatric Nurse is a SSN, APN, s/he would refer to the Competency Level assigned to the SSN role in addition to the items marked with an asterisk "*" under Proficiency Level 4.

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.4 Care Transition and Integration	E4 Discharge Planning and Care Transition Across Care Continuum	Facilitate and manage discharge planning and care transition of older adults across different settings and / or levels of care to ensure optimal care continuum and coordination

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Participate in discharge planning and care transition of older adults	Facilitate and manage discharge planning and care transition of older adults	Develop discharge plan and care transition framework in partnership with stakeholders	Review and streamline discharge planning strategies and care transition resources to enhance safety and quality of care
Knowledge	• Overview of healthcare delivery system and community resources with a focus on the geriatric / gerontology landscape • Basic concepts of discharge planning and care transition • Caregiver support and resources • Care transition models • Common issues and challenges during discharge planning and care transition process • Technology enablers for discharge planning and care transition • Overview of healthcare and social financing schemes and subsidies	• Overview of healthcare delivery system and community resources with a focus on the geriatric / gerontology care landscape • Principles of discharge planning and care transition • Caregiver support and resources • Care transition models • Opportunities and risks in discharge planning and care transition • Technology enablers for discharge planning and care transition • Overview of healthcare and social financing schemes and subsidies	• Overview of healthcare delivery system and community resources with a focus on the geriatric / gerontology landscape • Principles of discharge planning and care transition • Key stakeholders and resources capabilities in the care continuum • Care transition models • Evidence-based practice for discharge planning and care transition • Strategies of technology enablers for discharge planning and self-management in care transition into the community • Overview of healthcare and social financing schemes and subsidies affecting care transition and right siting of care	• Overview of healthcare delivery system and community resources with a focus on the geriatric / gerontology landscape • Principles of discharge planning and care transition • Key stakeholders and resources capabilities in the care continuum • Care transition models • Evidence-based practice for discharge planning and care transition • Emerging trends in technology enablers to promote self-management in the community • Healthcare and social financing schemes and subsidies and their impact in care transition

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D1 Person-centred Care	D1.4 Care Transition and Integration	E4 Discharge Planning and Care Transition Across Care Continuum	Facilitate and manage discharge planning and care transition of older adults across different settings and / or levels of care to ensure optimal care continuum and coordination

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Assist in identifying the needs and readiness of older adults, families and / or caregivers for care transition • Assist in identifying older adults', families' and / or caregivers' education and / or training needs for the continuity of care • Assist in developing care transition plans according to older adults' care needs, goals and preferences • Provide appropriate caregiver training to older adults and their caregivers • Assist in providing relevant information needed for continuity of care to enable older adults to navigate the care system • Support the coordination of care among different care providers • Assist in follow-up care to ensure care continuity for older adults	• Assess needs and readiness of older adults, families and / or caregivers for care transition • Assess the suitability of the living environment and arrangement for care transition • Assess older adults', families' and / or caregivers' education and / or training needs for the continuity of care • Develop care transition plans in collaboration with the interdisciplinary team according to older adults' care needs, goals and preferences • Provide relevant care information needed for continuity of care for older adults, families and / or caregivers and care providers • Refer older adults to appropriate level, site and type of care to meet their care needs and ensure safe transition • Liaise and / or follow up with the appropriate agency, government and community resource for continuity of care	• Identify older adults at risk of care transition failure and recommend solutions in collaboration with the interdisciplinary team and community partners • Identify the complex care needs of older adults to initiate appropriate referrals to facilitate right siting • Review and evaluate care transition plans for older adults at risk of care transition failure • Lead / facilitate family conference to assist in discharge planning if needed • Establish care transition framework for continuity of care in collaboration with the interdisciplinary team • Incorporate appropriate technologies into care transition processes • Build partnerships with appropriate agencies, government and community resources for continuity of care	• Advocate care transition as an organisational priority to enhance older adult care quality and safety • Establish organisational policies and procedures to address key care transition issues in collaboration with other stakeholders • Establish evidence-based care transition for effective discharge planning • Employ influencing strategies to advocate for healthcare financing to support care transition and right siting of care • Promote technology-enabled care transition • Forge formal pathways with agencies, government and community resources for continuity of care to meet the needs and issues of the growing ageing population

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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D2 Health Promotion, Wellness and Disease Prevention	-	E5 Health Promotion, Wellness and Disease Prevention	Promote healthy ageing through advocating interventions and behaviours that promote functional independence, social engagement, and physical and mental wellness. Advocate evidence-based immunisation and screening for diseases

