



**Working with Older People in Scotland –  
A Framework for Mental  
Health Nurses**





## ACKNOWLEDGEMENTS

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# Introduction

It is estimated that there are one million people in Scotland over the age of 65, representing one-fifth of the population. Older people are an invaluable resource for Scotland in terms of their knowledge experience and skill, and they make vital contributions within their families and to their communities.

Most older people do not develop mental health problems, but as their numbers increase, as a percentage of the total population, so will the number who experience problems associated with dementia, depression, phobias, psychosis, substance misuse, self-harm and suicide. These mental health problems can be found in people of all ages but their nature and course are different in older people, as are the care and treatments that may be effective. Therefore mental health nurses working in older people's mental health services must have the appropriate knowledge, skills and values to deliver high quality care to this client group, as outlined in this framework.

Additionally, the shift in service provision away from long-term NHS care towards care at home and in care home settings means that a significant amount of nursing care is provided by a range of workers with different and varied skills, knowledge and backgrounds. Mental health nurses play a key role in providing expert clinical advice, education and support in acute care, primary care and the care home sector.

## Background to the Framework

This framework was developed as a result of the findings and action plan of *Rights, Relationships and Recovery*, the report of the first national review of mental health nursing in Scotland (Scottish Executive Health Department (SEHD) 2006) (see [www.scotland.gov.uk/Publications/2006/04/18164814/0](http://www.scotland.gov.uk/Publications/2006/04/18164814/0)).

Additionally, in recognition of the changing demography in Scotland, several policy initiatives focus on the redesign of services to meet the needs of an ageing population. These include *Better Health, Better Care: Action Plan* (Scottish Government 2007a), *The Mental Health and Wellbeing in Later Life Programme 2003-2006* (Health Scotland 2006) and *All Our Futures* (SEHD 2007).

The Scottish Government has made dementia a national priority and the Mental Welfare Commission recently carried out unannounced visits to 16 continuing care wards across Scotland (Mental Welfare Commission 2007). While some areas demonstrated best practice there was considerable lack of service-user participation, social stimulation and appropriately planned care in many areas, and a wide range in the quality of ward environments. The report of the commission's findings, *Older and Wiser*, can be accessed at [www.mwscot.org.uk](http://www.mwscot.org.uk)

All of this highlights a continuing need for mental health nurses to play a central role in creating and developing a positive and enabling culture where older people's rights are promoted and they are active participants in care decisions. It also highlights the importance of prioritising access to education and training for staff working with this client group.

## What is a Capability Framework?

A capability is defined as having five dimensions:

- a performance component (what people need to possess)
- an ethical component (integrating a knowledge of culture, values and social awareness into practice)
- reflective practice
- ability to implement evidence-based practice effectively
- commitment to working with new models of professional practice and responsibility for life-long learning (Sainsbury Centre for Mental Health 2001).

A capability extends the concept of competence to include the ability to apply the necessary knowledge, skills and attitudes to a range of complex and changing settings, supporting the development of rights, values and recovery-focused practice in mental health nursing.

# The Purpose of the Framework

The capability framework aims to:

- set out the core developmental capabilities that mental health nurses need to work in older people's mental health services
- promote care of older people as an attractive and specialised area of practice with clear career-development pathways for practitioners
- assist practitioners and managers in personal development planning – highlighting developmental needs and supporting the planning of the training and education required to assist development
- communicate to people who use older people's services and their friends, families and carers what knowledge, skills and attitudes they should expect mental health nurses working in these settings to have.

In the future the framework should:

- help educationalists to develop training and education programmes to support capability development
- assist employers and NHS Education for Scotland in mapping existing training and education opportunities to help meet the capabilities, and inform the need for commissioning of further training and education and/or investment in educational or practice development infrastructure to support capability development.

The *Ten Essential Shared Capabilities Learning Materials* (Scotland) published by NHS Education for Scotland in April 2007 express the core capabilities that all staff working in mental health should have and are the foundation on which this framework is built ([www.nes.scot.nhs.uk/mentalhealth/publications/default.asp](http://www.nes.scot.nhs.uk/mentalhealth/publications/default.asp)).

Similarly, *A National Capability Framework for Working in Acute Mental Health Care* applies to mental health acute care services for older people ([www.nes.scot.nhs.uk/mentalhealth/publications/default.asp](http://www.nes.scot.nhs.uk/mentalhealth/publications/default.asp)).

# The Structure of the Framework

The framework is made up of six domains covering:

- respect, rights and choices
- communication
- relationships
- health and well-being
- end-of-life care
- dementia care

Each capability is defined on four levels, growing in complexity in terms of knowledge and skills, and practice required. The levels equate to levels 5 to 8 in the NHS Scotland careers framework (these are outlined in Appendix 2).

## Advanced practice

A number of initiatives have described core standards for advanced practice. For example, the Nursing and Midwifery Council (NMC) defined the 'advanced nurse practitioner' and has outlined draft competencies for the role (NMC 2005).

*Modernising Nursing Careers* (MNC) was launched in 2006 as part of the overarching Modernising Healthcare Careers strategy. It is a joint initiative involving the four UK countries, and Scotland is taking the lead on advanced practice. The Scottish Government Health Directorate, informed by work undertaken during the senior charge nurse review and NMC regulation, is developing an advanced practice toolkit. As part of the toolkit, the over-arching themes that are the main components of advanced practice have been defined, alongside the underpinning principles for advanced practice. These are outlined in Appendix 3 and Appendix 4.

The advanced practice capabilities described in this framework are *in addition* to these general components of the role and are specific to nurses working with older people with mental health problems.

The level descriptors outlined below reflect a baseline, and the capabilities at each progressive level are in addition to the previous level. For some capabilities, the next level requires limited additional knowledge and skills, but builds on the complexity of practice experience.

Nurses working at all levels need to be capable of recognising their own practice limitations, critically analysing their own practice and identifying their support and development needs. It is implicit that nurses practising within each level will act as a role model for those in the level below and act as a '**culture carrier**' across the spectrum of care. This will require active participation in reflective practice, clinical supervision and lifelong learning to enhance practice and improve care for older people.

### 'Culture carrier'

*An ability to create and embed a shared belief in valuing and respecting older people and sustaining a positive attitude towards them across an organisation. When faced with challenges, a culture carrier maintains passion, energy and enthusiasm, and inspires staff to want a culture that respects older people.*

# Using the Capability Framework

A number of generic competency and capability frameworks have been developed that are relevant to the care of older people, such as *A Route to Enhanced Competence in Caring for Older People* published by NHS Education for Scotland in 2003. Mental health nurses working with older people should possess all of the competencies outlined in that framework.

