National Clinical Programme for Older People

ADVANCED NURSING PRACTICE OLDER PERSONS

Clinical Guidance Framework

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the Nursing & Midwifery Services Director

OLDER PEOPLE

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Document Control

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Foreword

The health and well-being of older people is a key priority for nursing in Ireland. We are acutely aware that the face of gerontological nursing is evolving and changing in response to our ageing demographic and the growth and development of gerontological nursing capability.

With the advent of Sláintecare, further changes to organisational structures, including integration of Hospital Groups and Community Health Care Organisations (CHOs) are expected. In addition, the increasing older person's population and incidence of chronic diseases are placing increased demands on the health service in terms of capacity.

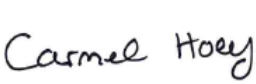
Registered Advanced Nurse Practitioners (RANPs) Older Persons Services have the capability to support integration across Hospital Groups and CHOs contributing to hospital avoidance, enabling earlier discharge, improved quality of care and patient experience. Developing the RANP service with stakeholders has the ability to foster an environment where new collaborations and ways of working are achieved. RANPs will play a crucial role in interdisciplinary teams, working together with a broad group of health care professionals who provide care for older people across the country.

Enablers to developing and expanding RANP Older Persons services now and into the future include; the Specialist Geriatric Services Model of Care (HSE & RCPI, 2012), Comprehensive Geriatric Assessment (HSE & RCPI, 2016), Frailty at the Front door (HSE & RCPI, 2017), National Frailty Education Programme (HSE & RCPI, 2017), Strategic Vision and Education Framework for Gerontological Nursing, What Matters to You (HSE & RCPI, 2018), Short Stay Bed report (HSE & RCPI, 2016), Specialist Mental Health Services for Older People, NCPOP part 2 (HSE & RCPI, 2017), and the 10 Step Integrated Care Framework (HSE, 2017). The following policy documents have been issued by the Department of Health to inform role development; 'A Policy on the Development of Graduate to Advanced Nursing and Midwifery Practice' (DoH, 2019) and Sláintecare Implementation Plan (DoH, 2018).

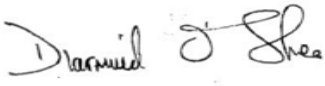
This Clinical Guidance Framework defines a common set of capabilities for RANPs Older Persons built around NMBI's six domains of competence. It emphasises the importance of dynamic interaction with all stakeholders in the development of advanced practice nursing services.

This Clinical Guidance Framework aims to reflect current knowledge and understanding in gerontological nursing and is subject to change due to the influence of social, cultural, economic and political environments of health care. We anticipate that nursing staff working with older people will find this framework beneficial in their career development.

Mary Wynne
Interim Nursing and Midwifery Services Director, & Assistant National Director, ONMSD, HSE



Carmel Hoey
Nursing Service Planner, National Clinical Programme for Older People



Dr Diarmuid O' Shea
Clinical Lead, National Clinical Programme for Older People

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Executive Summary

Population ageing is occurring rapidly and between 2015 and 2030, the number of people in the world aged 60 years or over is projected to increase by 56%. By 2050, the global population of older people is projected to more than double its size (United Nations, 2015). In Ireland, the old population (i.e. those aged 65 years and over) is projected to increase by between 58 and 63% from 2015 to 2030. The older old population (i.e. those aged 80 years of age and over) is set to rise even more dramatically, by between 85% and 94% in this time period (Wren *et al*, 2017). As older people have different healthcare requirements, the Irish healthcare system needs to adapt to meet the demands associated with these demographic changes.

Many older people age well in the community with no significant health problems, but as their numbers increase, as a percentage of the total population, so will the number who experience problems associated with old age. 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 interventions that may be effective. Therefore nurses working in older people's services must have the appropriate knowledge, skills and values to deliver high quality care.

Additionally, the shift in service provision away from acute care towards care in the community means that a significant amount of nursing care will be provided by nurses with the capability skills, knowledge and competence in caring for older people. Gerontological nurses in collaboration with healthcare professional colleagues play a key role in providing expert clinical advice, education and support in primary and secondary care.

Registered Advanced Nurse Practitioners (RANPs) in older person's services is relatively new in the Irish context, with only three such posts registered with NMBI prior to 2017. The Department of Health (DOH) introduced a draft policy entitled 'Developing a Policy for Graduate Specialist and Advanced Nursing & Midwifery Practice Consultation Paper' in 2017. As a result of this draft policy the DOH Demonstrator Project was introduced that facilitated the recruitment of 43 candidates Advanced Nurse Practitioners (cANPs) Older Persons in 2017, with an additional 18 positions recruited in 2018. A collaborative approach was required with stakeholders (Nursing, Clinicians, Management, Academic Partners, and Health and Social Care Professionals (HSCPs) to support the implementation and development of these new roles. 'A Policy on the Development of Graduate to Advanced Nursing and Midwifery Practice' (DoH, 2019) final document was launched in July 2019.

Purpose and Scope of the Advanced Practice Nursing Older Persons – Clinical Guidance Framework

The purpose of the Framework is to:

- Set the development of advanced practice roles in the context of current policy and regulation.
- Provide a clear pathway for services in the development of ANP roles within their organisation.
- Assist cANPs / RANPs identify their developmental needs to support ongoing capability.
- Define a common set of capabilities for RANPs Older Persons built around NMBI's six domains of competence.

This Clinical Guidance Framework applies to nursing, medical, health and social care professionals at all levels within organisations engaged in supporting the development of RANP Older Persons services.

Advanced Practice Nursing Older Persons Service Development

Advanced practice nursing services are developed as a direct response to population health need, informed by National Clinical and Integrated Care Programmes, Hospital Groups, Community Health Organisations (CHO's), and local service plans. Development of these roles is based on evidence informed practice and supported by key strategic health policy and related nursing rules and legislation.

This Clinical Guidance Framework sets out the necessary steps which should be confirmed prior to embarking on the post(s) development process; includes a consultation process at strategic organisational level with the aim of securing formal stakeholder commitment to the proposed role development from a clinical, financial and human resource perspective. Table 1 below maps the process steps to be taken when considering the development of an advanced practice older persons nursing service in your organisation.

TABLE 1 PROCESS STEPS FOR THE DEVELOPMENT OF ADVANCED PRACTICE OLDER PERSONS NURSING SERVICE

	Step	Process Step	Action Required	Responsibility
Initiation	**1**	**Identification of need for RANP Older Persons service** **Consider:** Department of Health Policy documents, HSE National Service Plan, National Clinical and Integrated Care Programmes Older Persons and / or local service needs	• High level identification of service need • Discuss the potential for a new advanced practice nursing/service with the relevant stakeholders locally • Engage with local Nursing & Midwifery Planning and Development (NMPD) Officer for advice and guidance at an early stage.	Chief DONM/ Director of Nursing/ /Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director Disability Services/ Existing RANP(s) Older Persons/Consultant Geriatrician
	2	**Initial scoping out of the role with key stakeholders**	High level engagement with senior management team and clinicians Obtain commitment to scope out the advanced practice older persons service requirement	Chief DONM/ Director of Nursing/ Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director /Manager of Disability Services in collaboration with key stakeholders including Consultant Geriatricians /GPs/RANP(s)Older Persons

Planning	**3**	**Development of business case for funding approval**	Review service data and align with service plans. See Appendix 2 Template for Developing a Business Case for RANP roles **Consider:** ✓ Existing clinical activity: HIPE , NQAIS Data Acute hospital ED, AMU, inpatient, outpatient, Day Hospital, Residential Units, Community Nursing Service by age - >65, >75, >85, reason for admission, readmission rates, delayed discharges, frailty syndromes, co-morbidities etc. ✓ Current level of Geriatric Service available acute Hosp. & CHO area. ✓ Human resources older person specific / in general - roles and responsibilities of team members, nursing role differentials. ✓ Patient Pathways in place for older people ✓ Projected level of new service ✓ Consider impact of new service on existing services Consider the professional scope of practice of the RANP role and the requirements to meet the role within the service Prepare and submit business case for approval The post must be approved and signed off by the senior management team including whole time equilivant and financial approval	Chief DONM/ Director of Nursing/ Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director /Manager of Disability Services in collaboration with key stakeholders including Consultant Geriatricians /GPs/RANP(s)Older Persons/ Nurse practice development co-ordinators
	4	**Recruitment of Candidate ANP**	Adapt nationally approved cANP Job Description (ONMSD) specifying post specific requirements in respect of older persons https://www.hse.ie/eng/about/who/onmsd/advanced-and-specialist-practice/sample-canmp-job-specification1.doc Recruit candidate (Human Resources processes)	Chief DONM/ Director of Nursing/ Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director /Manager of Disability Services in collaboration with key stakeholders including Consultant Geriatricians /GPs/RANP(s)Older Persons/ Nurse practice development co-ordinators

Implementation	**5**	**Development of Advanced Practice Older Persons nursing service**	Establish Key stakeholders Local Working Group (LWG): TOR Template (ONMSD, 2018) Appendix 3
			
			• Provide direction to the cANP in establishing the new service including infrastructure, clinical space, equipment, access to IT systems etc
			• Discuss and agree the caseload, Scope of Practice at an advanced level.
			• Agree the broad range of illnesses/conditions/health needs that can be managed by the cANP/RANP.
			• Agree the inclusion and exclusion criteria for the caseload.
			• Agree the range of therapeutic interventions to be provided by the cANP/ RANP.
			  ○ Comprehensive Geriatric Assessment
			  ○ Diagnostics
			  ○ Interpreting results
			  ○ Treatment / Interventions
			• Determine the specific competences required by the cANP/ RANP to manage the agreed caseload and ensure supporting structures are in place to enable achievement of competences (HEI & Associated Health Care Provider).
			• Agree appropriate referral pathways **to** and **from** the cANP/ RANP.
			• Agree Clinical & Professional Supervision processes
			• Identify and establish structures to support the advanced practice service e.g. Policies, Procedures, Protocols and Guidelines (PPPGs) / Service Level Agreement (SLAs)/ Memoranda of Understanding (MOU).
			• Promote market and advocate the importance and value of the development of the RANP service within Hospital /CHO.
			• Discuss and agree Key Performance Indicators applicable to the service consistent with Clinical & Integrated care Programmes/ DOH KPIs.
			• Consider other resources required to support the role i.e. clinical space, administration support etc.
			• Ensure that the service being developed is aligned to national policy direction e.g. National Clinical and Integrated Care Programmes.
			• Assist the cANP in preparing the job description and supporting documentation
			• Support the individual nurse(s) in meeting the NMBI criteria for registration as an Advanced Nurse Practitioner, as set out in the Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017).
			
			https://www.nmbi.ie/NMBI/media/NMBI/Advanced-Practice-Nursing-Standards-and-Requirements-2017.pdf?ext=.pdf
			
			Note:
			Link LWG to established older persons structures across hospital groups /CHOs older person governance group/OPS Forums/ICPOP teams etc. where applicable
				Director of Nursing/ Assistant Director of Nursing/ Clinical Nurse Managers / Public Health Nursing/ Consultant/RANP/GP/ Professional supervisors /NMPD officer /Service Manager/ Project Lead / ICT Lead/Health and Social Care Professional Representatives, Pharmacy, Radiology and Laboratory etc.

