Aims and objectives. The aim of this study was to review dementia nursing competencies. The objectives were to explain the relevancy of dementia competencies across care settings and levels of practice.

Background. Dementia is strongly associated with increasing age and as the world population ages there is an imperative to ensure the healthcare workforce is fully equipped to meet the needs of people with dementia and their carers.

Design. A literature review study addressed the research aim and objectives.

Method. Literature sources were (i) academic databases, (ii) the internet and (iii) snowballing. Search terms were ‘dementia’, ‘care standards’, ‘training and education’ and ‘competency’.

Results. The sample consisted of 59 reviewed publications. A synthesis of the findings generated 10 dementia competencies: (i) Understanding Dementia; (ii) Recognising Dementia; (iii) Effective Communication; (iv) Assisting with Daily Living Activities; (v) Promoting a Positive Environment; (vi) Ethical and Person-Centred Care; (vii) Therapeutic Work (Interventions); (viii) Responding the needs of Family Carers; (ix) Preventative Work and Health Promotion and (x) Special Needs Groups. There were also five levels of practice: (i) Novice; (ii) Beginner; (iii) Competent; (iv) Proficient and (v) Expert and no care setting specific competencies were generated.

Conclusion. Government initiatives demonstrate commitments to dementia, such as Australia’s adoption of dementia as a National Health Priority and the UK National Dementia Strategy. Registration boards for the nursing workforce in Japan and the UK included dementia competencies in generalist frameworks to emphasise the importance of dementia as a healthcare issue. This study demonstrated that there is no dementia competency framework relevant across care settings or levels of practice.

Relevance to clinical practice. An empirical study will develop a multi-disciplinary dementia competency framework relevant across care settings and levels of practice to ensure the healthcare workforce can effectively deliver services to people with dementia and their carers.

Key words: competency, dementia, gerontology, literature review, mental health

Accepted for publication: 13 August 2010

Introduction

In Australia, the recognition that dementia is strongly associated with increasing age (Access Economics 2006, Australian Institute of Health and Welfare 2007) and the imperative that contemporary societies, with their ageing populations, be fully equipped to meet the needs of people with dementia have been acknowledged with the adoption of dementia as a National Health Priority (Department of Health and Ageing 2005). Dementia is ‘the most likely...
condition to be associated with a profound or severe core activity limitation among older people’ (Australian Government Department of Health and Ageing 2006) and one of the main reasons older people access healthcare services. It is, therefore, important that healthcare workers develop a thorough understanding of dementia and are competent to deliver dementia care services. The term ‘competent’ is used purposefully to describe practitioners capable of effectively delivering dementia care (Gonczi et al. 1993, Eraut 1994, Redfern et al. 2002, Watson 2002, Watson et al. 2002, Cowan et al. 2005).

As the epidemiological data demonstrate, dementia is relevant to most healthcare settings. People with dementia and their carers receive services from a range of healthcare workers, particularly nurses, who work across community, acute and residential care settings and at the level of registered nurses, enrolled nurses and support care workers. It is important to consider how registered nurses ensure they meet the needs of people with dementia and their carers and work within a model of care in which support care workers deliver the care.

This study aimed to explore these issues through a literature review of dementia nursing competencies across care settings and levels of practice. There were few dementia-specific resources to draw on; thus, the sources accessed included competencies, care standards and education in generalist, mental health and gerontological nursing.

These resources were potentially useful to inform the development a dementia competency framework relevant across care settings and levels of practice. It is important to develop a competency framework in this way because practitioners and support workers require distinctive knowledge, skills and attitudes in different settings. The needs of people with dementia and their carers in different settings are also distinctive and the roles of practitioners and support workers need to be articulated clearly to ensure the effective delivery of services.

Background

It is important to define terms used to describe dementia nursing competencies across care settings and levels of practice.