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Support and participate in health promotion, wellness and disease-prevention activities	Plan and deliver health promotion, wellness and disease-prevention interventions	Develop and manage delivery of health promotion, wellness and disease-prevention interventions	Develop strategic direction and drive health promotion, wellness and disease prevention
Knowledge	• Fundamentals of health promotion and disease prevention • Clinical Practice Guidelines on functional screening of older adults • Basics of primary, secondary and tertiary disease prevention • Basics of health and disease screening, including mental health screening • National older adult immunisation schedule • Basic concepts of frailty and sarcopenia affecting older people • Age-appropriate physical activity, exercise and nutritional and psychosocial interventions	• Concepts and models of health and wellness, health promotion and older adult empowerment • Clinical Practice Guidelines on functional screening of older adults • Basics of primary, secondary and tertiary disease prevention • Evidence-based approaches to screening, immunisations, health promotion, and disease prevention • Basic concepts of frailty and sarcopenia affecting the older people • Age-appropriate physical activity, exercise and nutritional and psychosocial interventions	• Concepts and models of health and wellness, health promotion and older adult empowerment • Clinical Practice Guidelines on functional screening of older adults • Primary, secondary and tertiary disease prevention • Evidence-based approaches to screening, immunisations, health promotion, and disease prevention • Concepts of frailty and sarcopenia affecting older people • Evidence-based physical activity, exercise and nutritional and psychosocial interventions	• Best practices and strategies in the promotion of health and wellness • Clinical Practice Guidelines on functional screening of older adults • Primary, secondary and tertiary disease prevention • Evidence-based approaches to screening, immunisations, health promotion, and disease prevention • Concepts of frailty and sarcopenia affecting older people • Evidence-based physical activity, exercise and nutritional and psychosocial interventions • National health planning priorities and direction • Emerging trends in health promotion and disease prevention

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D2 Health Promotion, Wellness and Disease Prevention	-	E5 Health Promotion, Wellness and Disease Prevention	Promote healthy ageing through advocating interventions and behaviours that promote functional independence, social engagement, and physical and mental wellness. Advocate evidence-based immunisation and screening for diseases

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Provide information and education on health promotion, disease screening and immunisation recommendations as appropriate to older adults' needs • Promote healthy lifestyle behaviours while respecting older adults' autonomy • Support delivery of disease prevention activities such as immunisation, health and disease screening • Assist in functional, mental health and frailty screening • Assist to identify and implement frailty prevention interventions	• Provide information and education on health promotion, disease screening and immunisation recommendations as appropriate to the older adults' needs • Plan and implement health promotion activities while respecting older adults' autonomy • Implement evidence-based disease prevention activities such as screening, immunisations, and health promotion programmes • Perform functional and mental health screening and recommend appropriate interventions • Conduct frailty screening and implement individualised frailty prevention interventions	• Develop evidence-based, population-focused health promotion, wellness and disease prevention initiatives in collaboration with other health and social care experts • Evaluate the effectiveness of health promotion activities, functional and mental health recommendations • Develop evidence-based frailty screening and prevention programmes in collaboration with multidisciplinary stakeholders	• Oversee the implementation of population-based interventions for health promotion and disease prevention • Incorporate evidence-based research and knowledge to design and drive health promotion strategies • Participate in the development of health and wellness promotion and disease prevention policies • Develop strategies to promote functional and mental health • Evaluate evidence-based frailty screening and prevention programmes

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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D3 Professional Development and Leadership	-	E6 Develop and Lead Self	Develop awareness of one's role and abilities, enhance capabilities and manage behaviours and practises to achieve professional and / or organisational goals

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Understand own scope of practice and implement steps for self-development	Reflect on own practice and learning, and identify self-development needs	Review own practice and behaviours, and prioritise development needs	Enhance own leadership practice and behaviours and develop strategies in response to the changing healthcare landscape
Knowledge	• Code of Conduct for Nurses and Midwives • Emerging nursing roles in own practice • Nursing career structure and development pathways • Self-evaluation methods • Effective communication • Principles of interpersonal relationships	• Code of Conduct for Nurses and Midwives • Emerging nursing roles in own practice • Nursing career structure and development pathways • Self-evaluation methods • Effective communication • Principles of interpersonal relationships • Leadership development	• Professionalism in nursing practice • Emerging nursing roles and trends • Nursing career structure and development pathways • Self-evaluation methods • Effective communication • Principles of interpersonal relationships • Leadership development • National healthcare strategy and directions	• Professionalism in nursing practice • Emerging nursing roles and trends • Nursing career structure and development pathways • Self-evaluation methods • Effective communication • Principles of interpersonal relationships • Leadership development • National healthcare strategy and directions • Advanced systems and strategic thinking