	6	**cANP Older Persons Preparation for Registration as**	cANP will undertake the academic preparation and develop the clinical and leadership skills, competences and knowledge required to meet the criteria to go forward for registration as a RANP.	cANP/ Clinical & Professional Supervisor/Higher Education Institute/ Employer

		RANP Older Persons with NMBI		
	7	**cANP Older Persons to go forward for Registration with NMBI**	Complete the necessary documentation for registration with NMBI https://www.nmbi.ie/Registration/Advanced-Practice/Registering-as-an-ANP-AMP	cANP/DoN
	8	**Registration as RANP Older Persons**	The NMBI registration decision will be communicated from NMBI directly to the cANP. A new employment contract as RANP (agreed job description) issued which includes arrangements for on-going professional and clinical supervision	NMBI/cANP Employer
Mainstreaming	**9**	**Ongoing capability:** • Maintenance of Knowledge/ Skills /Competence • Continuing Professional Development • Expansion of Scope of Practice • Clinical & Professional supervision	RANP Older Persons have the capacity to provide a RANP led service working in new and creative ways to improve health and develop services that respond to older people's needs, demonstrating visibility, flexibility, integration and impact.	RANP /clinical & Professional Supervisors/

**Adapted from National Guideline for the Development of Advanced Nursing and Midwifery Practice Services Office of the Nursing and Midwifery Services Director, Health Service Executive (draft 9,2019)*

Conclusion

The Advanced Practice Nursing Older Persons – Clinical Guidance Framework recognises that capability development involves more than mandatory requirements and essential knowledge and skills. Capability development needs to move beyond discipline knowledge and understanding to reflect an integrated set of capabilities that support consolidation of learning within practice and advancement of the RANP Older Persons future career. The Clinical Guidance Framework aims to reflect current knowledge and understanding in gerontological nursing and is subject to change because of the influence of social, cultural, economic and political environments of health care.

Abbreviations

cANP	candidate Advanced Nurse Practitioner
ADON	Assistant Director of Nursing
CNSp	Clinical Nurse Specialist
CGA	Comprehensive Geriatric Assessment
CPA	Collaborative Practice Agreement
CPD	Continuing Professional Development
CHO	Community Health Organisation
DoH	Department of Health
DON	Director of Nursing
GP	General Practitioner
HG	Hospital Group
HSE	Health Service Executive
ICPOP	Integrated Care Programme Older People
KPI	Key Performance Indicator
LGBT	Lesbian, Gay, Bisexual & Transgender
MDT	Multidisciplinary Team
MOU	Memorandum of Understanding
NCPOP	National Clinical Programme for Older People
NLIC	National Leadership and Innovation Centre
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Director
OPS	Older Persons Services
PPPGs	Policies, Procedures, Protocols and Guidelines
RANP	Registered Advanced Nurse Practitioner
SLA	Service Level Agreement
UCC	University College Cork
WTE	Whole Time Equivalent

Introduction

Registered Advanced Nurse Practitioners (RANPs) in older person's services is relatively new in the Irish context, with only three such posts registered with NMBI prior to 2017. The Department of Health (DOH) introduced a draft policy entitled 'Developing a Policy for Graduate Specialist and Advanced Nursing & Midwifery Practice Consultation Paper' in 2017. As a result of this policy the DOH Demonstrator Project was introduced that facilitated the recruitment of 43 candidates Advanced Nurse Practitioners (cANPs) Older Persons in 2017, with an additional 18 positions recruited in 2018. A collaborative approach was required with stakeholders (Nursing, Clinicians, Management, Academic Partners, and Health and Social Care Professionals (HSCPs) to support the implementation and development of these new roles locally.

This Clinical Guidance Framework was developed at the request of clinicians in geriatric medicine who have a key role in supporting the development and supervision of advanced nurse practitioners in the clinical setting. This resource complements the Higher Education Institutes Master of Science in Nursing (Advanced Practice Nursing) curriculum and Clinical Practicum (Record and Assessment of Learning and Clinical Practice) documents. It is specifically for use by healthcare organisations to support candidate Advanced Nurse Practitioners (cANPs) / Registered Advanced Nurse Practitioners (RANPs) Older Persons to enhance their ongoing capability within the system in the management and care of older persons. This document should be used in association with Advanced Practice (Nursing) Standards and Requirements, Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) 2017. This framework holds a repository of information pertaining to the development of Advanced Nurse Practitioner Older Persons services in Ireland.

Additionally, in recognition of the changing demography in Ireland, several policy initiatives focus on the redesign of services to meet the needs of an ageing population. These include Sláintecare report (DoH, 2017), HSE Service Plan (HSE, 2019), National Positive Ageing Strategy (2016), National Dementia Strategy (2014), "Healthy and Positive Ageing for All" Research Strategy (2015-2019), Developing a Policy for Graduate Specialist and Advanced Nursing & Midwifery Practice Consultation Paper (DOH, 2017) and 'A Policy on the Development of Graduate to Advanced Nursing and Midwifery Practice' (DoH, 2019). It is imperative that each nurse working with older people develop the additional capability to embrace and deliver on new ways of working, and innovative methods of service delivery.

All of this research highlights the importance of prioritising role development in gerontological nursing for all nurses working with older people. It highlights a continuing need for gerontological 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 their own care decisions.

A number of published reviews and frameworks have informed the development of this Clinical Guidance Framework including the Systematic Literature Review and National Focus Groups to Support the Development of a Strategic Vision and Educational Framework for Gerontological Nursing (Coffey et al 2017), Advanced Clinical Practice Competencies (Goldberg et al 2016), Frailty-A framework of core capabilities (NHS Skills for Health 2018), Frailty Advanced Nurse Practitioner Competencies (NHS CGA Team 2016), Guiding Framework for the Development of Registered Advanced Nurse Practitioner - Acute Medicine, National Acute Medicine Programme (ONMSD 2018) and Working with Older People: Professional Guidance, Nursing & Midwifery Board of Ireland (2009/2015).

"Advanced Nurse Practitioner (ANP) roles are central to provision of a nursing service to an ageing population. ANPs are employed to complement and enhance the multidisciplinary team's capabilities. This requires active contribution to developing appropriate local roles and job descriptions for ANPs - they will be most successful in a mutually supportive multi-professional team where there is good understanding of and 'buy-in' to their roles. The roles will need local tailoring and specification to include pathways or protocols that ANPS can support to provide less variable and higher quality care for older people"

(Pulford, 2016)

1 Advanced Practice Nursing in Ireland

1.1 Regulation

The Nursing and Midwifery Board of Ireland (NMBI) is the statutory regulatory body for nursing and midwifery in Ireland and have the legislative authority for the regulation of advanced nursing and midwifery practice. Ireland is one of the few countries in the world that has a registration process for advanced practice. In accordance with the Nurses and Midwives Act http://www.irishstatutebook.ie/eli/2011/act/41/enacted/en/pdf

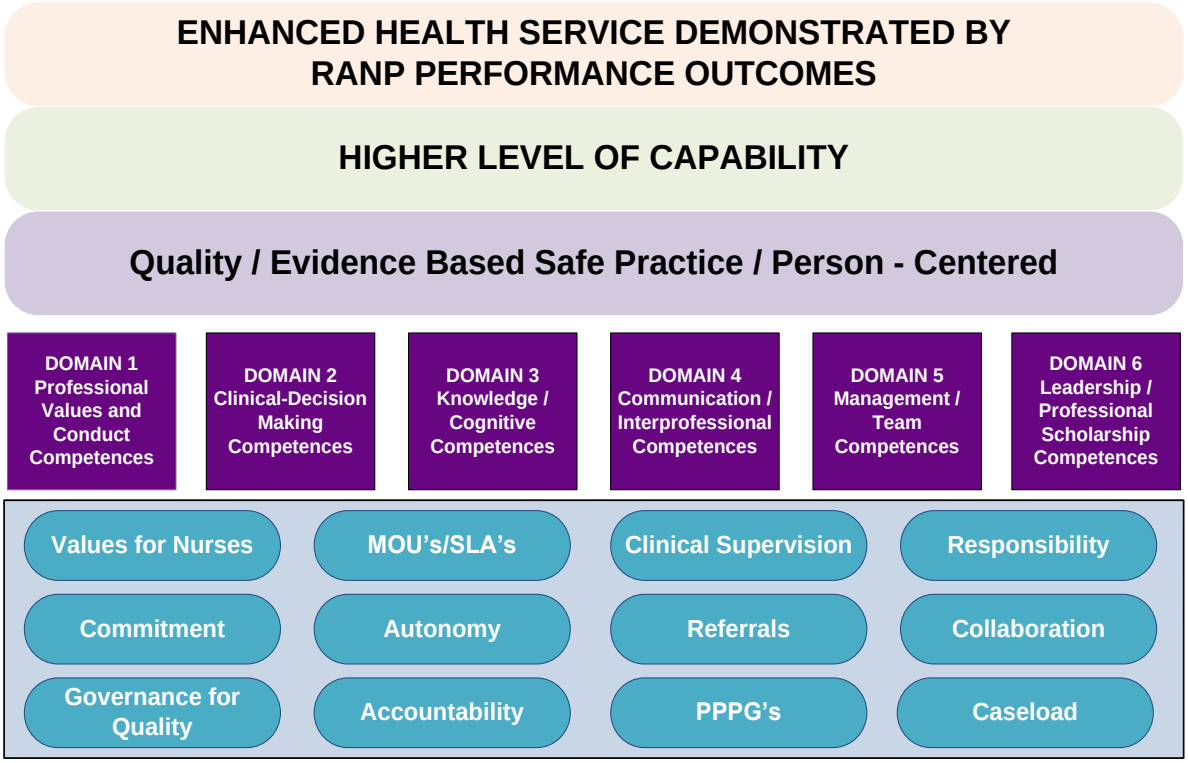
NMBI defines advanced practice nursing as a "career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of **capability** as **independent**, **autonomous**, and **expert** practitioners" (NMBI, 2017, p.15).

The Advanced Practice (Nursing) Standards and Requirements (2017) provide flexibility to Higher Education Institutions and associated Health Care Providers to be responsive and adaptable in the provision of evidence based education programmes that prepare nurses with the necessary competences to register as Advanced Nurse Practitioners. https://www.nmbi.ie/Education/Standards-and-Requirements

cANPs are required to meet the Criteria for Registration as set out by NMBI to enter the advanced practice division of the register https://www.nmbi.ie/Registration/Advanced-Practice/Registering-as-an-ANP-AMP.aspx

The competences for advanced practice nursing build on the competences achieved to register as a nurse with the NMBI, and are presented in Figure 1 below.

FIGURE 1: ADVANCED PRACTICE NURSING MODEL



1.2 Policy Context

In July 2019 the Minister for Health launched 'A Policy on the Development of Graduate to Advanced Nursing and Midwifery Practice' (DoH, 2019). The purpose of the policy is to present a model for graduate to advanced practice capable of developing a critical mass of nurses and midwives to address emerging and future service needs and drive integration between services. The overarching principle underpinning the policy is to develop the nursing and midwifery resource in response to patient and service need.

1.3 Aim

The aim of the DoH policy is to contribute to providing a solution to several challenges facing the health service. The key driver for the policy is the creation of a more responsive, integrated and person-centred health and social care service, as outlined in Strategic Priority 3 of the Department of Health Statement of Strategy (2016-2019). The availability of a critical mass of RANPs/RAMPs can support the shift in government health strategy from hospital to the community (Committee on the Future of Healthcare, Houses of the Oireachtas, 2017). Linked to this priority is the development of advanced practice nursing and midwifery services to support the implementation of the HSE Integrated Care Programmes across services to ensure consistent service across geographic areas (Goal 1, Action a; DoH Policy, 2019 p.13).