This framework focuses on the additional specialist capabilities mental health nurses should possess and reflects their role in:

- promoting mental health and detection of mental illness in the wider population
- the provision of outreach and advice to primary care, day care, acute care and care homes
- the specialist care of people with behavioural and psychological symptoms of dementia and of people with severe or complex functional mental health problems, employing psychological, social, physical and pharmacological therapies
- the provision of counselling and support to older people in the early stages of dementia at point of diagnosis.

Although the framework is aimed at mental health nurses working with older people the practitioner level could apply equally to all nurses working with older people. It should be used across the spectrum of care for older people with mental health problems. Nurses working with older people also have a responsibility to promote their specialty as a positive and exciting career option and recognise how their practice can make a difference. They should also work in a way that reflects best-practice guidance on protecting the rights and choices of older people.

The framework is in three parts: policy, core capabilities and dementia-specific capabilities. Text highlighted in bold indicates that additional information, such as useful references, websites and resources, is supplied in supporting boxes.



# 1. Respect, Rights and Choices

Capable of working alongside the older person to help them feel empowered and enabled to exercise rights and choice, practising in a way that promotes respect for a person's identity, equality and social inclusion.

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>Able to:</b></p> <p><b>1.1</b></p> <ul style="list-style-type: none"> <li>• Demonstrate sensitivity to the needs of the whole person, respecting their strengths and values related to their age, culture, spiritual and religious beliefs and their ethnicity, gender and sexual orientation.</li> </ul>	<p><b>Able to:</b></p> <p><b>1.1</b></p> <ul style="list-style-type: none"> <li>• Act as a role model in identifying and meeting the needs of the older person, and challenge poor practice in relation to equality and diversity.</li> </ul>		<p><b>Able to:</b></p> <p><b>1.1</b></p> <ul style="list-style-type: none"> <li>• Influence the development of national and local initiatives to help the older person to feel empowered to exercise rights and choices.</li> </ul>
<p><b>Able to:</b></p> <p><b>1.2</b></p> <ul style="list-style-type: none"> <li>• Engage with the older person to understand their values and aspirations.</li> </ul>	<p><b>Able to:</b></p> <p><b>1.2</b></p> <ul style="list-style-type: none"> <li>• Act as a role model during day-to-day care activities to enable the older person to exercise rights and choices.</li> </ul>	<p><b>Able to:</b></p> <p><b>1.2</b></p> <ul style="list-style-type: none"> <li>• Lead the development of systems and practices that promote opportunities for the older person to exercise rights and choices.</li> </ul>	

## Relevant legislation

- Mental Health (Care and Treatment) (Scotland) Act 2003
- Human Rights Act 1998
- Adult Support and Protection Act 2006
- Adults with Incapacity (Scotland) Act 2000

## Safeguards

### Mental Health Act:

- independent advocacy
- advance statement
- legal representations
- tribunal service
- Mental Welfare Commission
- named person

### Adults with Incapacity Act:

- welfare attorney
- welfare guardian
- guardianship

## National guidance relating to rights and choices

### Mental Welfare Commission

- *Rights, Risks and Limits to Freedom (2006)*
- *Consent to Treatment (2006)*

[www.mwscot.org.uk/GoodPractice/Publications/Guidance\\_documents.asp](http://www.mwscot.org.uk/GoodPractice/Publications/Guidance_documents.asp)

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>1.3</b></p> <ul style="list-style-type: none"> <li>Work alongside the older person in a way that maximises autonomy in day-to-day living and enables them to exercise <b>rights and choices</b>. Practise in a way that reflects the requirements of legislation such as the Human Rights Act (1998) and the Adult Support and Protection Act (2006).</li> </ul>	<p><b>1.3</b></p> <ul style="list-style-type: none"> <li>Ensure the older person has access to information in relation to rights and choices, such as appropriate independent advocacy, and is aware of other <b>safeguards</b> such as advance statements.</li> </ul>		
<p><b>1.4</b></p> <ul style="list-style-type: none"> <li>Seek informed consent before undertaking any intervention with the older person in a way that reflects the principles and requirements of the Mental Health (Care and Treatment) Scotland) Act (2003) and the Adults with Incapacity Act (2000).</li> </ul>	<p><b>1.4</b></p> <ul style="list-style-type: none"> <li>Maximise the older person's decision-making where ability to consent is compromised.</li> </ul>	<p><b>1.4</b></p> <ul style="list-style-type: none"> <li>Act as a source of expert knowledge where the issue of informed consent is complex and may be compromised.</li> </ul>	
<p><b>1.5</b></p> <ul style="list-style-type: none"> <li>Recognise and take steps to address the impact of age-related discrimination and social isolation on the older person's quality of life, health and well-being.</li> </ul>	<p><b>1.5</b></p> <ul style="list-style-type: none"> <li>Apply anti-discrimination and equality-monitoring processes relevant to the older person.</li> </ul>	<p><b>1.5</b></p> <ul style="list-style-type: none"> <li>Lead and develop practice that challenges discrimination and inequalities.</li> </ul>	



PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>1.6</b></p> <ul style="list-style-type: none"> <li>Recognise practices that may compromise the older person's dignity and respect, and take steps to challenge and address them.</li> </ul>	<p><b>1.6</b></p> <ul style="list-style-type: none"> <li>Create an environment that promotes respect and dignity for the older person.</li> </ul>	<p><b>1.6</b></p> <ul style="list-style-type: none"> <li>Lead the development of policies and protocols that promote respect and dignity for the older person.</li> </ul>	
<p><b>1.7</b></p> <ul style="list-style-type: none"> <li>Demonstrate an ability to identify the various forms of abuse the older person may experience.</li> </ul>	<p><b>1.7</b></p> <ul style="list-style-type: none"> <li>Practise in a way that enables the prevention and early identification of abuse, and supports others to report abusive situations that the older person may experience.</li> </ul>	<p><b>1.7</b></p> <ul style="list-style-type: none"> <li>Develop and monitor robust governance systems to prevent, detect and report abusive situations that the older person may experience.</li> </ul>	
<p><b>1.8</b></p> <ul style="list-style-type: none"> <li>Report and act confidently upon abusive and potentially abusive situations that the older person may experience.</li> </ul>			

## Communication in Practice

*'I was asked to see Mrs Craig by her GP; the referral letter described her as "confused". Her daughter was at the house with her and you could feel the tension in the air. The lady sat with her head down as her daughter described her fears that her mother had dementia. "She will say 'OK' to everything I remind her of but is never ready when I come for her to go anywhere and just looks bewildered."*

*After her daughter went to make tea, I tried to speak to Mrs Craig but only got the bewildered look her daughter described. I always carry a crystal hearing set with me; it has small headphones and simply amplifies sound. I have found it helpful more than once when assessing older adults.*

*When she put the headphones on and I spoke, Mrs Craig burst into tears. She hadn't heard voices clearly for nearly a year. She was too proud to say she was going deaf and had been trying to cope by saying "OK" to everything her daughter said. Her daughter was also tearful when she realised how much her mum had been struggling.'*

(Experience of a community psychiatric nurse and Working Group member)

The confusion Mrs Craig was experiencing was the result of a difficulty she had in understanding verbal communication due to a hearing impairment. Through the utilisation of a good assessment process, the nurse was able to elicit the cause of the 'confusion' and a pragmatic remedy was found by the fitting of a hearing aid. The anxiety that her daughter felt was dissipated and Mrs Craig was able to carry on her life as normal. Confusion is not an automatic symptom of dementia and should always warrant a thorough assessment to exclude other confounding factors.