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D3 Professional Development and Leadership	-	E6 Develop and Lead Self	Develop awareness of one's role and abilities, enhance capabilities and manage behaviours and practises to achieve professional and / or organisational goals

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Reflect on own practice and professional behaviours • Synthesise learning to improve own practice • Seek opportunities and participate in continuous learning and professional development • Initiate personal development planning for professional growth • Seek assistance promptly on situations and / or issues impinging on professional and clinical practice	• Reflect on own practice and competencies • Synthesise learning to improve own practice • Improve practice and professional behaviours based on feedback and self-reflection • Identify learning needs based on evaluation of own practice • Develop and implement a personal development plan • Manage situations and / or issues impinging on professional and clinical practice	• Review own practice and behaviours • Synthesise learning to improve own practice • Enhance own practice and change behaviours based on feedback and self-reflection to facilitate team's performance • Prioritise self-development needs based on organisational requirements • Align own practice with relevant national and professional policies, guidelines and legislation • Anticipate situations and / or issues impinging on professional and clinical practice and develop preventive solutions	• Reflect on own practice and behaviours to understand impact on organisation and stakeholders • Develop strategies to enhance the professional and clinical practice in response to the changing healthcare landscape • Enhance leadership practice and behaviours based on feedback, emerging trends and advancements in nursing practice

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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D3 Professional Development and Leadership	-	E7 Develop and Lead Others	Drive change, foster a collaborative culture, cultivate dynamic and competent care teams and network to shape population health for older adults

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Support a learning, collaborative and inclusive culture and maintain positive working relationships	Coach peers and junior care team members to promote professional development and embrace a dynamic, collaborative and inclusive team culture	Lead department and / or teams to achieve established objectives efficiently and provide clinical leadership	Lead the organisation by developing long-term strategies and goals, and implement strategies to improve key performance areas
Knowledge	• Approaches to teamwork and collaboration • Goal-setting concept • Effective communication techniques • Understanding expectations of the care team • Change management • Basic concepts of conflict management • Concept of precepting and coaching	• Culture building techniques • Goal-setting concept • Effective communication strategies • Team performance indicators • Change management • Concepts of conflict resolution • Concept of precepting and coaching • Staff engagement and motivation techniques • Staff development and training approaches	• Strategies to build organisational culture • Goal-setting concept • Effective communication strategies • Leadership principles • Change management and strategies • Conflict resolution strategies • Concept of coaching and mentoring • Staff development and training approaches	• Strategies to build organisational culture • Goal-setting concept • Effective communication strategies • Leadership development • Change management and strategies • Conflict management • Concept of coaching and mentoring • Staff development and training approaches

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D3 Professional Development and Leadership	-	E7 Develop and Lead Others	Drive change, foster a collaborative culture, cultivate dynamic and competent care teams and network to shape population health for older adults

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Initiate co-learning with peers for the development of the care team • Support a learning, collaborative and inclusive culture and maintain positive working relationships • Communicate expectations to care team members and seek clarity on goal setting • Monitor performance of care team members and provide feedback • Assist and support care team members to manage difficult situations • Provide input on new areas of education and training programmes • Guide nursing students and volunteers to meet their learning objectives	• Precept and coach nurses to promote professional development • Demonstrate a learning, collaborative and inclusive culture and maintain positive working relationships • Discuss expectations and monitor team's progress to recommend measures for optimising performance • Provide clinical supervision to enhance capabilities of the care team • Mediate between team members in conflict situations • Assist in the development of education and training programmes • Precept nursing students on their learning needs using various training techniques	• Mentor nurses to aid their professional development and build resilience • Promote a collaborative and dynamic work culture • Establish team members' performance indicators and measures for productivity and outcomes of services • Recommend appropriate strategies to improve care team's performance • Manage conflicts and propose resolutions, and escalate when necessary • Review and design education and training programmes as well as clinical supervision guidelines based on current best practices, skills and technology • Assess performance of nurses and develop individual training and development roadmaps in a collaborative manner • Identify talents for succession planning	• Foster a collaborative culture and develop dynamic and competent care teams • Develop long-term objectives and strategies based on the organisational vision • Translate organisational goals into tangible targets for the organisation • Align organisational performance and implement strategies to improve key performance areas • Lead discussion or mediate complex conflict situations involving varied key stakeholders • Provide clinical leadership including establishing parameters of services and clinical standards • Mentor others on complex change management and coping strategies • Develop and evaluate succession planning framework • Ensure the continuity of leadership in the organisation by nurturing potential leaders