2 Office of the Nursing and Midwifery Services Director

The Health Service Executive (HSE) supports the development of advanced practice roles throughout the HSE and HSE funded organisations through the workings of the Office of the Nursing and Midwifery Services Director (OMNSD) and Nursing and Midwifery Planning and Development Units (NMPDUs). On behalf of the ONMSD, a lead Director, Nursing and Midwifery Planning and Development has responsibility for the support, advice and guidance provided by each NMPDU implemented through a local Nursing and Midwifery Planning and Development (NMPD) Officer. The NMPD Officer engages with their local services providing a supporting, facilitating and guiding role to assist services with the development of advanced practice roles in line with NMBI Requirements, Visit: https://www.hse.ie/eng/about/Who/ONMSD/Advanced-and-Specialist-Practice/Advanced-Nursing-and-Midwifery-Practitioner-Role-Development.html The National Clinical Leadership Centre (NCLC) for Nursing and Midwifery supports and enhances the development of leadership competence in cANPs/RANPS, Visit: https://www.hse.ie/eng/about/who/onmsd/leadership/

3 Advanced Practice Older Persons Nursing Service Development

Advanced practice nursing services are developed as a direct response to population health need and organisational requirements, as identified through local, regional and national planning processes. The identification and confirmation of these specific role developments within HSE service areas is the responsibility of Group Directors of Nursing and Midwifery, Directors of Nursing, Service Managers and Clinicians in collaboration with the ONMSD /NMPDUs.

The necessary steps which should be confirmed prior to embarking on the post development process includes a consultation process at strategic organisational level with the aim of securing formal stakeholder commitment to the proposed service development from a clinical, financial and Human Resource (HR) perspective.

The vision for the advanced practice nursing role goes beyond that of the current scope of nursing practice. It is informed by National Clinical and Integrated Care Programmes, Hospital Groups, Community Health Organisations (CHO's), population needs and local service plans. It is based on evidence informed practice and supported by key strategic health policy and related nursing rules and legislation. RANPs older persons must operate within and to the full extent of their scope of practice to be truly effective in these roles.

TABLE 1: PROCESS STEPS FOR THE DEVELOPMENT OF ADVANCED PRACTICE OLDER PERSONS NURSING SERVICE

	Step	Process Step	Action Required	Responsibility
Initiation	1	**Identification of need for RANP Older Persons service** **Consider:** Department of Health Policy documents, HSE National Service Plan, National Clinical and Integrated Care Programmes Older Persons and / or local service needs	• High level identification of service need • Discuss the potential for a new advanced practice nursing/service with the relevant stakeholders locally • Engage with local Nursing & Midwifery Planning and Development (NMPD) Officer for advice and guidance at an early stage.	Chief DONM/ Director of Nursing/ /Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director Disability Services/ Existing RANP(s) Older Persons/Consultant Geriatrician
	2	**Initial scoping out of the role with key stakeholders**	High level engagement with senior management team and clinicians Obtain commitment to scope out the advanced practice older persons service requirement	Chief DONM/ Director of Nursing/ Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director /Manager of Disability Services in collaboration with key stakeholders including Consultant

				Geriatricians /GPs/RANP(s)Older Persons
Planning	**3**	**Development of business case for funding approval**	Review service data and align with service plans. See Appendix 2 Template for Developing a Business Case for RANP roles **Consider:** ✓ Existing clinical activity: HIPE , NQAIS Data Acute hospital ED, AMU, inpatient, outpatient, Day Hospital, Residential Units, Community Nursing Service by age - >65, >75, >85, reason for admission, readmission rates, delayed discharges, frailty syndromes, co-morbidities etc. ✓ Current level of Geriatric Service available acute Hosp. & CHO area. ✓ Human resources older person specific / in general - roles and responsibilities of team members, nursing role differentials. ✓ Patient Pathways in place for older people ✓ Projected level of new service ✓ Consider impact of new service on existing services Consider the professional scope of practice of the RANP role and the requirements to meet the role within the service Prepare and submit business case for approval The post must be approved and signed off by the senior management team including whole time equilivant and financial approval	Chief DONM/ Director of Nursing/ Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director /Manager of Disability Services in collaboration with key stakeholders including Consultant Geriatricians /GPs/RANP(s)Older Persons/ Nurse practice development co-ordinators
	4	**Recruitment of Candidate ANP**	Adapt nationally approved cANP Job Description (ONMSD) specifying post specific requirements in respect of older persons https://www.hse.ie/eng/about/who/onmsd/advanced-and-specialist-practice/sample-canmp-job-specification1.doc Recruit candidate (Human Resources processes)	Chief DONM/ Director of Nursing/ Director of Services/ Service Manager/DON/DPHN /Area Director Mental Health Nursing/Area Director /Manager of Disability Services in collaboration with key stakeholders including Consultant Geriatricians /GPs/RANP(s)Older Persons/ Nurse practice development co-ordinators

Implementation	**5**	**Development of Advanced Practice Older Persons nursing service**	Establish Key stakeholders Local Working Group (LWG): TOR Template (ONMSD, 2018) Appendix 3
			
			• Provide direction to the cANP in establishing the new service including infrastructure, clinical space, equipment, access to IT systems etc.
			• Discuss and agree the caseload, Scope of Practice at an advanced level.
			• Agree the broad range of illnesses/conditions/health needs that can be managed by the cANP/RANP.
			• Agree the inclusion and exclusion criteria for the caseload.
			• Agree the range of therapeutic interventions to be provided by the cANP/ RANP.
			  ○ Comprehensive Geriatric Assessment
			  ○ Diagnostics
			  ○ Interpreting results
			  ○ Treatment / Interventions
			• Determine the specific competences required by the cANP/ RANP to manage the agreed caseload and ensure supporting structures are in place to enable achievement of competences (HEI & Associated Health Care Provider).
			• Agree appropriate referral pathways **to** and **from** the cANP/ RANP.
			• Agree Clinical & Professional Supervision processes
			• Identify and establish structures to support the advanced practice service e.g. Policies, Procedures, Protocols and Guidelines (PPPGs) / Service Level Agreement (SLAs)/ Memoranda of Understanding (MOU).
			• Promote market and advocate the importance and value of the development of the RANP service within Hospital /CHO.
			• Discuss and agree Key Performance Indicators applicable to the service consistent with Clinical & Integrated care Programmes/ DOH KPIs.
			• Consider other resources required to support the role i.e. clinical space, administration support etc.
			• Ensure that the service being developed is aligned to national policy direction e.g. National Clinical and Integrated Care Programmes.
			• Assist the cANP in preparing the job description and supporting documentation
			• Support the individual nurse(s) in meeting the NMBI criteria for registration as an Advanced Nurse Practitioner, as set out in the Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017).
			
			https://www.nmbi.ie/NMBI/media/NMBI/Advanced-Practice-Nursing-Standards-and-Requirements-2017.pdf?ext=.pdf
			
			Note:
			Link LWG to established older persons structures across hospital groups /CHOs older person governance group/OPS Forums/ICPOP teams etc. where applicable
				Director of Nursing/ Assistant Director of Nursing/ Clinical Nurse Managers / Public Health Nursing/ Consultant/RANP/GP/ Professional supervisors /NMPD officer /Service Manager/ Project Lead / ICT Lead/Health and Social Care Professional Representatives, Pharmacy, Radiology and Laboratory etc.

	6	**cANP Older Persons Preparation for Registration as RANP Older Persons with NMBI**	cANP will undertake the academic preparation and develop the clinical and leadership skills, competences and knowledge required to meet the criteria to go forward for registration as a RANP.	cANP/ Clinical & Professional Supervisor/Higher Education Institute/ Employer
	7	**cANP Older Persons to go forward for Registration with NMBI**	Complete the necessary documentation for registration with NMBI https://www.nmbi.ie/Registration/Advanced-Practice/Registering-as-an-ANP-AMP	cANP/DoN
	8	**Registration as RANP Older Persons**	The NMBI registration decision will be communicated from NMBI directly to the cANP. A new employment contract as RANP (agreed job description) issued which includes arrangements for on-going professional and clinical supervision	NMBI/cANP Employer
Mainstreaming	**9**	**Ongoing capability:** • Maintenance of Knowledge/ Skills /Competence • Continuing Professional Development • Expansion of Scope of Practice • Clinical & Professional supervision	RANP Older Persons have the capacity to provide a RANP led service working in new and creative ways to improve health and develop services that respond to older people's needs, demonstrating visibility, flexibility, integration and impact.	RANP /clinical & Professional Supervisors/

**Adapted from National Guideline for the Development of Advanced Nursing and Midwifery Practice Services Office of the Nursing and Midwifery Services Director, Health Service Executive (draft 9,2019).*

4 Advanced Practice Roles in Gerontological Nursing

4.1 Gerontological Nursing

Gerontological nursing is the specialty of nursing pertaining to older adults. Gerontological nurses work in collaboration with older adults, their families, and communities to support healthy aging, maximum functioning, and quality of life (CGNA 2010). The term gerontological nursing, which replaced the term geriatric nursing in the 1970s, is seen as being more consistent with the specialty's broader focus on health and wellness, in addition to illness (Tuohy et.al 2014, Eliopoulos 2014). Gerontological nurses have an important role to play in meeting the health and social care needs of this rapidly aging population. There is significant evidence that the proportion of the population that is considered old is increasing, the number of people in the world aged 60 years or over is projected to increase by 56%. By 2050, the global population of older people is projected to more than double its size (United Nations, 2015). In Ireland, the old population (i.e. those aged 65 years and over) is projected to increase by between 58 and 63% from 2015 to 2030. The older old population (i.e. those aged 80 years of age and over) is set to rise even more dramatically, by between 85% and 94% in this time period (Wren et al. 2017).

4.2 Advanced Nurse Practitioner Older Persons

Nurses provide a significant volume of the care delivered within the Irish health system. As such appropriate utilisation of their capacity, building on the undergraduate degree programme and the implementation of the clinical career pathway are of significant importance.

In 2017, through the DOH Demonstrator Project, older persons services recruited the inaugural group of 43 candidate Advanced Nurse Practitioners (cANPs) with an additional 18 candidates recruited in 2018. Many of the successful applicants for these positions were already in preparation for advanced practice roles over a number of years and in some cases had almost all of their academic requirements complete. At the time of publication there are 8 RANPs Older Persons registered with the Nursing and Midwifery Board of Ireland. These RANPs will play a vital role in the delivery of improved care for older people in the years ahead. It is essential that the high standards, experience and gerontological background are maintained. It is crucial that those who participate in the education, guidance, clinical supervision and mentoring of these cANPs/RANPS are reassured that there is consistency, clarity and clear direction in the development and ongoing supervision of these cANPs/RANPs.

4.3 National Clinical and Integrated Care Programme - Older People

The National Clinical Programme for Older People (NCPOP) and Integrated Care Programme for Older Persons (ICPOP) have supported the development of these advanced practice services to enable alignment with programme objectives. There is acknowledgement of the considerable investment and commitment from clinicians involved in taking on additional supervision and mentoring roles to support these cANPs and the programme. The NCPOP Model of Care Acute Service Provision sets out a number of recommendations for the establishment of a Specialist Geriatric Service and successful delivery of measureable outcomes for older people. It also sets out the design for Comprehensive Geriatric Assessment (CGA), subspecialty services, and the key roles that interdisciplinary education in areas including frailty will play in supporting the evolution of age attuned and age accommodating services that

support ambulatory care. Access to the Acute Model of Care and Comprehensive Geriatric Assessment documents at:

http://www.hse.ie/eng/about/Who/clinical/natclinprog/olderpeopleprogramme/models

https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/comprehensive-geriatric-assessment-document-.pdf

It is widely accepted that mental health services for older people should develop in tandem with geriatric medicine services given the inseparable relationship between physical and mental health. In recognition of this, the NCPOP have developed a Specialist Mental Health Services for Older People Model of Care.