## Constraints in communicating with older people

### Organisational

- the way work is organised
- lack of resources to support effective communication

### Environmental

- noise
- lack of privacy

### Personal

- physical and mental health problems
- sensory problems
- lack of accessible and user-friendly information

### Social

- conflicts
- ability in relation to language, vocabulary or manner of communication

## 2. Communication

Capable of communicating with the older person and providing information to promote independence and maximise choice.

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>Able to:</b></p> <p><b>2.1</b></p> <ul style="list-style-type: none"> <li>Communicate in a way that supports and enables the <b>active participation</b> of the older person and others involved in the person's care.</li> </ul>	<p><b>Able to:</b></p> <p><b>2.1</b></p> <ul style="list-style-type: none"> <li>Support and develop other practitioners in understanding the significance of effective communication in terms of the older person's ability to maintain control and independence.</li> </ul>		
<p><b>2.2</b></p> <ul style="list-style-type: none"> <li>Communicate in a way that is consistent with the older person's level of understanding, cultural background and preferred way of communicating.</li> </ul>	<p><b>2.2</b></p> <ul style="list-style-type: none"> <li>Support and supervise others in overcoming particular communication difficulties using a range of creative methods.</li> </ul>	<p><b>2.2</b></p> <ul style="list-style-type: none"> <li>Contribute to the development of national guidelines to support effective communication with older people.</li> </ul>	

### Therapeutic communication

Nurses use a wide range of effective communication strategies and interpersonal skills to establish, maintain, re-establish and terminate relationships with older people.

#### Basic therapeutic skills

- Unconditional acceptance
- Empathy
- Attending and listening
- Reflection
- Concreteness
- Warmth and genuineness
- Maintain boundaries
- Physical and behavioural techniques

### Psychological and psychosocial interventions

- Cognitive behavioural therapy
- Interpersonal psychotherapy
- Psycho-education
- Family therapy
- Motivational interviewing
- Counselling
- Psychosocial skills training

*(Roth and Fongay 2006)*

### Co-morbidity

The term 'co-morbid' is used to indicate a medical condition existing simultaneously with, but independently of, another condition – in this instance, particularly depression and dementia.

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>2.3</b></p> <ul style="list-style-type: none"> <li>Communicate meaningfully with the older person, and be aware of and systematically address external and internal constraints.</li> </ul>	<p><b>2.3</b></p> <ul style="list-style-type: none"> <li>Recognise and effectively manage constraints on communication within own area of practice.</li> </ul>	<p><b>2.3</b></p> <ul style="list-style-type: none"> <li>Develop and implement systems and protocols that challenge and seek to remove constraints on communicating with the older person.</li> </ul>	<p><b>2.3</b></p> <ul style="list-style-type: none"> <li>Lead strategic developments that challenge constraints on communicating with the older person.</li> </ul>
<p><b>2.4</b></p> <ul style="list-style-type: none"> <li>Engage with the older person using appropriate psychological and psychosocial skills to develop a <b>therapeutic relationship</b>.</li> </ul>	<p><b>2.4</b></p> <ul style="list-style-type: none"> <li>Deliver protocol-based 'low-intensity' <b>psychological and psychosocial interventions</b> (adapted to meet the needs of the older person).</li> </ul>	<p><b>2.4</b></p> <ul style="list-style-type: none"> <li>Draw on expertise in a range of different psychological and psychosocial approaches appropriate to the older person.</li> </ul>	<p><b>2.4</b></p> <ul style="list-style-type: none"> <li>Develop and lead research and governance in psychological and psychosocial approaches appropriate to the older person.</li> </ul>
		<p><b>2.5</b></p> <ul style="list-style-type: none"> <li>Modify and adapt protocol-based 'high-intensity' psychological and psychosocial interventions.</li> </ul>	
	<p><b>2.6</b></p> <ul style="list-style-type: none"> <li>Recognise the possibility of <b>co-morbidity</b> and refer on for more detailed assessment where necessary.</li> </ul>	<p><b>2.6</b></p> <ul style="list-style-type: none"> <li>Refer to specialist neuropsychological assessment where appropriate.</li> </ul>	



## 3. Relationships

Capable of working with the older person in a way that respects them as a person belonging to a network of social relationships, maintaining partnerships with the person and the wider support network.

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>Able to:</b></p> <p><b>3.1</b></p> <ul style="list-style-type: none"> <li>Recognise the key components that contribute to an enriched environment of care.</li> </ul>	<p><b>Able to:</b></p> <p><b>3.1</b></p> <ul style="list-style-type: none"> <li>Support practitioners in developing practice that enriches the environment.</li> </ul>	<p><b>Able to:</b></p> <p><b>3.1</b></p> <ul style="list-style-type: none"> <li>Demonstrate confidence in negotiating with service planners to provide resources.</li> </ul>	<p><b>Able to:</b></p> <p><b>3.1</b></p> <ul style="list-style-type: none"> <li>Use strategic negotiating and influencing skills to ensure the creation of enriched environments across the spectrum of care.</li> </ul>
<p><b>3.2</b></p> <ul style="list-style-type: none"> <li>Promote collaboration when working with the older person, recognising their individual life story and values.</li> </ul>	<p><b>3.2</b></p> <ul style="list-style-type: none"> <li>Use the older person's life story and values to inform all care decisions.</li> </ul>	<p><b>3.2</b></p> <ul style="list-style-type: none"> <li>Create a culture of enablement where the focus of care is on knowing the older person's life story and values.</li> </ul>	

## Conceptual framework

A set of assumptions, values, and definitions under which we all work together.

## Examples of conceptual frameworks

- Conceptual Frameworks: The Senses Framework (Nolan 1997); Davies et al 1999; Nolan et al 2001, 2002
- The 'authentic consciousness framework' (McCormack 2001a, 2001b, Parker 2003)
- The 'positive person framework' (Kitwood 1997a, 1997b, Parker 2003)
- The 'skilled companionship framework' (Titchen 2000, 2001)

## The senses framework

The senses framework captures the subjective and perceptual dimensions of caring relationships and reflects both the interpersonal processes involved and the intrapersonal experiences of giving and receiving care.