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Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D4 Improvement, Innovation and Research	-	E8 Quality Improvement, Innovation and Research	Develop and implement quality improvement and innovation to drive evidenced-based practice care for older adults to achieve optimal outcomes

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Description of Competency Element	Participate and provide feedback on the implementation of evidence-based practice to deliver care	Recommend and implement quality improvement, innovation and / or research to deliver evidence-based care	Lead quality improvement, innovation and / or research to deliver evidence-based care	Drive quality improvement, innovation and / or research to deliver evidence-based care
Knowledge	• Concepts of innovation and quality improvement • Problem-solving skills • Basic concepts of evidence-based practice • Basic research ethics • Concepts of change management	• Innovation and quality improvement framework • Root cause analysis • Concepts of evidence-based practice and outcome measurement • Research ethics • Research methodology and process • Research guidelines and regulations • Basic statistics for research • Framework for change management	• Innovation and quality improvement framework • Root-cause analysis • Concepts of evidence-based practice • Research ethics • Research methodology and process • Research guidelines and regulations • Statistics for research • Change management strategies • Data visualisation • Analytical skills • Clinical audit processes • National and international evidence-based practice guidelines and protocols	• Innovation and quality-improvement framework • Root-cause analysis • Concepts of evidence-based practice • Research ethics • Research methodology and process • Research guidelines and regulations • Statistics for research • Change management strategies • Data visualisation • Analytical skills • Systems thinking • National and international evidence-based practice guidelines and protocols

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D4 Improvement, Innovation and Research	-	E8 Quality Improvement, Innovation and Research	Develop and implement quality improvement and innovation to drive evidenced-based practice care for older adults to achieve optimal outcomes

Proficiency Level	Level 1	Level 2	Level 3	Level 4
Abilities	• Identify potential areas for improvement • Support quality improvement activities • Provide feedback on innovation and quality improvement interventions • Apply evidence-based practice to deliver care • Participate in research and evidence-based practice projects	• Analyse potential areas for improvement • Participate in innovation and quality improvement activities • Assist in evaluation of innovation and quality-improvement interventions • Assist in spreading innovation and quality improvement interventions within department and / or across the organisation • Support quality audits to maintain and improve standards of care • Identify challenges and barriers to innovation and quality-improvement initiatives • Identify gaps and research problems in the delivery of care based on issues escalated • Appraise available evidence and participate in research activities • Participate in research activities • Incorporate evidence-based practice to deliver care • Discuss and share results of innovation, improvement and / or research with relevant stakeholders	• Review and prioritise potential areas for improvement • Lead innovation and quality improvement projects • Spread innovation and quality improvement interventions across the organisation / department • Evaluate the effectiveness of innovation and quality improvement interventions • Assess feasibility of new technologies, services and delivery methods to own setting / older adult population • Conduct and evaluate quality audits to maintain and improve standards of care • Lead research activities in collaboration with relevant stakeholders • Integrate and promote evidence-based practice in the delivery of care • Evaluate evidence-based practice outcome and recommend practice changes • Disseminate results of innovation, improvement and / or research with relevant stakeholders	• Set direction for improvement efforts in alignment with organisational objectives • Synergise relevant stakeholders to drive innovation and quality improvement initiatives • Prioritise resources for innovation and quality improvement initiatives • Develop strategies to spread and sustain innovation and quality improvement interventions through various platforms • Guide the development of quality assurance frameworks and provide input based on best practices • Set research direction and identify priority areas for evidence-based practice • Influence relevant stakeholders to provide access to relevant sources of evidence • Garner support of relevant stakeholders for research activities • Build a culture of evidence-based practice for the delivery of care • Translate practice change from results of innovation, improvement and / or research with relevant stakeholders to obtain optimal outcomes

Competency Domain	Competency Sub-Domain	Competency Element	Definition of Competency Element
D4 Improvement, Innovation and Research	-	E8 Quality Improvement, Innovation and Research	Develop and implement quality improvement and innovation to drive evidenced-based practice care for older adults to achieve optimal outcomes