The ICPOP 10-step Framework for Older People provides a conceptual map of integrated care that includes overarching functions required to deliver integrated care (e.g. multi-disciplinary working and information technology support), population-based approaches and evidence-based clinical pathways (HSE, 2016). The programme combines the development of high quality primary care and community-based services with improved coordination and integration of secondary care to provide an integrated care programme for older adults with complex health and social care needs. The Framework can be accessed at https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/A-practical-guide-to-the-local-implementation-of-Integrated-Care-Programmes-for-Older-Persons.pdf

5 Gerontological Nursing Roles

Nurses have a clear responsibility to maintain and improve the health and well-being of older people in their care. Working as members of multi-disciplinary, integrated care teams, they also have an outstanding opportunity to take a leading role in developing new and innovative services for older people. Nursing services in Ireland are being modelled to meet the new challenges facing an ageing population including older people with mental health and / or intellectual disability. Nursing has responded to these challenges through the following publications.

https://www.hse.ie/eng/services/publications/nursingmidwifery%20services/a%20vision%20for%20psychiatric%20mental%20health%20nursing.pdf

https://www.hse.ie/eng/about/who/onmsd/news/executive-summary-shaping-the-future-of-intellectual-disability-nursing-in-ireland.pdf

As such, much of the focus of nursing is a move towards adopting integrated approaches to care, identifying health needs, putting in place health improvement initiatives to meet the needs of this population.

5.1 Strategic Vision and Educational Framework for Gerontological Nursing

The NCPOP supported by the ONMSD commissioned University College Cork (UCC) to undertake a research project to:

- Define a strategic vision for gerontological nursing.
- Determine the knowledge, skills and competence required to produce a nursing workforce that can provide quality person-centred care to older people wherever they access healthcare.
- Develop an educational framework that will enable nurses to acquire and maintain the necessary knowledge, skills and competence; at the appropriate level to deliver quality person-centred care to older people, throughout the Irish Health Service.

This work has resulted in the development of an educational framework to enable nurses to acquire and maintain the necessary knowledge, skills and competences, at the appropriate level to deliver care to older people, throughout the Irish Health Service. A national Higher Education Institute (HEI) Working Group was established and colleagues from HEIs have mapped their undergraduate and post graduate education programmes to the framework. The literature review can be accessed at Strategic Vision Literature Review (Coffey *et al*, 2017).

The strategic vision literature review highlights the need for further investment in the development of RANPs and Clinical Nurse Specialists (CNSp.) in gerontological nursing. This framework leads the way for how nursing will build capacity in generalist, specialist and advanced practice roles to support an integrated delivery of care for older people enabling the nursing profession to respond to the challenges and opportunities that arise from the changing demographic and new ways of working. It articulates the knowledge, skills and competence required to produce a nursing workforce that can provide quality person-centred care to older people and provides a way forward for the development of the gerontological nursing workforce in Ireland. Responsibility for professional development; expanded roles and clear career progression is shared between the individual nurse and the service in which they

practice. The Strategic Vision literature review provides an evidenced based framework to support the development of varied nursing roles in gerontological practice.

The Nursing and Midwifery Board of Ireland have defined six domains of competences (Nurse Registration Programmes Standards and Requirements, NMBI, 2016) which each nurse must demonstrate in order to be registered to practice. These six domains of competences are used to outline the domains of competence and gerontological related standards viewed as being fundamental to gerontological nursing (Coffey *et al* 2017).

TABLE 2: DOMAINS OF COMPETENCE AND GERONTOLOGICAL ASSOCIATED STANDARDS

Domain	Gerontological Associated Standards
Professional values and conduct of the nurse competences	• The practice of the nurse in gerontology is based upon respect for the person with genuine value being placed upon person-centeredness. The nurse promotes real choice and flexibility for the person. The nurse is an ethical, reflective practitioner who is passionate and interested in working with older people. • The nurse is responsible for their own professional development and actively seeks out learning opportunities and contributes to the development and education of others. The nurse strives to improve the quality of gerontological nursing practice and the health and social care services provided to older persons wherever they access service.
Nursing practice and clinical decision making competences	• The nurse endeavours to get to know the older person, seeks to enter the world of the person meeting the person where they are and advocates with and for the person. The nurse conducts a timely and considered comprehensive and systematic assessment to inform clinical decision making. The nurse translates and integrates evidence into practice and in partnership with the person agrees a plan of care which has purposefully sought to enable and encourage independence for as long as possible. The nurse is creative in their care planning, incorporating interventions that are often social in origin, which have a combined health, disease, wellness and living focus. Nurses provide and may delegate, quality evidence based care actions. Nurses evaluate care interventions and respond in timely manner to changes/alterations/deteriorations.
Knowledge and cognitive competences	• The practice of the nurse in gerontology is based upon the best available evidence in making decisions, the person's preferences, a sustained focus on quality improvement and the nurse's critical and analytical skills. The nurse endeavours to provide safe, quality nursing practice within person-centred and evidence-based practice frameworks which are underpinned by a shared gerontology vision and philosophy.
Communication and interpersonal competences	• The practice of the nurse in gerontology is based upon respect for the person, their life experiences and their unique needs. The nurse spends time with and purposefully listens to the person, takes time to get to know the person and actively engages in developing therapeutic relationships with the person and their family. The nurse places the person and their needs at the centre of all communication, interdisciplinary collaborations

	and care activities.
Management and team competences	• The nurse supports the maintenance of the older person's wellbeing, recovery, independence and safety through recognition of the collaborative partnership between the older person their family and /or carer and multidisciplinary health care team. The nurse keeps the older person at the centre in all management decisions whilst being cognisant of the need to balance risks with preferences of the older person.
Leadership and professional scholarship competences	• The nurse advocates for, contributes to, and leads systems that support safe quality care, professional partnerships and professional growth of self and others. The nurse seeks to positively influence policy, clinical practice, gerontological nursing as a specialism through their leadership, collaborations, professional organisations.

In 2016 with the support of the Life Long Learning Programme of the European Union, the ELLAN (European Late Life Active Network), a consortium of 26 countries published a Core Competences Framework for Health and Social Care Professionals working with older people (ECCF). University College Cork utilised these seven roles within the framework: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional to provide role descriptors for gerontological nursing roles. The role of "expert" within the ECCF was modified from the original to represent profession specific expertise developed from professional knowledge and skills acquired during formal education. For further information, please visit: http://ellan.savonia.fi/images/ECCF_final_version.pdf

An adapted overview of the roles and competences in the ECCF are presented in table 3 below.

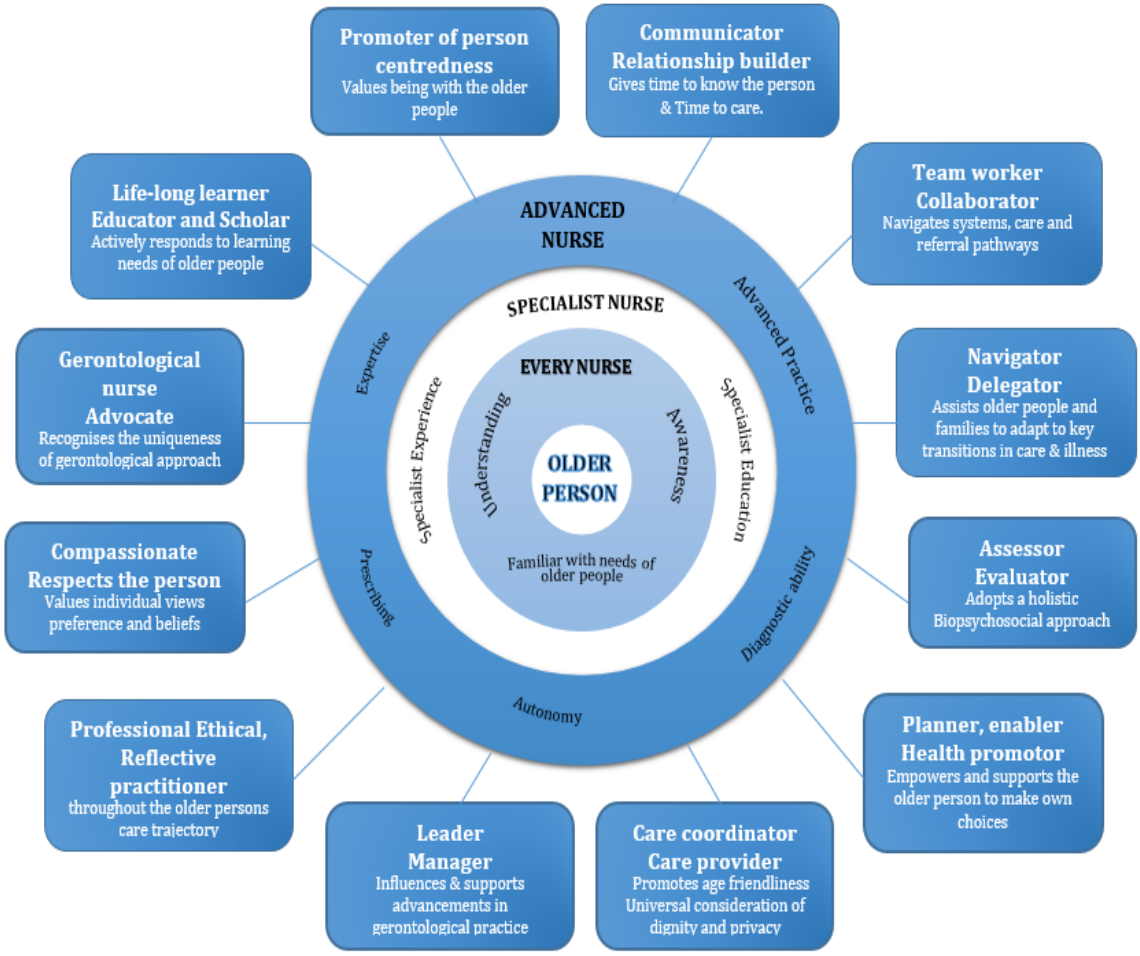
TABLE 3: ROLE DESCRIPTORS AND ASSOCIATED COMPETENCES IN GERONTOLOGICAL NURSING

Role	Competence
Expert	**Assessment:** Systematic data collection. Assessment of physical and mental well-being, social factors. Identify the needs and wishes of the older person.
	Analysis and problem identification: Analyse the data and identify the problems for the older person and his/her family. Formulate conclusion and/or a diagnosis.
	Planning: Clear, timely, and appropriate plan; measurable objectives with the focus on best health, well-being and quality of life. Shared decision making.
	Carry out interventions based on professional standards: Provide care, help and support to the older person and his/her family.
	Evaluation: Re-evaluate and adjust service or care plans on a continuing basis.
Communicator	**Maintaining relationships and effective communication:** Build relationships based on empathy, trust, respect and reciprocity. Considering the older person's individuality, dignity, background and needs.