Competence and competencies

The definitions informing this study drew on the work of the Australian academic Andrew Gonczi, who has influenced the role of competence and competencies in teaching and healthcare (Eraut 1994). Gonczi et al. (1993) suggest competencies are derived from professions possessing a certain set of relevant attributes defined by a combination of ‘knowledge, skills and attitudes’. No one attribute is sufficient to describe an individual or profession as competent. Rather, a combination of knowledge, skills and attitudes is necessary for an individual or profession to be regarded as competent.

Method

There is a description of the literature search and critical analysis of the sources accessed (Hart 2001, Cochrane Collaborations 2006).

Search strategy

A prerequisite key word ‘dementia’ and ‘alzheimer’s’ to ensure USA sources accessed was included in all search combinations (Table 1).

Three search strategies were adopted:

- **Search strategy 1**: Academic databases, including CINHAL, Medline, the Australasian Digital Thesis Program and the USA Virginia Henderson Library for nursing.
- **Search strategy 2**: Grey literature using a ‘Google’ search, resulting in the identification of publications from peak bodies, regulatory organisations, charitable and non-government organisations and policy documents.
- **Search strategy 3**: Snowballing technique to search secondary sourced references.

In this way, a sufficiently broad and systematic approach ensured access to up-to-date sources was achieved.

<table>
<thead>
<tr>
<th>Search terms used</th>
<th>Table 1 Summary of search terms used in combination with ‘dementia’ or ‘alzheimer’s’</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘dementia’ OR ‘alzheimer’s’ AND</td>
<td>‘competenc*' OR ‘competenc* standard*'</td>
</tr>
<tr>
<td>‘competenc*' OR ‘competenc* statement*' OR</td>
<td>‘education*' OR</td>
</tr>
<tr>
<td>‘care standard*' OR</td>
<td>‘geront*' OR ‘geriatric*’ OR</td>
</tr>
<tr>
<td>‘mental health’ OR ‘psychogeriatric*’</td>
<td></td>
</tr>
</tbody>
</table>
Inclusion criteria

The review included guidelines for care standards, education programmes and competency frameworks and generalist, mental health and gerontological sources. The term ‘nurse’ included registered nurses, enrolled nurses and support care workers. The differences between registered nurses (second-level nurses in the UK), enrolled nurses (certified nurses in the USA or first-level nurses in the UK) and support care workers (assistants in nursing or ‘unregistered’ practitioners) are determined through registration or regulation, training requirements and delegated levels of responsibility.

Exclusion criteria

Sources that excluded were those focusing on rare forms of dementia occurring in children. Sources describing medical or social models of dementia care were also excluded, for example, models of care or services managed by medics or social workers. These exclusion criteria were set postsearching when selecting publications to review. The outcome is that ‘nursing’ and ‘adults’ are the focus of the publications accessed and reviewed.

Quality reviewing of publications accessed and reviewed

Most publications identified came from grey literature sources. These included local, state and national policy directives; frameworks from ‘peak bodies’ responsible for regulating healthcare practitioners and the aged care industry; non-government and charitable organisations; and unpublished reports. Too few of the publications identified were derived from high-quality research methods; rejection on grounds of poor quality research was inappropriate. A broad definition of ‘academic’ publications was adopted to describe the non-grey literature sources identified. This was appropriate because of the limited number of peer review publications. Thus, we included clinical, practice and opinion-based publications (Hart 2001, Cochrane Collaborations 2006).

Findings

Of the 164 publications identified, a total of 59 publications were accessed and reviewed. Most publications (86%) were from grey literature sources; only 14% were from academic sources (Table 2). The findings had an international perspective, with sources from Australia, Canada, Japan, the USA and the UK.

The findings from a critical analysis of the content of the 59 publications informed the creation of a framework to explain dementia nursing competence and competencies (Table 2). Throughout the literature review, special needs groups were considered and ideas about how to include their needs in a competency framework were sought. None of the publications, from Australia and beyond, included reference to the needs of Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse or Rural and Remote communities.