Proficiency Level	Level 1	Level 2	Level 3	Level 4

Sources of Information

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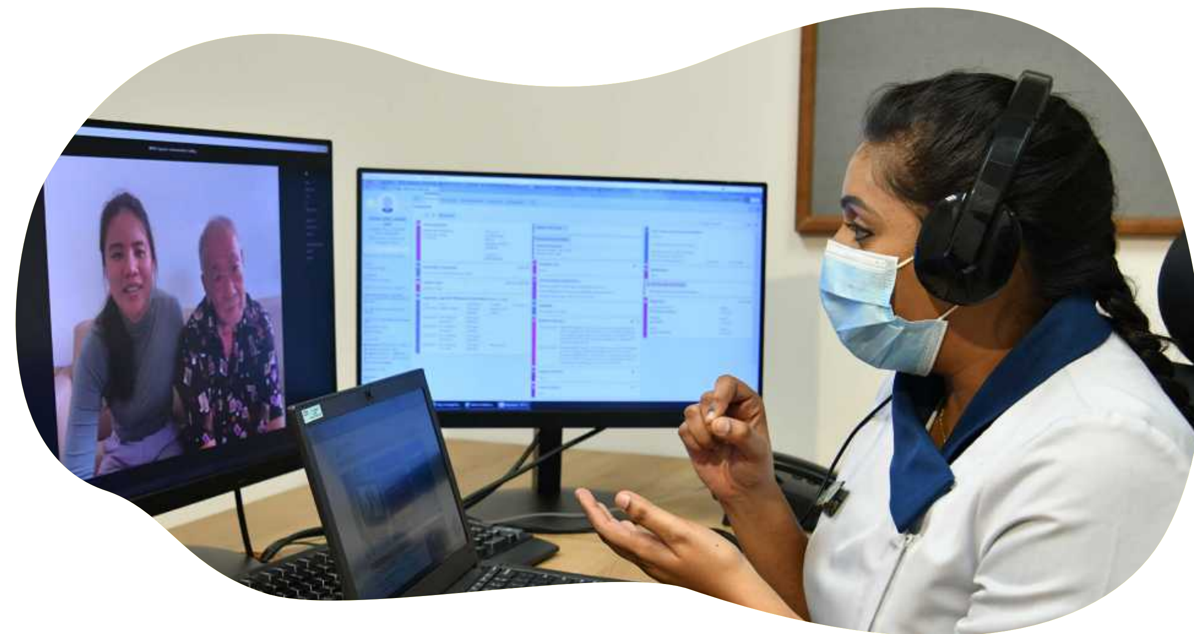
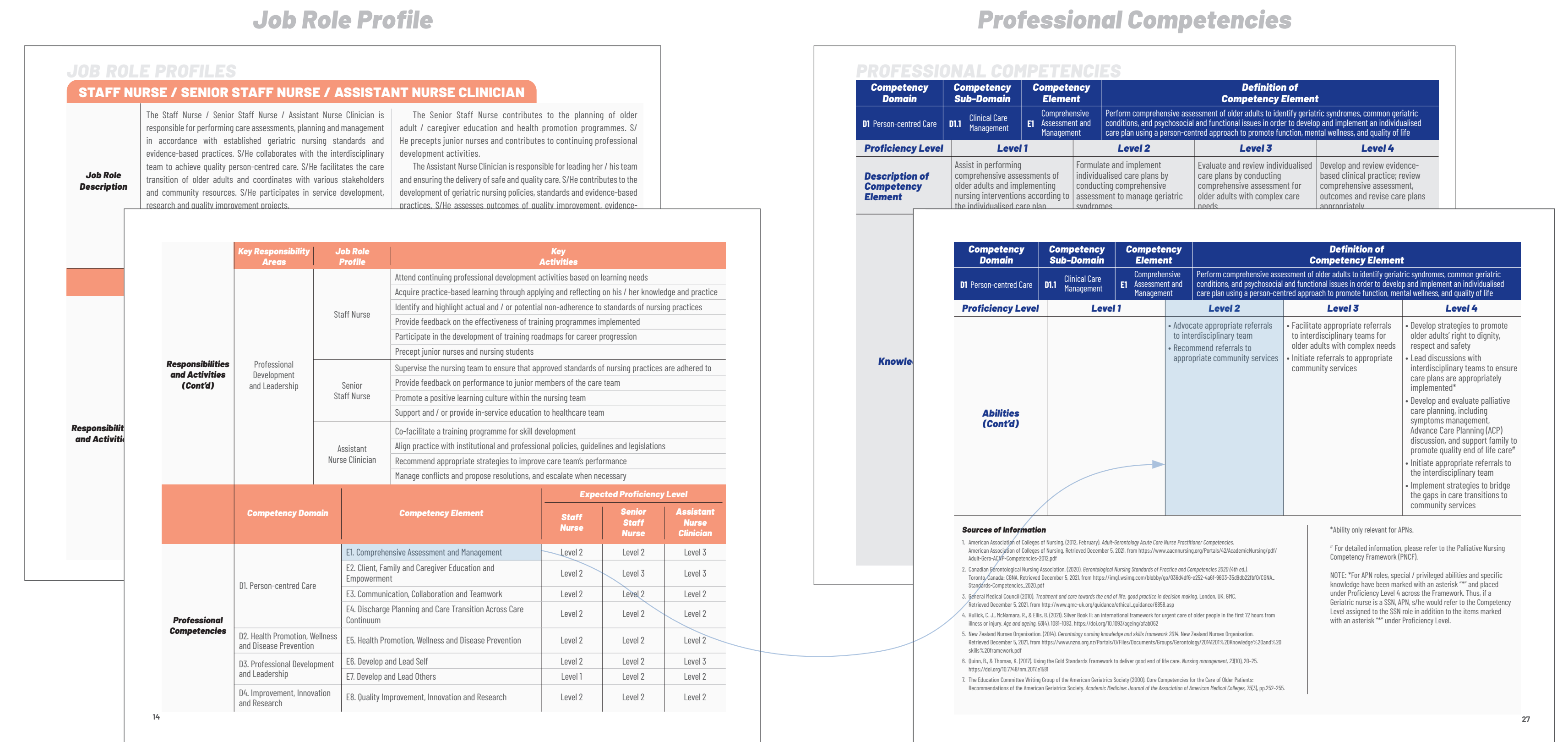