	Empowerment: Promote capacities and resources in older people and their families. Contribute to autonomy, independence, and quality of life.
	Coaching: Stimulate, motivate and coach the older person/related others in self-management, self-reliance and co-reliance.
Collaborator	**Integral cooperation and integrated services:** Multi- and inter professional cooperation to achieve optimal support and care to optimize health and well-being.
	Informal care and support: Work together with older people's families, informal caregivers and their social network and stimulate informal care and support.
Organiser	**Planning and coordination of care and services:** Plan, arrange, and coordinate the care and services provided by formal and informal health and social care workers, across different organisations.
	Programme of care: Contribute to the organisation of the existing care and services. Take an active part in developing, adapting and implementing long term policy actions.
Health and welfare advocate	**Collective prevention and health promotion:** Advocate for health with, and on behalf, of older people and their families, communities and organisations
	Social map and social networks: Access and share information about the social map, healthcare benefits, social support and public programs.
Scholar	**Expertise:** Expand their own professional expertise about working with older people and their families. Spread relevant evidence based research.
	Innovation of care and support: Implement and apply new insights, standards, and technologies in the content of promoting the quality, efficiency and effectiveness of care.
Professional	**Professional ethics:** Demonstrate commitment to best practice; adhere to ethical standards and professional-led regulation; show high personal standards of behaviour.
	Professional commitment and personal awareness: Reflect on one's own actions to improve own professional behaviour. Demonstrate commitment to the health and well-being of older people. Show awareness of diversity and cultural differences.

Figure 2 below provides an illustration of the varied roles represented within a framework for gerontological nursing (Coffey *et al*, 2017). The descriptors encompass the holistic gerontological approach of the role that is more than knowledge and skill.

FIGURE 2: VARIED GERONTOLOGICAL NURSING ROLES



6 Enhancing Skills and Capabilities

6.1 Introduction

Chapter six facilitates the operationalisation of advanced practice older persons nursing services in various care settings within the Irish Healthcare System. It supports the preparation of cANPs and provides a structure for future proofing RANP roles from a clinical and professional perspective.

The 'Standards and Requirement's' defined advanced practice as a career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a **higher level of capability as independent, autonomous, and expert practitioners** (NMBI, 2017). They provide a regulatory and structured clinical career pathway for the specialism of gerontological nursing through to advanced practice.

6.2 Capability versus Competence

Evidence in the literature supports the move from achieving competency to a capability model. "Capability has been described as the combination of skills, knowledge, values and self-esteem which enables individuals to manage change, be flexible and move beyond competency" (O'Connell, Gardner & Coyer, 2014).

In achieving specific competencies, the RANP develops the capability to extend practice in line with service need and developments. In developing capability, the journey of the RANP moves from providing care that is dependent on structure, protocol and procedure to be in a position to utilise their capability in decision-making toward independent practice and decision making. This results in the ability to manage uncomplicated to complicated health conditions (DoH, 2019).

Scott *et al.* (2010) states that "capability involves a mixture of emotional and cognitive intelligence including the ability to determine when and when not to deploy these competences. Brewer *et al*, (2014) describes capability as extending "well beyond discipline knowledge and understanding. It includes communication, reflective skills, team function, conflict resolution and client-centred care requiring a sophisticated, integrated set of capabilities that encompass more than discipline specific knowledge, skills and understandings".

6.3 Clinical and Professional Mentorship

Progression of the advanced practice role requires appropriate supervision, mentorship, and continuing clinical practice in the specialist area. The RANP Older Persons is clinically accountable to a Consultant/RANP clinical Supervisor and professionally accountable to a Director of Nursing. Success for advanced practice role development is dependent on significant commitment and support from clinicians and senior nurses (RANPs /ADONs) for provision of clinical and professional supervision throughout the RANPs career.

Clinical supervision can be described as a structured process of clinical support and learning that enables individual advanced nurse practitioners to develop knowledge and competence, assume responsibility for

their own practice and enhance consumer protection and the safety of care in complex clinical situations. It focuses upon the reflective learning process enabling the expansion of the scope of practice through self-assessment and development of enhanced analytical and reflective skills. Importantly, clinical supervision has been linked to good clinical governance, by helping to support quality improvement, managing risks and by increasing accountability (HSE, 2017).

Professional supervision provides the cANP/RANP with protected time and space to reflect on their clinical practice and professional identity. It enables the cANP/RANP to reflect and develop new insights and approaches to practice.

6.4 Structure of the Capability Framework

Section 6.4 provides a Capability Framework for nurses working with older people in or towards 'advanced practice'. It is acknowledged that nurses using this Capability Framework will have achieved a level of competence and capability that equates to that of a cANP/RANP. This Capability Framework will support and consolidate this learning within practice. It is important that cANP/RANPs Older Persons can articulate what they do that contributes value to the organisation, impact on the older persons experience and integration of services throughout care settings. It is envisaged that this Capability Framework will enhance cANP/RANPs ongoing capability at advanced practice level.

The framework is presented under NMBI's six domains for Advanced Practice Nursing (NMBI 2017):

1. Professional Values and Conduct
2. Clinical-Decision Making
3. Knowledge and Cognitive
4. Communication and Interpersonal
5. Management and Team
6. Leadership and Professional Scholarship

6.4.1 Domain 1 Professional Values and Conduct

Standard 1 - The RANP Older Persons will apply ethically sound solutions which identify and address complex healthcare needs of older people and populations.

Cues (knowledge, skills, attitudes and behaviours that the cANP/ RANP Older Persons should be capable of demonstrating in practice)	**Key Content** (outlines of knowledge base required to achieve cues)
Demonstrate accountability and responsibility for professional practice as a lead healthcare professional in care of the older person	✓ Adhere to DOH Nursing & Midwifery Values; ✓ adhere to HSE Values in Action; ✓ have defined professional & clinical governance reporting structures; ✓ have a high level of awareness of their own values and beliefs, and work with service users/carers as equal partners; ✓ operate within and to the full extent of the scope of practice as per NMBIs Code of Professional Conduct & Ethics; Scope of Nursing and Midwifery Practice Framework and Standards and Requirement for Advanced Practice Nursing (www.nmbi.ie); ✓ understand the role of the Nursing and Midwifery Board of Ireland in regulation; ✓ understand the role of the Health Information and Quality Authority (HIQA) in regulation as it applies to older persons; ✓ understand the impact of Legislation as it applies to older persons; ✓ raise awareness of ageism, elder abuse and confronting negative attitudes to ageing and older people; ✓ adopt an ethical framework in and for practice with particular consideration for vulnerable older people e.g. older people with diminished capacity; ✓ ability to recognise and challenge poor practice.
Articulate safe boundaries and engage in timely referral and collaboration for those areas outside his/her scope of practice, experience and competence	✓ consult with and/or refer patient to other healthcare professionals utilising agreed referral pathways; ✓ establish integrated working (across health, social care, community and voluntary organisations) to attend to the complex medical, functional, social and psychological aspects of ageing more effectively; ✓ demonstrate high level of clinical skills; ✓ exhibit advanced communication skills; ✓ employ evidence-based practice; ✓ assess and manage risk in highly complex situations; ✓ be a reflective practitioner in a gerontological nursing context.
Demonstrate leadership by practicing compassionately to	✓ Lead and promotes a philosophy of person centred compassionate care; ✓ lead and promote respect for diversity and equality; ✓ engage with the older person to assess their needs, concerns and priorities together with their families and / or carers in a person-centred

facilitate, optimise, promote and support the health, comfort, quality of life and wellbeing of older persons whose lives are affected by altered health, chronic disorders, disability, distress or life-limiting conditions	way, and support them to meet these needs; ✓ engage in health promotion and health literacy; ✓ work with the older person their families and/or carers to co-produce a care and support plan that balances interventions with the needs and wishes of the person; ✓ support older people to understand positive risk and shared decision making by: ○ understanding the priorities and outcomes that are important to the older person their families and /or careers; ○ explaining in non-technical language all the available options (including the option of doing nothing if appropriate); ○ exploring with the person the risks, benefits and consequences of each option and discussing what these mean in the context of their life and goals; ○ supporting the person to make the decision and / or agreeing together the way forward. ✓ understand the implications of relevant legislation and guidance for consent and shared decision making; Visit: **(Assisted Decision Making (Capacity) Act 2015 - Ireland's Health ...** https://www.hse.ie/eng/about/who/qid/.../assisteddecisionmaking/ **Deprivation of Liberty: Safeguard Proposals Consultation Paper** https://health.gov.ie/wp-content/uploads/2017/12/Public-Consultation-paper-on-draft-deprivation-of-liberty-proposals.pdf **Fair Deal Legislation- The Nursing Home Support Scheme** **Fair Deal Scheme - HSE.ie** https://www.hse.ie/eng/fair-deal-scheme/ **Public and Private Long Term Care** **Health (Long-term Residential Care Services) Bill - Department of ...** https://health.gov.ie/wp-content/uploads/2014/04/fair_deal_ria.pdf **Medical Card** **Medical Cards | Department of Health** https://health.gov.ie/future-health/reforming...care.../medical-cards/

	√ Recognise and operationalise referral pathways to prevent and reduce risk of elder abuse; Visit: **Protecting Older People from Abuse - HSE.ie** https://www.hse.ie/eng/.../protecting-older-people-from-abuse.html) https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/
Articulate and promote the RANP Older Persons role in clinical, political and professional contexts	✓ Bring a high level of professionalism to gerontological advanced nursing practice; ✓ maintain and expand on professional knowledge and capabilities including new and emerging themes in gerontology and gerontological nursing; ✓ act as an exemplary and positive role model, enabling change and practice improvement; ✓ promote gerontological nursing through publication, networking and other scholarly activities; ✓ establish clinical credibility—being respected for their knowledge and expertise of an ageing population; ✓ contribute to the achievement of key performance indicators locally and nationally; ✓ market of RANP Older Persons role at local and national level; ✓ align service provision to best practice including National Clinical Programme Older People and Integrated Care Programme Older Persons policy objectives.

6.4.2 Domain 2 Clinical-Decision Making

Standard 2 The RANP Older Persons will utilise advanced knowledge, skills, and abilities to engage in senior clinical decision making

Cues (knowledge, skills, attitudes and behaviours that the cANP/ RANP Older Persons should be capable of demonstrating in practice)	**Key Content** (outlines of knowledge base required to achieve cues)
Conduct a Comprehensive Geriatric assessment using evidenced based frameworks to determine diagnoses and inform autonomous advanced nursing care	✓ Understand the CGA assessment process to include medical (physiological and physical), psychological, social and environmental components as well as functional components at the level of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Refer to: https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/Comprehensive-Geriatric-Assessment-Document-.pdf ✓ demonstrates autonomous and expert nursing practice in relation to assessment and evaluation of the needs of older people; ✓ understand the aetiology and pathophysiology of heart failure, atrial fibrillation, ischaemic heart disease, hypertension, stroke, parkinsons, diabetes, depression and anxiety as they relate to ageing; ✓ the application of comprehensive, holistic approaches to assessment i.e. Bio-Psycho-Social assessment and evaluation skills, community profiling and health needs assessment approaches, risk assessments, screening tools; ✓ Assessing the impact of: ○ ageing ○ acute and chronic conditions and illnesses (e.g. dementia, delirium and other neurological conditions) For further information, please visit: http://www.understandtogether.ie/national-dementia-office/ ○ impact of multi-morbidity and corresponding treatment regimes, Visit: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409424/ ○ mental health issues on well-being including depression and anxiety; ○ chronic symptoms e.g. pain, shortness of breath, fatigue, ○ frailty ○ psychological responses, social stressors and spiritual dimensions on the ability to engage with “activities of daily living” and on health and social well-being; ○ the impact of the context of care and the environment on health and social well-being;