Theme 1. Generalist: competency frameworks

Although regulatory bodies involve specialist organisations in the development of its guidelines outlining the expectations of registered practitioners across specific clinical specialities (for example the John A. Hartford Foundation Institute for Geriatric Nursing) few specifically describe specialist expectations. An exception from the UK (Department of Health 2006) addressed competencies and capabilities for mental health practitioners with specifics about dementia competencies to be included at a preregistration level. There was a similar document from Australia outlining a multi-disciplinary competency framework for mental health workers (National Mental Health Education and Training Advisory Group, National Education and Training Initiative and National Mental Health Strategy 2002) but lacks articulation of clinical specialisation at a preregistration level.

<table>
<thead>
<tr>
<th>Theme No.</th>
<th>Title of theme</th>
<th>No. of publications sourced</th>
<th>Grey literature</th>
<th>Academic publication</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1</td>
<td>Generalist: competency standards</td>
<td>11</td>
<td>0</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Theme 2</td>
<td>Gerontological: educational frameworks</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Theme 3</td>
<td>Gerontological: competency frameworks</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Theme 4</td>
<td>Dementia: standards of care</td>
<td>13</td>
<td>0</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Theme 5</td>
<td>Dementia: educational frameworks</td>
<td>9</td>
<td>6</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Theme 6</td>
<td>Dementia: competency frameworks</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td></td>
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<tr>
<td>Total</td>
<td></td>
<td>51</td>
<td>8</td>
<td>59</td>
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</tbody>
</table>
In 2005, the Japanese Nursing Association (Japanese Nursing Association 2005) adopted a similar approach to the UK Department of Health (2006) mental health model. The Japanese nursing standards addressed the specifics of dementia care by adding gerontological competencies. It was important to review generalist competency frameworks in this study to understand how regulatory bodies addressed clinical specialisation. It was also useful to understand how regulatory organisations addressed important areas of healthcare need. The UK and Japanese regulatory bodies understand the need to ensure that practitioners’ competencies are contemporaneous by including dementia competencies to reflect the needs of an evolving society.

Theme 2. Gerontological: educational frameworks

As the search became more specific, gerontological nurse education publications were discovered. The John A Hartford Foundation Institute for Geriatric Nursing (2002) in the USA offers a range of professional development and academic modules in ‘gerontological nursing care’. Its specialist curriculum includes what gerontological nurses learn, for example, one module focused on depression, delirium and dementia and guidance for the specialist nursing roles in dementia using these assessment tools and treatment strategies.

Curriculum standards for a Japanese clinical specialist course in gerontology also addressed dementia care in three essential areas (Noguchi 1996):
1. Gerontology in hospital and care facilities
2. Gerontology in homes
3. Dementia care.

Thus, dementia is included as a core activity for gerontological nurses in Japan. Experts defined the content of these publications and described the essential elements of dementia as a clinical specialty. This content now needs translated into dementia competencies.

A partnership between the American Association of Colleges of Nursing & John A Hartford Foundation Institute for Geriatric Nursing (2000) has outlined essential competencies for degree-prepared nurses specialising in aged care. In this way, they usefully integrated education programmes within their competency frameworks. Two other USA publications (Crabtree et al. 2002, John A Hartford Foundation & American Association of Colleges of Nursing 2004) also include dementia in a gerontological nursing context but their detail is insufficient to provide insight into dementia-specific content for a competency framework.

A ‘principles’ paper outlining core components of the aged care undergraduate nursing curriculum and an accompanying web-based resource with supporting educational activities (Queensland University of Technology 2004, 2007) are potentially important initiatives in Australia. Neither resource includes sufficient detail about dementia care to inform a competency framework but they provide building blocks from which to develop undergraduate dementia curriculum. The NSW/ACT Dementia Training Study Centre (http://dementia.uow.edu.au) used these resources as a launch pad for further undergraduate content development.