USING THE FRAMEWORK

Linking the Job Role Profiles and Professional Competencies

The Job Role Profiles (JRPs) and Professional Competencies (PCs) are linked as illustrated below. In the last section of each JRP document, a list of PCs is stated at the required proficiency levels. The proficiency level indicates the level of knowledge and abilities an incumbent needs to exhibit for a specific PC. Referring to the illustration below, the Staff has Comprehensive Assessment and Management competency tagged at Level 2. This means that the Staff Nurse is required to understand or possess knowledge of the items listed, including the capability to perform the abilities stated in Level 2 of the Competency.

Fig 1: Illustration of Linkage Between Job Role Profiles and Professional Competencies



Glossary

As the Framework draws from international resources, this glossary is developed to contextualise the key terms to the Singapore setting. It also contains the sources from which the definitions are derived.

Terms	Definition and Sources
Advance Care Planning	Advance Care Planning (ACP) is a process of discussion about future care between an individual, healthcare providers and often those close to the individual. *Source: Kite S. (2010). Advance care planning. Clinical medicine (London, England), 10(3), 275–278. https://doi.org/10.7861/clinmedicine.10-3-275*
Collaborative Practice Agreement	Collaborative Practice Agreement (CPA) is an agreement between the CP Practitioner and their collaborating medical practitioner, endorsed by the clinical and professional heads of department, and approved by the healthcare institution's Credentialing Committee. *Source: Ministry of Health, Singapore (2018). Guidelines For the Implementation of Collaborative Prescribing Services. Retrieved April 18, 2022, from https://www.moh.gov.sg/docs/librariesprovider4/guidelines/guidelines-for-implementation-of-collaborative-prescribing-services.pdf.*
Common Geriatric Conditions	Common Geriatric Conditions refer to health conditions which are commonly presented in older adults such as dementia, immobility and visual / hearing impairment. *Source: Harper, G.M., Johnston, C.B., & Landefeld, C.S. (2020). Management of Common Geriatric Problems. Current Medical Diagnosis & Treatment 2020. Retrieved April 18, 2022, from https://accessmedicine.mhmedical.com/content.aspx?bookid=2683§ionid=225032453*
Comprehensive Geriatric Assessment	Comprehensive Geriatric Assessment (CGA) is defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan to maximise overall health with ageing. *Source: Chen, Z., Ding, Z., Chen, C., Sun, Y., Jiang, Y., Liu, F., & Wang, S. (2021). Effectiveness of comprehensive geriatric assessment intervention on quality of life, caregiver burden and length of hospital stay: a systematic review and meta-analysis of randomised controlled trials. BMC geriatrics, 21(1), 377. https://doi.org/10.1186/s12877-021-02319-2*
Complex Needs	Complex needs refer to people who have more than one problem. It is commonly the combination of health needs (including diagnosis, treatment and rehabilitation) and social needs (such as housing, social care and independent living). *Source: National Complex Needs Alliance (2014). National Complex Needs Alliance: Position Paper. Canberra, Australia: National Complex Needs Alliance. Retrieved March 18, 2022, from https://www.aph.gov.au/DocumentStore.ashx?id=117efbf9-dc33-4fb2-9727-14082d526938&subId=303434*