	○ the needs of vulnerable populations e.g. socially isolated individuals, the homeless, individuals with intellectual disabilities; ○ identify the older person's resilience, physiological assets that have enabled health and well-being to date
Synthesise and interpret assessment information particularly history including prior treatment outcomes, physical findings and diagnostic data to identify normal, at risk and subnormal states of health	✓ Recognising clinical deterioration and need for escalation of care e.g. clinical deterioration, sepsis, deterioration in physical, psychological and social well-being; ✓ make appropriate referrals to multidisciplinary team/ specialist colleagues & services; ✓ develop ways to support and enable the older person to explore end-of-life issues; ✓ knowledge and skills in palliative care and ability to work collaboratively with palliative care team and other professionals to agree referral protocols and timely interventions.
Demonstrate timely use of diagnostic investigations to inform clinical-decision making	✓ Identify comprehensive problem list based on CGA assessment; ✓ Formulate diagnosis and priorities health and care issues for urgent, intermediate and longer-term management; ✓ understanding of independent and interdependent decision making.
Exhibit comprehensive knowledge of therapeutic interventions including pharmacological and non-pharmacological advanced nursing interventions	✓ Co-ordinate care across multiple agencies; ✓ "promote functional ability that are essential for older people to do the things that they value: meet their basic needs; learn, grow, and make decisions; move around; build and maintain relationships; and contribute" (Beard 2016). ✓ determine therapeutic interventions taking into account the patient's and carers wishes, their cultural and spiritual priorities, and their capacity and best interest decision making; ✓ identify health behaviours and empower older people to engage in supported self-management and self-care activities: ○ facilitating as much independence and autonomy as possible promoting enablement and rehabilitation; ○ promoting health and positive health behaviours; ○ promotion of self-care in the activities of daily living; ○ using evidence to underpin clinical decisions and health promotion advice and activities; ○ making decisions, planning, prioritising care and interventions; ○ managing and evaluation of care interventions; ○ confidence to discuss and commence Advanced Care planning; ○ enable older people and family to articulate preferences around End-of-Life, ceilings of treatment, Do Not Resuscitate (DNR). ✓ understanding of medication management to include: ○ Actively probe to assess treatment and medication burden including drug-drug or drug condition interactions; ○ assess adherence and tolerance of medication regime especially in polypharmacy;

	○ principles of STOPP/START & STOPPfrail recognising harmful medication for older people in particular older people living with frailty; ○ de-prescribing or change medicines during the patient's episode of care; ○ prescribing legislation and its impact in association with Collaborative Practice Agreement. ✓ Understanding the requirement to plan the successful transfer of an older person though care settings: ○ effectively liaises with colleagues in health and social care to formulate successful discharge planning for independent and supported independence living; ○ recognises need for short term discharge support; ○ understand processes for admission or transfer of patients; ○ preparation of transfer documents and discharge letters; ○ education of other members of the team on discharge planning and understanding the difference between a patient being safe to transfer and fit for rehabilitation; ○ recognises the limitations of hospital-based care and value the contribution of community based services for older persons their families and /or carers using a case management approach; ○ challenge disconnected pathways or policies that act as a barrier to health promotion and rehabilitation services ○ undertake carer assessment for ability to cope, carer burden and burnout; ○ refer to: Integrated Discharge Planning Documents – HSE https://www.hse.ie/eng/about/who/qid/resourcespublications/indisdocs.html Health Service Executive (2017) Making a start in Integrated Care for Older Persons- A Practical Guide to the local implementation of Integrated Care Programmes for Older People: https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/A-practical-guide-to-the-local-implementation-of-Integrated-Care-Programmes-for-Older-Persons.pdf

6.4.3 Domain 3 Knowledge and Cognitive Standard

Standard 3 The RANP Older Persons will actively contribute to the professional body of knowledge related to advanced practice in care of the older person

Cues (knowledge, skills, attitudes and behaviours that the cANP/ RANP Older Persons should be capable of demonstrating in practice)	**Key Content** (outlines of knowledge base required to achieve cues)
Provide leadership in the translation of new knowledge to clinical practice	✓ Create an empowering work environment that enables the transfer of knowledge into practice; ✓ manages care using their clinical expertise in combination with advanced nursing knowledge to provide appropriate, high quality patient-centred care to older people their families/carers; ✓ demonstrates and shares expertise in relation to referral pathways, processes and procedures to enable effective multidisciplinary working that underpin effective person-centred care; ✓ leads implementation of innovative strategies and interventions using evidence-based quality improvement or translation frameworks; ✓ ability to assess research/use information systems/critical appraisal and evaluation skills; ✓ involvement in research/audit; ✓ ability to implement research findings into practice, including development of policies/protocols and guidelines; ✓ deliver presentations, publications etc. on aspects of ageing.
Educate others using an advanced expert knowledge base derived from clinical experience, on-going reflection, clinical supervision and engagement in continuous professional development in respect of older persons	✓ Being self-aware; ✓ develop peer and interdisciplinary professional networks to keep up-to-date with new and emerging evidence in the care of older people; ✓ maintaining own commitment to life-long learning; ✓ leading by example—showing others how to see things differently and how to respond professionally to challenges; ✓ role models required behaviours and awareness of own attitudes towards ageing, disability and death; ✓ shares expertise through mentorship and clinical supervision; ✓ providing information and educating others; ✓ nurturing future gerontological practitioners; ✓ developing teaching strategies to facilitate learning ; ✓ being a preceptor or mentor.
Demonstrate a vision for advanced practice nursing based on a competent expert knowledge base that is developed through research,	✓ Generates research evidence, and related older persons care standards and guidelines; ✓ contributes to the development of new knowledge and implements new insights and innovations to affect high quality evidence based care and services;

critical thinking and experiential learning	✓ contributes to the development of gerontological nursing as a career specialism; ✓ participates in and develops educational programmes related to gerontology.
Demonstrate accountability in considering access, cost and clinical effectiveness when planning, delivering and evaluating care	✓ Contributes to service planning and budgetary processes; ✓ considers access, cost, efficacy, and quality when making care decisions; ✓ maintains organisational, financial and systems knowledge as it affects the delivery of care; ✓ initiates, manages, and engages in a cycle of audit and evaluation whereby findings and data inform timely changes in the service; ✓ utilise quality improvement and evidence translation frameworks to accelerate research translation into practice; ✓ interprets variances in outcomes and metrics, and uses data to improve practice; ✓ manages resources within the scope of their role and responsibilities; ✓ monitors and ensures the quality of advanced practice; ✓ promotes a culture of openness, transparency and learning in all activities.

6.4.4 Domain 4 Communication and Interpersonal Standard

Standard 4 The RANP Older Persons will negotiate and advocate with other health professionals to ensure the beliefs, rights and wishes of the older person are respected.

Cues (knowledge, skills, attitudes and behaviours that the cANP/ RANP Older Persons should be capable of demonstrating in practice)	**Key Content** (outlines of knowledge base required to achieve cues)
Communicate effectively with the patients their families and the healthcare team through sharing of information in accordance with legal, professional and regulatory requirements	✓ Recognise how effective communication with the older person can contribute to them engaging in service development, achieve health and quality of life goals; ✓ use opportunities to identify goals and actions for the older person their families and/or carers in support of self-care; ✓ utilising varying purpose and types of communication i.e. accessible language, promote health literacy, use effective communication strategies to verify person's understating (e.g. teach-back, written and oral communication); ✓ interacting with individuals with varying communication barriers or disorders (in particular hearing, visual, communication and cognitive impairments/disorders); ✓ utilising interpreters to communicate with individuals who do not have English as their preferred language; ✓ utilising communication passports in Intellectual Disability services; ✓ Professional Communication Cues: ○ engages in conversations with other professionals, demonstrating a commitment to partnership working to facilitate care; ○ understands the role of MDT members; ○ use of ISBAR tool to communicate clinical findings.
Demonstrate leadership in professional practice by using professional language (verbally and in writing) that represents the plan of care, which is shared with the older person and other members of the inter-professional team	✓ Demonstrates and shares expertise in relation to diagnosis; ✓ leads on innovative strategies and interventions in relation to building relationships with older people and their families; ✓ leads and contribute to the development of practices and services that meet the communication needs of all older people their families and/or carers.
Facilitate clinical supervision and mentorship through utilising one's expert knowledge and clinical competences	✓ Provide support and empower junior members of the multidisciplinary team including doctors, nurses and Health and Social Care Professionals; ✓ engender trust so that healthcare professional colleagues feel confident about sharing difficult problems; ✓ utilise every opportunity to teach nursing and health professional colleagues (formal setting & informal settings); ✓ support the delivery of the National Clinical Programme

	Older People- National Frailty Education Programme; ✓ encourage use of HSELanD - eLearning resources for Irish Health and Social Care Staff ... https://www.hseland.ie/
Utilise information technology, in accordance with legislation and organisational policies and procedures, to record all aspects of advanced nursing care.	✓ Leads on the utilisation of Information Technology structures to effectively manage, evaluate and improve on service delivery; ✓ using different mediums of communication: ○ Written; ○ verbal; ○ Information and Communication Technologies; ○ Social Media; ○ Informatics. ✓ record keeping, record sharing; ✓ understanding of General Data Protection Legislation (GDPR)

6.4.5 Domain 5 Management and Team

Standard 5 The RANP Older Persons will manage risk to older people who access the service through collaborative risk assessments and promotion of a safe environment

Cues (knowledge, skills, attitudes and behaviours that the cANP/ RANP Older Persons should be capable of demonstrating in practice)	**Key Content** (outlines of knowledge base required to achieve cues)
Promote a culture of quality care	✓ Understand and manage individual risk; ✓ understand organisational risk; ✓ understanding of HSE Risk Management Policies; ✓ understanding of HSE Clinical governance and quality improvement frameworks; ✓ engage in Older Persons Quality Care Metrics https://www.hse.ie/eng/about/who/onmsd/safecare/qcm/qcm-pppgs.html ✓ ability to access and manage risk i.e. highly complex health and care needs of vulnerable older people; ✓ understands the role of MDT members; ✓ understands the information needed by other members of the MDT; ✓ consults with and/or refer patient to other healthcare professionals utilising agreed referral pathways; ✓ communicate with other professionals, demonstrating a commitment to promoting quality care; develop self and others in relation to care and support for older people; ✓ Refer to: https://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/A-practical-guide-to-the-local-implementation-of-Integrated-Care-Programmes-for-Older-Persons.pdf
Proactively seek feedback from older persons receiving care, families and staff on their experiences and suggestions for improvement	✓ actively engages with older persons experience of the service; Healthcomplaints.ie - HSE: Your Service Your Say https://www.healthcomplaints.ie/.../hse-your-service-your-say ✓ engender trust so that older people their families and/or carers and healthcare professional colleagues feel confident about sharing difficult problems and feel able to point out deficiencies in care at an early stage; ✓ use research and Quality Improvement (QI) methodologies to systematically collect and interpret feedback on quality and deficits in services and patient experiences;

	✓ use effective communication and research strategies to engage with marginalised and unrepresented groups of older people e.g. travelling community, Lesbian, Gay, Bisexual & Transgender (LGBT)Community; ✓ initiates, manages, and engages in a cycle of audit and evaluation whereby findings and data inform timely changes in the service; ✓ interprets variances in outcomes and metrics, and uses data to improve practice; ✓ uses expert knowledge, relational skills and professional courage to engage in advocacy on behalf of the older person and their interests: ○ Advocacy and being an advocate; ○ supporting autonomy and empowerment; ○ being an advocate for vulnerable groups e.g. older people with learning disabilities, cognitive impairments, intellectual disability and mental illness.
Implement practice changes using negotiation and consensus building, in collaboration with the multidisciplinary team and older persons receiving care	✓ Planning, prioritising and facilitating a case load; ✓ knowledge of the system, how the system operates, who and what is involved at different levels; ✓ create and support opportunity to grow old in an age-friendly environment; ✓ balancing safety and risk to facilitate person-centred care; ✓ complying with quality and safety legislation and regulations and working to enhance quality of person-centred care delivery; ✓ knowing the relevant health and social care systems, care delivery models, policy and political environment pertinent to older people's health and well-being.