It is underpinned by the belief that all parties involved in caring (the older person, family carers and paid or voluntary carers) should experience relationships that promote a sense of:

- security – feeling safe within relationships
- belonging – feeling 'part' of things
- continuity – experiencing links and consistency
- purpose – having a personally valuable goal or goals
- achievement – making progress towards a desired goal or goals
- significance – feeling that 'you' matter

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>3.3</b></p> <ul style="list-style-type: none"> <li>Is aware of the range of <b>conceptual frameworks</b> that can be used as a foundation for enhancing the care of the older person.</li> </ul>	<p><b>3.3</b></p> <ul style="list-style-type: none"> <li>Apply a range of conceptual frameworks that can be used as a foundation for enhancing the care of the older person, which are person-centred and relationship-focused e.g. the <b>senses framework</b>.</li> </ul>	<p><b>3.3</b></p> <ul style="list-style-type: none"> <li>Modify and adapt conceptual frameworks for own area of practice and support other practitioners in using them effectively.</li> </ul>	<p><b>3.3</b></p> <ul style="list-style-type: none"> <li>Act as a source of expert knowledge for practitioners and service planners on the contribution of conceptual frameworks.</li> </ul>

## Guidance on carers and confidentiality

Mental Welfare Commission

[www.mwscot.org.uk/GoodPractice/Publications/Guidance\\_documents.asp](http://www.mwscot.org.uk/GoodPractice/Publications/Guidance_documents.asp)

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>3.4</b></p> <ul style="list-style-type: none"> <li>Listen to the carer of the older person and respect them as a partner in care. Provide support in a way that does not breach confidentiality, in line with the Mental Welfare Commission's <b>best practice guidance on carers and confidentiality.</b></li> </ul>	<p><b>3.4</b></p> <ul style="list-style-type: none"> <li>Enable the carer to access support individually or collectively, ensuring they are aware of their right to an assessment of need and services that best support them.</li> </ul>	<p><b>3.4</b></p> <ul style="list-style-type: none"> <li>Developing systems that support carers as individuals and groups.</li> </ul>	<p><b>3.4</b></p> <ul style="list-style-type: none"> <li>Convey good practice to relevant bodies on facilitating carers to participate actively in campaigning and influencing national and local policies.</li> </ul>

### Assessment tools

- General Care Nap – CGA: Comprehensive Geriatric Assessment
- Nutrition – MUST: Malnutrition Universal Screening Tool
- MNA: Mini Nutritional Assessment
  
- Skin
  - Waterlow
  - Norton
  
- Wound
  - Stirling
  
- Pain
  - the Abbey Pain Scale
  - the Assessment of Discomfort in Dementia
  - the Checklist of Non-Verbal Pain Indicators
  - the Dolphus 2
  
- Depression
  - Geriatric Depression Scale
  
- Short Anxiety Screening Test – Sinoff et al (1999)
  
- Michigan Alcoholism Screening Test (Blow 1991) – Geriatric Version (Mast-G) University of Michigan Research Centre

## 4. Health and Wellbeing

Capable of promoting and enabling the older person to self-care to maximum potential

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>Able to:</b></p> <p><b>4.1</b></p> <ul style="list-style-type: none"> <li>Recognise how mental health problems differ in presentation, impact and required response when encountered by older people.</li> </ul>	<p><b>Able to:</b></p> <p><b>4.1</b></p> <ul style="list-style-type: none"> <li>Engage with practitioners across the spectrum of care to support them in working with older people with mental health problems.</li> </ul>	<p><b>Able to:</b></p> <p><b>4.1</b></p> <ul style="list-style-type: none"> <li>Act as expert knowledge source for practitioners across the spectrum of care.</li> </ul>	<p><b>Able to:</b></p> <p><b>4.1</b></p> <ul style="list-style-type: none"> <li>Working with higher education institutions, government and other agencies to improve the evidence for responding to the mental and physical care needs of the older person.</li> </ul>
<p><b>4.2</b></p> <ul style="list-style-type: none"> <li>Demonstrate an understanding of the spectrum of self-care.</li> </ul>	<p><b>4.2</b></p> <ul style="list-style-type: none"> <li>Work alongside the older person to help them feel empowered to self-care and agree the level of care needed.</li> </ul>	<p><b>4.2</b></p> <ul style="list-style-type: none"> <li>Develop and support other practitioners' understanding of self-care.</li> </ul>	<p><b>4.2</b></p> <ul style="list-style-type: none"> <li>Promote the self-care model when working with older people with mental health problems.</li> </ul>

## Strengths perspective

A strengths perspective focuses on identifying a person's strengths rather than their deficits, which is characteristic of traditional disease-model approaches. The target of intervention and rehabilitation is to maintain and develop strengths and abilities to maximum potential.

The underlying principles of the strengths perspective are:

- every individual, group, family and community has its strengths
- trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity
- assume that you do not know the upper limits of the capacity to grow and change, and take individual, group and community aspirations seriously
- we best serve clients by collaborating with them
- every environment is full of resources

*(Saleebey 1997)*

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>4.3</b></p> <ul style="list-style-type: none"> <li>Undertake a holistic <b>assessment</b> of the older person to determine complexity of care needs, strengths and abilities.</li> </ul>	<p><b>4.3</b></p> <ul style="list-style-type: none"> <li>Act as care co-ordinator or care manager where the older person has complex care needs.</li> <li>Develop practitioners' understanding and ability to utilise the <b>strengths perspective</b> across the spectrum of care.</li> </ul>	<p><b>4.3</b></p> <ul style="list-style-type: none"> <li>Provide expert clinical advice in complex decisions relating to assessment and levels of intervention.</li> </ul>	
<p><b>4.4</b></p> <ul style="list-style-type: none"> <li>Use a range of physical and mental health assessment tools to support good mental health, nutrition, skin care, continence and pain management.</li> </ul>	<p><b>4.4</b></p> <ul style="list-style-type: none"> <li>Determine when to make referral to specialist services.</li> </ul>	<p><b>4.4</b></p> <ul style="list-style-type: none"> <li>Ensure that other practitioners are proficient in carrying out assessments.</li> </ul>	<p><b>4.4</b></p> <ul style="list-style-type: none"> <li>Provide expert clinical advice on assessing and meeting the healthcare needs of the older person across the spectrum of care.</li> </ul>

### **Guidance on covert medication**

Mental Welfare Commission

Covert Medication – A Legal and Practice Guide

[www.mwscot.org.uk/GoodPractice/Publications/Guidance\\_documents.asp](http://www.mwscot.org.uk/GoodPractice/Publications/Guidance_documents.asp)

### **Polypharmacy**

The act or practice of prescribing more drugs than can be clinically justified (Reid 2005).