Terms	Definition and Sources
Deprescribing	The term "deprescribing" refers to a process of medication withdrawal, supervised by a health care professional, with the goal of managing polypharmacy and improving outcomes. This can encompass efforts to comprehensively review a patient's medication list and systematically discontinue or reduce the dose of all medications with an unfavourable balance of benefits and harms, as well as efforts focused on specific types of high-risk medication. *Source: Reeve, E., Gnjidic, D., Long, J., & Hilmer, S. (2015). A systematic review of the emerging definition of 'deprescribing' with network analysis: implications for future research and clinical practice. British journal of clinical pharmacology, 80(6), 1254–1268. https://doi.org/10.1111/bcp.12732*
Frailty	Frailty is defined as "a medical syndrome with multiple causes and contributors that is characterised by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and / or death." *Source: Morley, J. E., Vellas, B., van Kan, G. A., Anker, S. D., Bauer, J. M., Bernabei, R., Cesari, M., Chumlea, W. C., Doehner, W., Evans, J., Fried, L. P., Guralnik, J. M., Katz, P. R., Malmstrom, T. K., McCarter, R. J., Gutierrez Robledo, L. M., Rockwood, K., von Haehling, S., Vandewoude, M. F., & Walston, J. (2013). Frailty consensus: a call to action. Journal of the American Medical Directors Association, 14(6), 392–397. https://doi.org/10.1016/j.jamda.2013.03.022*
Geriatric Syndromes	Geriatric Syndromes (GSs) is the term used to describe a group of common health conditions in older people that do not fit into discrete disease categories. These conditions include frailty, functional limitation, falls, depression, polypharmacy, malnutrition, and cognitive impairment. Collectively, GSs arise from a complex interplay between age-related physiologic changes, chronic disease, and functional stressors in older adults. Each interacts with the other, and often the syndromes co-occur. *Sources: Cheung, J., Yu, R., Wu, Z., Wong, S., & Woo, J. (2018). Geriatric syndromes, multimorbidity, and disability overlap and increase healthcare use among older Chinese. BMC geriatrics, 18(1), 147. https://doi.org/10.1186/s12877-018-0840-1* *Gołębiowski, T., Augustyniak-Bartosik, H., Weyde, W., & Klinger, M. (2016). Geriatric syndromes in patients with chronic kidney disease. Postepy higieny i medycyny doswiadczalnej (Online), 70(0), 581–589. https://doi.org/10.5604/17322693.1204562*
Informed Consent	Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. *Source: Shah, P., Thornton, I., Turrin, D., & Hipskind, J. E. (2021). Informed Consent. StatPearls. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK430827/*

Terms	Definition and Sources
Interdisciplinary Care Team	An interdisciplinary care team consists of practitioners from different health professions, who have a shared older adult population and common older adult care goals, and have responsibility for complementary tasks. The team is actively interdependent, with an established means of ongoing communication among team members to ensure that various aspects of older adults' healthcare needs are integrated, aligned, addressed, and met in a time-efficient manner. *Source: Academic Geriatric Resource Center, & Reynolds, D. W. (n.d.). Interdisciplinary Team Care Facilitator Guide. University of California Los Angeles, David Geffen School of Medicine. Retrieved April 18, 2022, from https://www.pogoe.org/productid/21709*
Interprofessional Collaboration Framework	The Interprofessional Collaboration Framework refers to a collaborative approach among healthcare professionals to improve patient-centred care, optimising health and systems outcomes. *Source: McLaney, E., Morassaei, S., Hughes, L., Davies, R., Campbell, M., & Di Prospero, L. (2022). A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. Healthcare management forum, 35(2), 112–117. https://doi.org/10.1177/08404704211063584*
Medication Adherence	Medication adherence refers to the extent to which a person adheres to the timing and dosing regime of the prescribed medication. *Source: Gast, A., & Mathes, T. (2019). Medication adherence influencing factors-an (updated) overview of systematic reviews. Systematic reviews, 8(1), 112. https://doi.org/10.1186/s13643-019-1014-8*
Medication Reconciliation	Medication reconciliation is a structured and explicit process of creating the most accurate list possible of all medications an older adult is taking, with the goal to ensure accurate and complete medication information transfer during transitions of care. This is usually preceded by the medication review process. *Source: Ministry of Health, Singapore. (2018). The National Medication Reconciliation Guidelines. Retrieved April 18, 2022, from https://www.moh.gov.sg/resources-statistics/medication-safety*
Motivational Interviewing	Motivational Interviewing (MI) is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. *Source: Miller, W.R. & Rollnick, S. (2013) Motivational Interviewing: Helping people to change (3rd Edition). Guilford Press.*
Personal Health Literacy	Personal health literacy is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." *Source: Santana, S., Brach, C., Harris, L., Ochiai, E., Blakey, C., Bevington, F., Kleinman, D., & Pronk, N. (2021). Updating Health Literacy for Healthy People 2030: Defining Its Importance for a New Decade in Public Health. Journal of public health management and practice: JPHMP, 27(Suppl 6), S258–S264. https://doi.org/10.1097/PHH.0000000000001324*