6.4.6 Domain 6 Leadership and Professional Scholarship Standard

Standard 6 The RANP Older Persons will lead in multidisciplinary team planning for transitions across the continuum of care

Cues (knowledge, skills, attitudes and behaviours that the cANP/ RANP Older Persons should be capable of demonstrating in practice)	**Key Content** (outlines of knowledge base required to achieve cues)
Demonstrate clinical leadership in the design and evaluation of services	"The scholar demonstrates a life-long commitment to skill and knowledge enhancement as a means to attain personal and professional growth and to promote optimal care and quality of life, and maximize function for the older person" (CGNA 2010). ✓ Have confidence in one's self as a RANP Older Persons and in one's ability to lead; ✓ have a high level of curiosity, critical thinking, continuous learning and reflection; ✓ assume an active role in creating and perpetuating an environment in which professional scholars will grow and be nurtured through sharing and learning; ✓ inspire and support others to achieve their potential; ✓ contribute to service development though evaluation of ANP data collection and monitoring of agreed Key Performance Indicators (KPI's); ✓ actively engage with older persons' policy development, its implementation and evaluation; ✓ leads on the utilisation of IT structures to effectively manage, evaluate and improve on service delivery; ✓ acts as a resource in the design and development of older adult services in hospital and the community; ✓ be professional, compassionate and approachable, have high standards of care, good organisational, interpersonal and communication skills and the ability to cope with the demands placed on them; ✓ advocate to create/enhance positive, health promoting environments and maintain a climate of dignity, compassion and privacy; ✓ Engage with the National Clinical Leadership Centre (NCLC)for Nursing and Midwifery to develop and enhance leadership competence, Visit: https://www.hse.ie/eng/about/who/onmsd/leadership/
Engage in health policy development, implementation, and	✓ Keeps abreast of developing policy; ✓ participate in and actively promote professional and inter-professional networking i.e. (All Ireland Gerontological Nurses Association (A.I.G.N.A.), Irish Gerontological Society (IGS), British Geriatrics Society (BGS), and

evaluation	European networks); ✓ contributes directly and indirectly through professional networks to local, national and international policy and strategies.
Identify gaps in the provision of care and services pertaining to his/her area of advanced practice and apply the best available evidence	✓ Evaluates own performance and the service in which they work; ✓ facilitate service developments and provide new services based upon policy developments, relevant research evidence, audit findings and teaching and learning pursuits.
Lead in managing and implementing change	✓ Be politically aware and engaged; ✓ courage to challenge unfair/discriminatory practices and policies; ✓ be innovative with best practices and ideas, creating and implementing change—being up to date and connected to facilitate practice improvements in older persons care which lead to safe, timely high quality care; ✓ utilise HSE change management resources Change Guide / Leadership & Management Development : Change Management Hub https://www.hse.ie/eng/staff/resources/changeguide/

7 Performance Management and Evaluation

It is vital that cANP/RANPs measure the outcomes and contribution of nursing interventions and initiatives on older persons care. Performance Indicators (PI's) are required to demonstrate the impact of nursing interventions and implement initiatives to improve quality and quantity of the nursing care provided. They should have a clinical nursing focus as well as a breakdown of activity, including patients seen and treated. In addition, they identify areas of good practice that must be recognised and celebrated (HSE, 2015). The Department of Health (2017), *Framework for National Performance Indicators for Nursing and Midwifery* provides a guiding framework for the development of Nursing and Midwifery PI's.

"Performance measurement promotes accountability to all stakeholders, including the public, service users, clinicians and the Government. It does this by facilitating informed decision-making and safe, high quality and reliable care through monitoring, analysing and communicating the degree to which organisations meet key goals (HIQA, 2010, updated 2013). There are three types of PIs: Structure, Process and Outcome" (DOH, 2017).

The HSE have identified a suite of Quality Care Metrics (QCM) for older person's services using a robust academic evidence-based framework they have determined a range of process measures sensitive to the influences of nurses and agreed nationally.
https://www.hse.ie/eng/about/who/onmsd/safecare/qcm/qcm-pppgs.html

Table 4 below summaries the different types of performances indicators (Skills for Health, 2016)

TABLE 4: TYPES OF PERFORMANCE INDICATORS

Structure Performance Indicators	**Process Performance Indicators**	**Outcome Performance Indicators**
Structure PIs relate to the resources of the healthcare system that contribute to its ability to meet the healthcare needs of the population. Structural indicators refer to the resources used by an organisation to deliver healthcare and includes buildings, equipment, the availability of specialist personnel and available finances e.g. • Agency Nurse WTE use • Sick Absence Rate • Staff Turnover Rate	Process PIs relate to the care delivered to the service user and how well it is delivered. Process indicators measure the activities carried out in the assessment and treatment of service users and are often used to measure compliance with recommended practice, based on evidence or the consensus of experts e.g. • Medication administration practice • Assessment of falls risk • Assessment of pressure ulcer risk	Outcome PIs relate to the stage of health of the individual or population resulting from their interaction with the healthcare system. It can include lifestyle improvements, emotional responses to illness or its care, alterations in levels of pain, morbidity and mortality rates and increased level of knowledge e.g. • Incidence of falls • Incidence of pressure ulcers • Patient experience of care

In collaboration with Local Working Group the cANP/RANP need to identify and develop nursing PI's for their area of older persons practice, collect and collate data which will provide evidence of the impact and effectiveness of their role aligned to Recommendation 2, Action B; DOH Policy 2019 p.84.

APPENDICES

7.1 Appendix 1 - Consultation Overview

As part of the development of this Framework the NCPOP undertook an extensive consultation process at national, regional and local level. The NCPOP wishes to acknowledge those individuals / groups that have contributed to the final document. Their views have been considered in the revisions made to this Clinical Guidance Framework, culminating in this published version.

Stakeholder Consultation
Chief Nursing Office Department of Health
Higher Education Institute (UCC,NUIG,TCD & UCD)
Nursing and Midwifery Board of Ireland
Office of the Nursing and Midwifery Services Director
Nursing and Midwifery Planning & Development Units
Centres of Nursing & Midwifery Education
Office of the Nursing and Midwifery Services Director- Advanced Practice Network
Irish Association of Directors of Nursing and Midwifery
Irish Association of Advanced Nurse Midwife Practitioners
National Clinical Programme Older People ANP Network
National Clinical Programme Older People NCPOP Nurse Interest Group
National Clinical Programme Older People Clinical Advisory Group
National Clinical Programme Older People Working Advisory Group
Integrated Care Programme Older Persons
Irish Society of Physicians in Geriatric Medicine
Group Directors of Nursing
Directors of Nursing Acute hospitals
Directors of Public Health Nursing
Directors of Nursing Older Persons Services
Directors of Nursing Intellectual Disability Services
Practice Development Coordinators
Community Health Care Organisations
Managers Older Persons Community Services

7.2 Appendix 2 - Business Case Template Advanced Nursing Practitioner Services 2018

Introduction

Advanced nursing practitioner services are developed as a direct response to current, emerging and future patient/women and their babies/service/health needs and organisational requirements at local and national level. Advanced practice services must have a vision for areas of nursing led practice, developed beyond the current scope of nursing practice. The focus will be on person-centredness, quality, safety, driving integration between services, improving timely access to services, promoting hospital avoidance, improving patient flow and allowing early discharge, along with a commitment to the development of these areas (DoH,2017). The value of the nursing contribution as a distinct profession must be safeguarded and articulated in the development of new services led by RANPs/RAMPs (NMBI. 2017 p.9; NMBI. 2018 p.7). The steps outlined in the Strategic Framework for Role Expansion of Nurses and Midwives (DoH, 2011) support the necessary considerations for nursing service development.

The identification and confirmation of these specific service developments within HSE and HSE funded service areas is the responsibility of Chief DoNM Hospital Groups/DONs/Service Managers. The ONMSD through the NMPDUs provide support and guidance to the DON services in the preparation of business cases for presentation to the Senior Management Teams for approval and sign off. The business case should be supported with all available evidence.

Guidance on next steps

- Compile and present a business case to senior management team for approval and sign off
- Financial approval for WTE
- Recruit and appointment of ANP/AMP candidate
- Establish a Key Stakeholder Governance Group/ Local Implementation Group
- Support the cANP/cAMP in meeting the eligibility criteria for registration as a RANP/RAMP with the Nursing and Midwifery Board of Ireland: Academic Preparation; Clinical Supervision; Clinical Practice; Portfolio Development

References:

- *Adapted from: Service Needs Analysis: Informing Business and Services Plans, National Council for the Professional Development of Nursing and Midwifery, November (2009)*
- *Department of Health (2017) Policy for Graduate, Specialist and Advanced Nursing and Midwifery Practice, Dublin: Office of the Chief Nursing Officer, Department of Health*
- *Nursing and Midwifery Board of Ireland (2017) Advanced Practice (Nursing) Standards and Requirements*
- *Nursing and Midwifery Board of Ireland (2018) Advanced Practice (Midwifery) Standards and Requirements*
- *The Department of Health (2011) Strategic Framework for Role Expansion of Nurses and Midwives: promoting quality patient care.*

TEMPLATE FOR BUSINESS CASE	
Name(s) and title of DON/DOM/Service Manager developing the business case	
Name of hospital/hospital group/CHO area	
Name & Addresses of other organisations involved - if applicable	
Business Case should address	
Proposition	This should include the: Title, role, and location of the proposed service Number of ANPs/AMPs proposed for the service Proposed hours of the service
Context	**Brief rationale for the proposed post to include details of the service:** • What service does the unit/service/catchment area provide? • What client group is served by the unit/service/catchment area? • What are the possible future developments for the service? • What is the team structure? • What area is covered by this service? • How the proposed post fits into the service plan for the organisation • How the post will impact on the service user and the healthcare setting • Integration of the role including collaboration with other specialties and with other services e.g. hospitals/ hospital groups/ CHO area
Service Needs Analysis	The identification of the need for advanced practice roles is the first vital step in the process of establishing the post or service. **International/national/local evidence forms part of the needs analysis and involves reviewing relevant information for example:** • Epidemiology or disease patterns • Population health/demographics • Scale of the challenges within the organisation • Hospital/service data/organisational drivers i.e. local service plan, local statistics on disease trajectory/results of audits/waiting list targets/Key Performance Indicators/ED attendance & presentation categories/ PET in ED and AMAU/ Length of stay/delayed discharges etc • Relevant regional and national health policy documents e.g. National Clinical & Integrated Care Programmes, National Service Plan, Healthy Ireland Strategy, Sláinte Care, CNO DoH Policy documents, Local Organisational requirements • Geographic context of service provision e.g. population served, catchment area, outreach service options, care closer to home etc. • Current roles and potential areas for development of services to patients/clients i.e. nursing role differentials

Data supporting the identification of the need for RANP/RAMP service to include:

- Identification of gaps within services that an RANP/RAMP service can address
- How the RANP service will contribute to the overall delivery of patient care
- How will the proposed RANP service meet objectives of access to services, hospital avoidance, early discharge, addressing waiting lists, improving patient flow, and integration of care/services - Demonstrate by using data and highlight the skillset /competencies that the RANP will bring to the service.