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>4.5</b></p> <ul style="list-style-type: none"> <li>• Demonstrate understanding of the specific pharmacological issues relating to the older person and support them in managing medication.</li> <li>• Apply the Mental Welfare Commission's <b>best practice guidelines on covert medication</b> where necessary.</li> </ul>	<p><b>4.5</b></p> <ul style="list-style-type: none"> <li>• Work alongside the older person to identify the risks in relation to, for example, <b>polypharmacy</b> and adverse reactions.</li> <li>• Ensure guidance is used appropriately within own area of practice.</li> </ul>	<p><b>4.5</b></p> <ul style="list-style-type: none"> <li>• Provide advice and develop systems to ensure best practice across the spectrum of care.</li> </ul>	<p><b>4.5</b></p> <ul style="list-style-type: none"> <li>• Provide expert clinical advice on pharmacological issues for the older person across the spectrum of care</li> </ul>

### **Life plans**

Life plans can assist in developing a clear picture of what the person values about their life and how they make sense of what is happening, rather than focusing on their functional abilities and dependence.

A life plan is a presentation of what a person wants to do in life. It enables reflection on life goals within the context of achieving integration in one's life. It evolves over time, with new experiences being integrated into it to create future goals and projects. It should include at least one activity that the person wants to pursue, a value that the person wants to advance or an emotional bond that the person wants to sustain. It informs the need to adapt the context of care to create a caring environment that nurtures individual personhood.

*(McCormack 2004)*

### **Relevant suicide prevention training**

- Applied suicide intervention
- Skills training
- Skills-based Training on Risk Management (STORM)

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>4.6</b></p> <ul style="list-style-type: none"> <li>Enable and support the older person to access a motivating and challenging environment with opportunities to socialise and become involved in meaningful activities that reflect their needs and interests.</li> </ul>		<p><b>4.6</b></p> <ul style="list-style-type: none"> <li>Provide expert advice across the spectrum of care on maintaining a socially stimulating environment that reflects the older person's needs and interests.</li> </ul>	<p><b>4.6</b></p> <ul style="list-style-type: none"> <li>Influence service providers to develop flexible and innovative approaches to enable the older person to access mainstream services.</li> </ul>
<p><b>4.7</b></p> <ul style="list-style-type: none"> <li>Recognise the factors associated with risk, utilising appropriate assessment tools particular to the older person.</li> </ul>	<p><b>4.7</b></p> <ul style="list-style-type: none"> <li>Adopt a positive approach to risk-taking and engaging with the older person and their social network to manage risks effectively.</li> </ul>	<p><b>4.7</b></p> <ul style="list-style-type: none"> <li>Advocate confidently on behalf of the older person and demonstrate creativity, flexibility and innovation in setting up systems and protocols to support the management of risk.</li> </ul>	<p><b>4.7</b></p> <ul style="list-style-type: none"> <li>Confidently promote positive risk-taking while influencing policy at a strategic level across the spectrum of care.</li> </ul>
<p><b>4.8</b></p> <ul style="list-style-type: none"> <li>Recognise when someone may have <b>suicidal thoughts</b> and have the confidence to engage with them in a direct and open manner.</li> </ul>	<p><b>4.8</b></p> <ul style="list-style-type: none"> <li>Ensure evidence-based suicide prevention and intervention approaches are used within own area of responsibility.</li> </ul>	<p><b>4.8</b></p> <ul style="list-style-type: none"> <li>Develop systems to support suicide prevention, and intervention training and implementation.</li> </ul>	<p><b>4.8</b></p> <ul style="list-style-type: none"> <li>Use strategic negotiating and influencing skills to ensure practitioners and others significant to the older person receive the correct level of training in relation to suicide prevention.</li> </ul>

### Defining end-of-life care

'All patients with a chronic, progressive and generally fatal illness, or an advanced or irreversible disease, need high quality, well-organised, end-of-life care. This group includes patients with organ failure such as heart disease and chronic obstructive pulmonary disease, stroke, general frailty, dementia and other neurological conditions, as well as people with cancer.'

*(NHS Confederation 2005)*

'End-of-life care requires an active, compassionate approach that treats, comforts and supports older individuals who are living with, or dying from, progressive or chronic life-threatening conditions. Such care is sensitive to personal, cultural and spiritual values, beliefs and practices, and encompasses the support for families and friends up to and including the period of bereavement.'

*(Ross and Fisher, 2000. See also Seymour et al 2005)*

### Gold Standards Framework

Royal College of General Practitioners (2005) *Gold Standards Framework*. RCGP, London  
[www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk)

### Care of the dying pathway

Marie Curie Cancer Care (2006) *The Liverpool Care of the Dying Pathway*.  
Marie Curie Cancer Care, London  
[www.lcp.mariecurie.org.uk](http://www.lcp.mariecurie.org.uk)

## 5. End-of-Life Care

Capable of ensuring that the older person has the opportunity, is enabled and supported to consider care and treatment options and to make informed choices about end-of-life care.

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>Able to:</b></p> <p><b>5.1</b></p> <ul style="list-style-type: none"> <li>Recognise the complexity of end-of-life care issues for the older person.</li> </ul>	<p><b>Able to:</b></p> <p><b>5.1</b></p> <ul style="list-style-type: none"> <li>Engage sensitively with the older person about their choices in relation to preferred place of death, privacy and dignity. Meet requirements for care and treatment to enable them to plan for end-of-life care.</li> </ul>	<p><b>Able to:</b></p> <p><b>5.1</b></p> <ul style="list-style-type: none"> <li>Develop systems and processes to support practitioners and enable the older person to explore end-of-life issues.</li> </ul>	<p><b>Able to:</b></p> <p><b>5.1</b></p> <ul style="list-style-type: none"> <li>Take a strategic lead in promoting practices that enable the older person to make choices about end-of-life care.</li> </ul>
<p><b>5.2</b></p> <ul style="list-style-type: none"> <li>Apply the principles and processes of the <b>Gold Standards Framework</b> and contribute to the implementation of a recognised <b>care pathway</b> to ensure that positive palliative care is delivered.</li> </ul>	<p><b>5.2</b></p> <ul style="list-style-type: none"> <li>Ensure the <b>Gold Standards Framework</b> is implemented and an appropriate pathway is in place to support the advanced care plan for the older person.</li> </ul>	<p><b>5.2</b></p> <ul style="list-style-type: none"> <li>Develop practitioners' knowledge and skills in palliative care and work collaboratively with palliative care specialists and other professions to agree referral protocols and timely packages of care.</li> </ul>	<p><b>5.2</b></p> <ul style="list-style-type: none"> <li>Promote the need for a palliative care approach in caring for older people with mental health problems who become terminally ill across the spectrum of care.</li> </ul>



PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>5.3</b></p> <ul style="list-style-type: none"> <li>Act compassionately and sensitively with regard to the personal cultural and spiritual values, beliefs and practices of the older person and their carer.</li> </ul>	<p><b>5.3</b></p> <ul style="list-style-type: none"> <li>Support the carer and others significant to the older person through the end-of-life journey and after the person has died.</li> </ul>	<p><b>5.3</b></p> <ul style="list-style-type: none"> <li>Develop policies and procedures that ensure carers are offered appropriate support and that contact is maintained for a time after the person has died.</li> </ul>	
<p><b>5.4</b></p> <ul style="list-style-type: none"> <li>Recognise the legal and ethical considerations in relation to end-of-life care.</li> </ul>	<p><b>5.4</b></p> <ul style="list-style-type: none"> <li>Ensure the older person's wishes are respected and guided by current legal frameworks, and that active care is appropriate and likely to be effective.</li> </ul>	<p><b>5.4</b></p> <ul style="list-style-type: none"> <li>Act confidentially in protecting the wishes of the older person in relation to ethical considerations.</li> </ul>	<p><b>5.4</b></p> <ul style="list-style-type: none"> <li>Act as an expert knowledge source for practitioners in understanding ethical considerations in relation to end-of-life care.</li> </ul>



## 6. Dementia Care

All other domains apply equally to dementia care and in addition mental health nurses need to be capable of enabling and supporting the older person who experiences problems associated with dementia to maintain their ability, skills and expression of choice and emotions to enrich their lives.

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>Able to:</b></p> <p><b>6.1</b></p> <ul style="list-style-type: none"> <li>Explain confidently the problems associated with dementia in a positive and sensitive manner to the older person and their carer and others significant to them.</li> </ul>	<p><b>Able to:</b></p> <p><b>6.1</b></p> <ul style="list-style-type: none"> <li>Apply the strengths perspective as a recovery approach when working with an older person who is experiencing changes associated with dementia.</li> </ul>	<p><b>Able to:</b></p> <p><b>6.1</b></p> <ul style="list-style-type: none"> <li>Provide expert advice to practitioners across the spectrum of care, promoting the strengths perspective as a recovery approach to care.</li> </ul>	<p><b>Able to:</b></p> <p><b>6.1</b></p> <ul style="list-style-type: none"> <li>Promote a positive attitude towards dementia among the wider population and convey the meaning of recovery in relation to dementia.</li> </ul>
<p><b>6.2</b></p> <ul style="list-style-type: none"> <li>Select and implement different <b>models and perspectives on dementia care</b> most appropriate to the individual and which seek to maintain strengths and enhance abilities.</li> </ul>	<p><b>6.2</b></p> <ul style="list-style-type: none"> <li>Ensure that models and approaches that match the needs of the individual are implemented within own area.</li> </ul>	<p><b>6.2</b></p> <ul style="list-style-type: none"> <li>Lead in the development of flexible and innovative models and approaches to ensure the individual needs of the older person are met.</li> </ul>	<p><b>6.2</b></p> <ul style="list-style-type: none"> <li>Research the impact of dementia, presenting the evidence base to contribute to the development of contemporary practice.</li> </ul>

## Models and perspectives on dementia care

- Dementia stress management
- Relationship-focused care model
- Strengths model
- Medical                    }
- Psychological         } perspectives
- Social                     }

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>6.3</b></p> <ul style="list-style-type: none"> <li>Document the life story of the older person and use it to develop a care plan with them, their carer and others significant to them.</li> </ul>	<p><b>6.3</b></p> <ul style="list-style-type: none"> <li>Ensure the older person's life story is used to inform care within own area.</li> </ul>	<p><b>6.3</b></p> <ul style="list-style-type: none"> <li>Implement and monitor procedures to record the older person's life story, including a values-based framework.</li> </ul>	<p><b>6.3</b></p> <ul style="list-style-type: none"> <li>Promote the value of listening to the older person's narrative and ensure their voice is heard and their right to influence their care is fully considered by practitioners and the wider community</li> </ul>
<p><b>6.4</b></p> <ul style="list-style-type: none"> <li>Enable and support the older person's continual engagement in life's roles, relationships and activities as a means of maintaining their independence and enriching their life.</li> </ul>	<p><b>6.4</b></p> <ul style="list-style-type: none"> <li>Be flexible, creative and innovative in overcoming constraints on the older person's continual engagement as they progress through the course of their dementia.</li> </ul>	<p><b>6.4</b></p> <ul style="list-style-type: none"> <li>Develop systems and practices to prioritise the older person's continual engagement in life's roles, relationships and activities</li> </ul>	<p><b>6.4</b></p> <ul style="list-style-type: none"> <li>Act as a source of expert and up-to-date knowledge on how to enrich the life of the older person with dementia in complex situations.</li> </ul>

### Appropriate Interventions

- There are many psychological and psychosocial interventions, as described and outlined in the Scottish Intercollegiate Guidelines Network guideline 86 (SIGN 2004), that can be used when working with people with dementia. However, it is necessary to ensure that approaches are individualised. The interventions include:
  - sensory and cognitive stimulation
  - psychotherapy
  - cognitive behavioural therapy
  - preventative approaches

*(Roth and Fongay 2006)*

### Physical environment

The physical environment should be made sensitive to the older person's needs, be safe and pleasant, and encourage exercise and interaction, as well as providing adequate space to reduce feelings of confinement and containment, which contribute to anxiety and distress.

- See *Safe to Wander – Principles and Guidance* (Mental Welfare Commission 2005)  
[www.mwscot.org.uk/GoodPractice/Publications/Guidance\\_documents.asp](http://www.mwscot.org.uk/GoodPractice/Publications/Guidance_documents.asp)