Terms	Definition and Sources
Person-centred care	Person-centred Care (PCC) is a holistic approach to delivering care that is respectful and individualised, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care. *Source: Morgan, S., & Yoder, L. H. (2012). A concept analysis of person-centred care. Journal of holistic nursing: official journal of the American Holistic Nurses' Association, 30(1), 6–15. https://doi.org/10.1177/0898010111412189*
Polypharmacy	Polypharmacy, defined as the regular use of at least five medications, is common in older adults and younger at-risk populations and increases the risk of adverse medical outcomes. *Source: Halli-Tierney, A. D., Scarbrough, C., & Carroll, D. (2019). Polypharmacy: Evaluating Risks and Deprescribing. American family physician, 100(1), 32–38.*
Population Health	Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group. *Source: Kindig, D., & Stoddart, G. (2003). What is population health? American journal of public health, 93(3), 380–383. https://doi.org/10.2105/ajph.93.3.380*
Quality of Life	An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. *Source: World Health Organization. (2014). WHOQOL: Measuring Quality of Life. Retrieved June 29, 2022, from https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/*
Sarcopenia	Sarcopenia is a progressive and generalised skeletal muscle disorder that is associated with increased likelihood of adverse outcomes including falls, fractures, physical disability and mortality. *Source: Cruz-Jentoft, A. J., Bahat, G., Bauer, J., Boirie, Y., Bruyère, O., Cederholm, T., Cooper, C., Landi, F., Rolland, Y., Sayer, A. A., Schneider, S. M., Sieber, C. C., Topinkova, E., Vandewoude, M., Visser, M., Zamboni, M., & Writing Group for the European Working Group on Sarcopenia in Older People 2 (EWGSOP2), and the Extended Group for EWGSOP2 (2019). Sarcopenia: revised European consensus on definition and diagnosis. Age and ageing, 48(1), 16–31. https://doi.org/10.1093/ageing/afy169*
Self-advocacy	Self-advocacy is defined as an assertiveness and willingness to represent one's own interests when managing a disease or disability. *Source: Schmidt, E. K., Faieta, J., & Tanner, K. (2020). Scoping Review of Self-Advocacy Education Interventions to Improve Care. OTJR : occupation, participation and health, 40(1), 50–56. https://doi.org/10.1177/1539449219860583*

Terms	Definition and Sources
Self-management	Actions that individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health, meet social and psychological needs, prevent illness or accidents, care for minor ailments and long-term conditions, and maintain health and wellbeing after an acute illness or discharge from hospital. *Source: Ferrer, L. (2015). Engaging patients, carers and communities for the provision of coordinated / integrated health services: Strategies and tools. Copenhagen, Denmark: WHO Regional Office for Europe. Retrieved April 18, 2022, from https://www.euro.who.int/__data/assets/pdf_file/0004/290443/Engaging-patients-carers-communities-provision-coordinated-integrated-health-services.pdf*
Social Integration	Social integration refers to one's attachment to society through informal ties to family and friends and formal links to community institutions. *Source: Fothergill, K. E., Ensminger, M. E., Robertson, J., Green, K. M., Thorpe, R. J., & Juon, H. S. (2011). Effects of social integration on health: A prospective study of community engagement among African American women. Social science & medicine (1982), 72(2), 291–298. https://doi.org/10.1016/j.socscimed.2010.10.024*
Technology-enabled Care	Technology-enabled Care (TEC) is a collective term for telecare, telehealth, telemedicine, mobile, digital and electronic health services. *Source: Leonardsen, A. L., Hardeland, C., Helgesen, A. K., & Grøndahl, V. A. (2020). Patient experiences with technology enabled care across healthcare settings- a systematic review. BMC health services research, 20(1), 779. https://doi.org/10.1186/s12913-020-05633-4*

Acknowledgements

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