Estimated savings:

- Look at healthcare spending currently which can be different to what is budgeted for- for example unexpected rises in cases, new technologies etc.
- Identify what could be saved by the introduction of this new role.
- Outline a plan for the proposed future sustainability of the RANP service

Organisational Impact

National and International research has identified the benefits of advanced nurse/midwife practitioner roles which lead to improved health outcomes. These include:

- Shorter waiting times
- Increased patient satisfaction
- Improved health education for patients
- Increased quality and cost effective care
- Reduction in complaints
- Improved staff satisfaction
- Improved continuity and consistency of care.

(Mason et al., 2013; Cole et al., 2001; Griffen & Melby, 2006; Coopers & Lybrand Health Practice, 1996; Dolan et al., 1997; Dunn, 1997; Maclaine, 1998; Byrne et al., 2000a; Walsh, 2001; Sakr et al., 2003; Roblin et al., 2004; McGee & Kaplan, 2007; Small, 1999; Dunne, 2001).
Articulate the benefits of the proposed role under the headings outlined below for e.g.

Service Impact:

- Quality streamlined service
- Caseload management will be provided by an expert experienced registered practitioner
- Provision of education and support to other nursing and other healthcare colleagues
- Quantify the impact of the role on key performance areas such as: quality, reduced waiting times, increased patient satisfaction
- Reduction in re-admission rates
- Reduction in waiting lists and times
- Identify key performance indicators to be used to obtain patient and service outcomes as a result of the introduction of the role.

Patient Impact:

- Quality of life benefits for patients attending advanced practice service
- Reduced hospital visits for patients through access to telephone service/outreach services etc.
- Patients availing of the advanced practice service will receive comprehensive and holistic care for their condition
- Early interventions will minimise interruptions to treatment regimens and unnecessary hospital admissions thus improving patient outcomes
- Improved continuity of care which will reduce patient anxiety
- Key contact for patients or significant other if they develop any concerns
- Seamless follow-up for patients
- Acknowledge and address disease progression issues thus improve patients' and carers'

	quality of life • Reduced waiting times for patients attending advanced practice led clinic • Improved patient and staff satisfaction. **Nursing Impact:** • Opportunity to provide health promotion, education and intervention • Opportunity to initiate and conduct nursing research and audit, to inform future practice and care delivery • Utilisation of evidence based nursing /midwifery research in practice • Appropriate utilisation of nursing resources.
Governance and Supervision arrangements	The RANP/RAMP is a senior clinical decision maker within the organisations. An integral and underpinning component of all aspects of the advanced practice role is the application of governance structures to ensure quality, risk, and safety are managed appropriately and effectively in all aspects of the role, both from the perspective of the individual practitioner, the organisation and the service user. An organisational chart should be included which outlines the reporting relationships within the organisation. The governance arrangements need to stipulate that the organisation is in compliance with the Advanced Practice (Nursing) Standards and Requirements (NMBI 2017). Reference should be made to governance arrangements that span organisational boundaries i.e. Hospital/Hospital Group/CHO area etc. A description of the professional and clinical supporting mechanisms which are in place to support the advanced practice role should be provided and needs to include the following: **Professional:** Director of Nursing liaison with Assistant Director of Nursing/Directorate Manager, and liaison with clinical Nursing Colleagues **Clinical:** Consultants in specialist area, clinical supervision, both formal and informal and clinical exposure **Professional Development-ongoing portfolio maintenance:** Ongoing education, maintenance of competence, review of scope of practice, master classes, monthly CPD teaching sessions, poster presentations etc. **Clinical Supervision:** The Registered Advanced Nurse/Midwife Practitioner (RANP/RAMP) will undertake clinical supervision in the following ways: Informally on a daily basis with consultant Case discussions: The RANP/RAMP will as part of the team present clinical cases for discussion with the consultant Formal clinical supervision: a scheduled thirty-sixty minute session each month will be dedicated to formal clinical supervision between the consultant and the RANP/RAMP.
Human Resource & Financial considerations	**Human Resources:** • Whole time equivalent (WTE) allocation • Recruitment process, appointment of a candidate ANP/AMP • Cost of achieving educational requirements for the post • Skills and competency development e.g. clinical exposure in another site

- Cost implications and associated backfill replacement costs
- Time costs in terms of developing the site for accreditation
- Identify savings in staff costs such as reduction in the requirement to call medical personnel.

Other costs:
Estimated costs, non-recurring (once off) costs,

- Equipment, training, evaluating and continuing costs.
- Demonstrate the commitment to provide the necessary supports for e.g. location of clinical space/office space, ICT support, etc

If Applicable:

		Date:
Signature of Business Case Developer		
Signature of Director of Nursing		

7.3 Appendix 3 - Terms of Reference Local Working Group

Candidate Advanced Practice (Older Persons)
Local Working Group
Terms of Reference Template

Introduction
The role of the Candidate Advanced Nurse Practitioner (cANP) Older Persons Local working Group is to oversee and steer the development of the role and job description for the post. Support at local level is required to facilitate the development of candidate Advanced Nurse Practitioners (cANP's) as they progress to become Registered Advanced Nurse Practitioners (RANPs) in the area of older persons care. In achieving specific competences the cANP develops his/her capabilities to extend his/her practice in line with service needs and evidence based competencies.

Aims of the Older Persons Hospital Group/CHO Local Working Group
The main aims of the Older Persons Hospital Group/ CHO LWG are to:

- Oversee and steer the development of the ANP service and to report on progress to the Hospital/CHO Local Implementation Group.
- Support candidate ANPs in meeting the NMBI criteria for registration as an Advanced Nurse Practitioner, as set out in the Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017)

Objectives of the Older Persons Hospital Group/ CHO LWG
The objectives are as follows:

- Agree effective governance structures to support the role of the cANP/ Registered Advanced Nurse Practitioner (RANP) Older Persons.
- Monitor alignment with National Clinical and Integrated Care Programmes Older Persons.
- Ensure compliance with Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017).
- Report progress to the Local Implementation Group.
- Identify and mitigate or escalate risks as appropriate.

Overview of Older Persons Hospital Group/CHO Local Working Group
Advanced nurse practitioner roles are developed as a direct response to population health need and organisational requirements, as identified though local and national planning processes. The identification and confirmation of these specific role developments within HSE service areas is the responsibility of Chief Directors of Nursing, DON's, , DPHNS and Service Managers in collaboration with the NMPD Director.

Roles & Responsibilities
The main purpose of the Candidate ANP Older Persons role is to:

- Develop the job description and supporting documentation under the direction of the Local Working Group, to enable the individual nurse to meet the NMBI Criteria for Registration as an Advanced Nurse Practitioner as set out in Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017).
- Undertake the academic preparation and develop the clinical and leadership skills, competencies and knowledge required to meet the criteria to be registered as a RANP with NMBI. The scope of the cANP role must reflect the incremental development of expertise and as such, the cANP cannot deliver care as an autonomous practitioner.
- Develop and submit their personal portfolio and all other necessary documentation to NMBI in order to register as a RANP.

Local Working Group Members

- Identify service need for the role by examining supporting data from local area, local population demographic and need – presentations, diagnoses, gender, age profile, reality of current service etc.
- Provide direction to the cANP Older Persons in establishing the new service.
- Discuss and agree the Scope of Practice at an advanced level.
- Agree the broad range of illnesses/conditions/health needs that can be managed by the cANP/RANP Older Persons.
- Agree the inclusion and exclusion criteria for the caseload.
- Agree the range of therapeutic interventions to be provided by the cANP/ RANP Older Persons .
- Determine the specific competences required by the cANP/ RANP Older Persons to manage the agreed caseload and ensure supporting structures are in place to enable achievement of competences (HEI & Associated Health Care Provider).
- Agree appropriate referral pathways to and from the cANP/ RANP Older Persons.
- Develop a Service Level Agreement (SLA) for Clinical Supervision.
- Identify and establish structures to support the advanced practice service e.g. Policies, Procedures, Protocols and Guidelines (PPPGs) / Service Level Agreement (SLAs)/ Memoranda of Understanding (MOU).
- Promote market and advocate the importance and value of the development of the RANP Older Persons service within Older Persons Hospital /CHO.
- Discuss and agree Key Performance Indicators applicable to the service that are consistent with DOH objectives.
- Ensure that the service being developed is aligned to national policy direction e.g. National Clinical and Integrated Care Programmes.
- Assist the cANP in preparing the job description.
- Support the individual nurse(s) in meeting the NMBI criteria for registration as an Advanced Nurse Practitioner, as set out in the Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017).

Membership of the Older Persons Hospital Group LWG

The NMPDUs {insert} will provide support to the Older Persons Hospital Group LWG, as required. Support may also be available from the national clinical and integrated care programmes.

Suggested membership of the Older Persons Hospital Group / CHO LWG may include the following

- Director of Nursing / Assistant Director of Nursing
- Consultants/ Consultant/ Clinical Lead
- Candidate ANP
- NMPD Officer
- ADON Medical Directorate
- Clinical Nurse Manager
- Health and Social Care Professional Representatives (as appropriate)
- Pharmacy, Radiology and Laboratory Representatives (as appropriate)
- Representatives from other areas may be invited as required

Accountability

The Local Working Group is operationally accountable to the Hospital Group /CHO Local Implementation Group.

Chairperson

The Chairperson will be the Director of Nursing / Assistant Director of Nursing.

Frequency and Duration of Meetings

The Older Persons Hospital Group/CHO LWG will meet monthly initially

Quorum:
{Adapt as relevant to the Older Persons Hospital Group / CHO Area}

Minutes and Agenda of Meetings
The agenda and minutes of previous meeting will be sent out one week in advance of the scheduled meeting and accompanied by any supporting documentation.

Administrative Support
Administrative support should be available to the Local Working Group as required.

Term
The Advanced Practice (Nursing) Local Working Group Terms of Reference (TOR) is effective from the establishment of the group and will be ongoing until terminated by agreement between the parties.

Approved by: _____

Date: _____

Chairperson of the Advanced Practice (Nursing) Hospital Group/CHO Local Working Group

7.4 Appendix 4 - Meeting Notes Template

Candidate Advanced Nurse Practitioner Older Persons Local Working Group Meeting Notes

Date:

In Attendance:

Apologies:

Agenda Item	Discussion/Decision/Action	Responsibility for Action	Timeframe
Welcome & Introductions			

7.5 Appendix 5 - Acknowledgements

- Dr Diarmuid O' Shea, Clinical Lead, National Clinical Programme for Older People
- Helen Whitty, Programme Manager, National Clinical Programme for Older People
- Ms Deirdre Lang, Director of Nursing/National Lead Older Persons Services, Clinical & Integrated Programmes, Office Nursing & Midwifery Services Director
- Dr Siobhán Kennelly, NCAGL for Older Persons, HSE
- Dr Rónán O' Caoimh, Consultant Geriatrician, Mercy University Hospital, Cork
- Ms. Mary Wynne, Interim Nursing and Midwifery Services Director, Office of the Nursing & Midwifery Services Director (ONMSD)
- Ms. Mary Frances O'Reilly, Director, Nursing and Midwifery Planning and Development Unit & ONMSD Lead Advanced Practice
- Nursing & Midwifery Planning and Development Officers, ONMSD Advanced Nursing & Midwifery Practice Network
- Ms. Geraldine Shaw, Area Director ONMSD & Clinical Strategy and Programmes

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