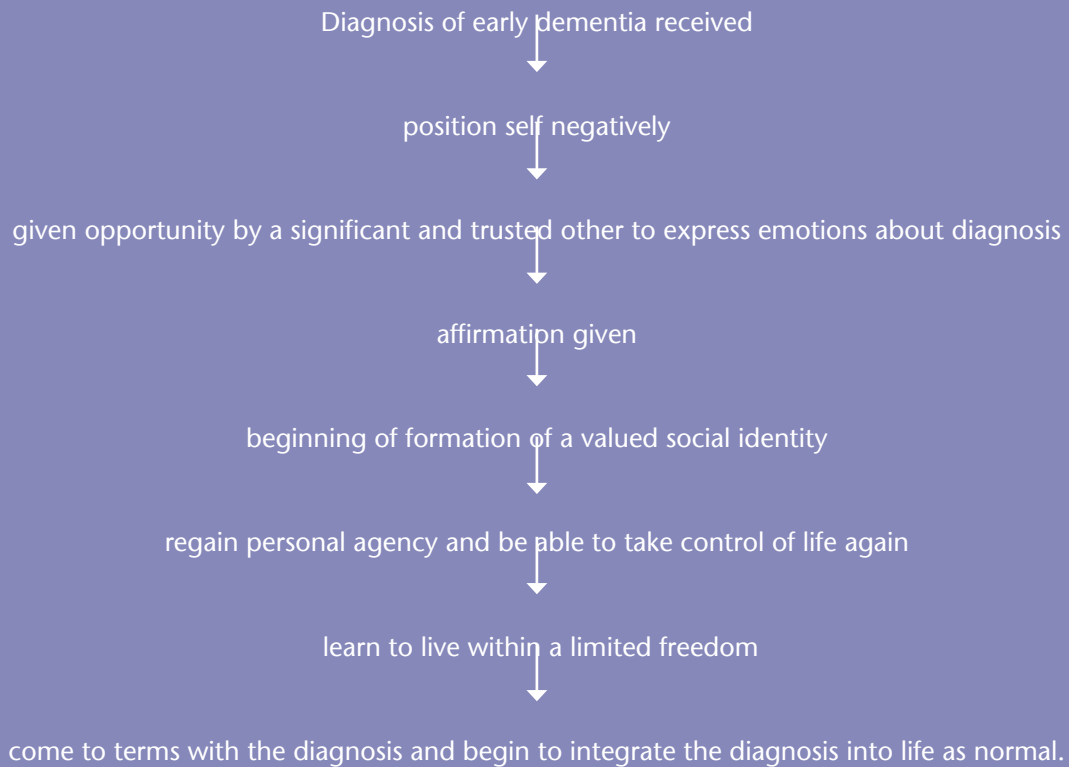
### Nine therapeutic tasks after a dementia diagnosis

- Exploring the possibility of life as normal
- Evaluating the usefulness of different sources of information
- Understanding changing roles and relationships
- Understanding the emotional process
- Addressing deep philosophical questions around personal identity
- Facing up to dealing with and challenging stigma
- Creating a modified personal and social identity
- Telling and retelling their story
- Finding a way through the health system

*Weaks et al, 2007*

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>6.5</b></p> <ul style="list-style-type: none"> <li>Engage with the older person and provide <b>appropriate interventions</b> to reduce the impact of changes and unfamiliar environments on care needs.</li> </ul>	<p><b>6.5</b></p> <ul style="list-style-type: none"> <li>Consider how the <b>physical environment</b> can be disabling for the older person and take steps to create the appropriate individual environment and provide relevant interventions for the older person.</li> </ul>	<p><b>6.5</b></p> <ul style="list-style-type: none"> <li>Influence service planners to ensure that the <b>physical environment</b>, resources and range of interventions available help meet the individual needs of the older person.</li> </ul>	<p><b>6.5</b></p> <ul style="list-style-type: none"> <li>Act in an advisory capacity to service planners at a strategic level.</li> </ul>
<p><b>6.6</b></p> <ul style="list-style-type: none"> <li>Recognise the emotional distress experienced by the older person and the impact on relationships following a diagnosis of dementia. Engage in a therapeutic relationship with the older person and their family to provide early support and interventions.</li> </ul>	<p><b>6.6</b></p> <ul style="list-style-type: none"> <li>Use counselling skills to work through the <b>nine therapeutic tasks</b> relevant to the person with dementia and their family in the immediate post-diagnosis period.</li> </ul>	<p><b>6.6</b></p> <ul style="list-style-type: none"> <li>Provide counselling to work through the <b>nine therapeutic tasks</b> when complex situations occur in the immediate post-diagnosis period and provide supervision for other practitioners.</li> </ul>	<p><b>6.6</b></p> <ul style="list-style-type: none"> <li>Provide supervision for advanced practitioners.</li> </ul>

### Process of coming to terms with early dementia



*Weeks et al, 2007*

### Comment from service user after counselling

*'I would like people to know that this is not the end of life; you know, life goes on, you can still play golf, you can still be part of the social intercourse etc. You don't need to, you know, climb down in the hole and shut the door behind you; people are much more approachable and much more sympathetic than I ever thought. I think people are actually nicer than I ever thought.'*

(Service user with diagnosis of early dementia after counselling)

*Weeks et al, 2007*

PRACTITIONER	SENIOR PRACTITIONER	ADVANCED PRACTITIONER	CONSULTANT
<p><b>6.7</b></p> <ul style="list-style-type: none"> <li>Recognise that changes in behaviour are a means of communicating and are always an expression of unmet need.</li> </ul>	<p><b>6.7</b></p> <ul style="list-style-type: none"> <li>Anticipate and interpret changes in behaviour where their meaning is difficult to elicit by engaging with the older person, their carer and others significant to them.</li> </ul>	<p><b>6.7</b></p> <ul style="list-style-type: none"> <li>Promote a positive culture, that challenges negative interpretations of behaviour and provide advice to practitioners across the spectrum of care.</li> </ul>	<p><b>6.7</b></p> <ul style="list-style-type: none"> <li>Address the development needs of practitioners through education, research and role-modelling.</li> </ul>
<p><b>6.8</b></p> <ul style="list-style-type: none"> <li>Ascertain unmet need and provide appropriate intervention, care or treatment.</li> </ul>	<p><b>6.8</b></p> <ul style="list-style-type: none"> <li>Proactive in averting distressing situations.</li> </ul>	<p><b>6.8</b></p> <ul style="list-style-type: none"> <li>Act as a knowledge source on how to avert distressing situations for practitioners across the spectrum of care.</li> </ul>	
<p><b>6.9</b></p> <ul style="list-style-type: none"> <li>Recognise the impact of dementia on the health and wellbeing of the carer and assess their needs holistically to contribute to the development of a care package to support them.</li> </ul>	<p><b>6.9</b></p> <ul style="list-style-type: none"> <li>Design a care package in collaboration with the carer and family that reflects each individual situation and provide psychotherapy and coping skills training.</li> </ul>	<p><b>6.9</b></p> <ul style="list-style-type: none"> <li>Use evidence-based family therapies in supporting complex family dynamics.</li> </ul>	<p><b>6.9</b></p> <ul style="list-style-type: none"> <li>Act in an advisory and supervisory capacity in developing practitioners' understanding of family dynamics in caring for an older person with dementia.</li> </ul>
<p><b>6.10</b></p> <ul style="list-style-type: none"> <li>Identify when an older person is experiencing delirium, recognising the risks to health and wellbeing and responding quickly and sensitively to their needs.</li> </ul>	<p><b>6.10</b></p> <ul style="list-style-type: none"> <li>Distinguish between dementia and delirium, and recognise when dementia is being compounded by delirium.</li> </ul>	<p><b>6.10</b></p> <ul style="list-style-type: none"> <li>Act in an advisory capacity across the spectrum of care and utilise anticipatory skills to prevent delirium occurring.</li> </ul>	



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# Appendix 1 - NES Older People Mental Health Working Group

## NHS EDUCATION FOR SCOTLAND (NES) OLDER PEOPLE MENTAL HEALTH WORKING GROUP MEMBERSHIP

Margaret	Aitken	NHS Greater Glasgow and Clyde
June	Andrews	The Dementia Sciences Development Centre
Elizabeth	Baikie	NHS Lothian
Gill	Boardman	Alzheimer Scotland's Council
Robert	Boyd	NHS Greater Glasgow and Clyde
Margaret	Brown	The West of Scotland University
Alice	Campbell Reay	NHS Greater Glasgow and Clyde
Pauline	Carmichael	NHS Greater Glasgow and Clyde
Peter	Cartwright	Argyll & Bute Hospital
Ken	Dick	Royal Edinburgh Hospital
Susan	Donnelly	Care Commission
Alison	Drinnan	NHS Lanarkshire
Susanne	Forrest	NHS Education for Scotland
Stephen	Gallagher	NHS Greater Glasgow and Clyde
Trudy	Gane	NHS Borders
Stephen	Hare	NHS Dumfries & Galloway
Ann	Haugh	NHS Forth Valley
Patrick	Healy	Dundee University
Greggor	Henderson	Scottish Government
Patricia	Howie	NHS Education for Scotland
Martin	Kerrigan	NHS Orkney
Janice	Laing	NHS Borders
Shona	Mackie	NHS Forth Valley
Anne	Mason	Stirling University
Willie	McDonald	Glasgow Caledonian University
Karen	McDowall	NHS Ayrshire & Arran
Gillian	McLean	NHS Forth Valley
Cindy	McLeish	NHS Borders
Donna	Quinn	NHS Greater Glasgow & Clyde
Sarah	Rhynas	Edinburgh University
Helen	Riddell	Queen Margaret University
Shona	Sinkins	NHS Grampian
Avril	Stobbart	NHS Lothian
Andrew	Swanson	NHS Ayrshire and Arran
Alison	Thomson	Mental Welfare Commission
Ian	Torrance	NHS Borders
Dot	Weeks	NHS Tayside & Abertay University
Ambi	Wildman	NHS Lothian

# KEY ELEMENTS OF THE CAREER FRAMEWORK

9

## **More Senior Staff - Level 9**

Staff with the ultimate responsibility for clinical caseload decision making and full on-call accountability.

8

## **Consultant Practitioners- Level 8**

Staff working at a very high level of clinical expertise and/or have responsibility for planning of services.

7

## **Advanced Practitioners - Level 7**

Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas.

6

## **Senior Practitioners/Specialist Practitioners - Level 6**

Staff who would have a higher degree of autonomy and responsibility than 'Practitioners' in the clinical environment, or who would be managing one or more service areas in the non-clinical environment.

5

## **Practitioners - Level 5**

Most frequently registered practitioners in their first and second post-registration/professional qualification jobs.

4

## **Assistant Practitioners/Associate Practitioners - Level 4**

Probably studying for foundation degree, BTEC higher or HND. Some of their remit will involve them in delivering protocol-based clinical care that had previously been in the remit of registered professionals, under the direction and supervision of a state registered practitioner.

3

## **Senior Healthcare Assistants/Technicians - Level 3**

Have a higher level of responsibility than support worker, probably studying for, or have attained NVQ level 3, or Assessment of Prior Experiential Learning (APEL).

2

## **Support Workers - Level 2**

Frequently with the job title of 'Healthcare Assistant' or 'Healthcare Technician' - probably studying for or has attained NVQ Level 2.

1

## **Initial Entry Level Jobs - Level 1**

Such as 'Domestics' or 'Cadets' requiring very little formal education or previous knowledge, skills or experience in delivering, or supporting the delivery of healthcare.

## Appendix 3 - Four Overarching Themes

Leadership	Facilitating learning	Research	Advanced clinical practice
<ul style="list-style-type: none"> <li>• Identifying need for change, leading innovation and managing change, including service development.</li> <li>• Developing case for change.</li> <li>• Negotiation and influencing skills.</li> <li>• Networking.</li> </ul>	<ul style="list-style-type: none"> <li>• Principles of teaching and learning.</li> <li>• Supporting others to develop knowledge and skills.</li> <li>• Promotion of learning/creation of learning environment.</li> <li>• Patient teaching and information-giving.</li> <li>• Developing patient education materials.</li> <li>• Advanced values base knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Ability to access research/use information systems.</li> <li>• Critical appraisal/evaluation skills.</li> <li>• Involvement in research/audit.</li> <li>• Ability to implement research findings into practice, including development of policies/protocols and guidelines.</li> <li>• Conference presentations.</li> <li>• Publications.</li> </ul>	<ul style="list-style-type: none"> <li>• Decision-making/clinical judgement and problem-solving.</li> <li>• Critical thinking and analytical skills incorporating critical reflection.</li> <li>• Managing complexity.</li> <li>• Clinical governance.</li> <li>• Equality and diversity.</li> <li>• Ethical decision-making.</li> <li>• Assessment, diagnosis referral, discharge.</li> <li>• Achievement of NMC draft competencies.</li> <li>• Developing higher levels of autonomy.</li> <li>• Assessing and managing risk.</li> <li>• Prescribing.</li> <li>• Developing confidence.</li> <li>• Developing therapeutic nursing to improve patient outcomes.</li> <li>• Higher level communication skills.</li> <li>• Patient focus/public involvement.</li> </ul>

## Appendix 4 - Underpinning Principles for Advanced Practice

### **Autonomous practice**

Advanced practitioners practice autonomously. This involves the freedom to exercise judgement about actions, in turn accepting responsibility for them and being held to account.

### **Critical thinking**

Practising autonomously requires higher level critical thinking skills. Critical thinking allows advanced practitioners to explore and analyse evidence, and cases and situations in clinical practice, enabling a high level of judgement and decision-making.

### **High levels of decision-making and problem-solving**

Advanced practitioners demonstrate expertise in complex decision-making in relation to their role. This includes determining what to include in the decision-making process, and making a decision based on judgement and critical thinking/problem-solving. This in turn affects the ability to practise autonomously.

### **Values-based care**

At this level of practice, individuals require a high level of awareness of their own values and beliefs, and work with service users/carers as equal partners.

### **Improving practice**

Advanced practice involves acting as a positive role model, enabling change and practice improvement.



NHS Education for Scotland  
Thistle House  
91 Haymarket Terrace  
Edinburgh  
EH12 5HE

[www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)