Theme 3. Gerontological: competency frameworks

In the USA, a core set of hospital nursing competencies, developed by the John A Hartford Foundation Institute for Geriatric Nursing (2002), explicitly addressed dementia. They emphasised the importance of assessment, including the use of scales differentiating dementia from delirium or depression. This framework clearly reflected the content of the institute’s gerontological education programme, as discussed (John A Hartford Foundation Institute for Geriatric Nursing 2002). This example illustrates a useful specialist competency framework addressing the specific dementia knowledge and skills required by gerontological nurses but more detail was required about how their use contributed to the delivery of effective nursing care to people with dementia and their carers.

By contrast, the gerontological standards developed in Australia for advanced gerontological nurses (Geriaction 2000) did not deviate sufficiently from generalist competencies (Australian Nursing and Midwifery Council 2006a,b) to be useful (Traynor 2005). There is a need for further development of this work in Australia. In Scotland, a specialist gerontological portfolio included useful guidance on working towards ‘Enhanced competence in caring for older people’ (National Health Service Scotland 2003). A distinguishing feature of this competency framework was that higher-level concepts were described using six ‘domains’ of practice necessary for enhanced gerontological competence (Table 3). Another distinguishing feature was the inclusion of details about how to work towards achieving gerontological nursing competence across five levels of practice (Table 4).

These authors also developed guidance on developing a portfolio and gathering evidence to achieve the competencies (National Health Service Scotland 2003). Practitioners used this documentation to inform the type of evidence they generated from an ongoing evaluation of their dementia care and demonstrate externally the level of competence at which they were practising.

Another report from Scotland, ‘Older people with long term conditions competency framework’ (Marshall et al.
Table 3 Summary of the six domains for ‘enhanced competence in caring for older people’

<table>
<thead>
<tr>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respecting and valuing older people as individuals</td>
</tr>
<tr>
<td>2. Maximising the capability of older people</td>
</tr>
<tr>
<td>3. Providing holistic and individualistic care and treatment for older people</td>
</tr>
<tr>
<td>4. Delivering person-centred care within a multi-professional and multi-agency context</td>
</tr>
<tr>
<td>5. Maximising older people’s capacity to communicate effectively</td>
</tr>
<tr>
<td>6. Develops effective partnerships with family members and carers</td>
</tr>
</tbody>
</table>

Adapted from National Health Service Scotland (2003).

Table 4 Summary of the five levels of competency for ‘enhanced competence in caring for older people’

<table>
<thead>
<tr>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Novice</td>
</tr>
<tr>
<td>2. Beginner</td>
</tr>
<tr>
<td>3. Competent</td>
</tr>
<tr>
<td>4. Proficient</td>
</tr>
<tr>
<td>5. Expert</td>
</tr>
</tbody>
</table>

Adapted from National Health Service Scotland (2003).

2006, demonstrates 10 competencies, with five competency levels ranging from novice to expert (Table 5). The framework is a succinct assessment tool, but distinguishing between dementia competencies is not straightforward. This framework included useful information about how to establish different levels of competence in a dementia nursing competency framework relevant across levels of practice.

A UK report from the Royal College of Psychiatrists (2005) outlining the core competencies required for mental health nurses liaising with older people was surprising in its superficial reference to specific dementia competencies. Dementia is an important health issue for older people. A gap remains within these core competencies for mental health nurses. The addition of dementia competencies would be useful.

Table 5 Summary of four levels of competence in dementia nursing

<table>
<thead>
<tr>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic core competencies</td>
</tr>
<tr>
<td>2. Advanced competencies</td>
</tr>
<tr>
<td>3. Specialist competencies</td>
</tr>
<tr>
<td>4. Strategic directions</td>
</tr>
</tbody>
</table>

Adapted from Marshall et al. (2006).

Theme 4. Dementia: standards of care

Resources were also available describing standards for dementia care. GeroNurseOnline 2006, a USA resource, includes information and resources for geriatric nursing; dementia is one of 24 areas of essential geriatric care. The resource consists of a range of assessment and screening tools, including nine dementia tools. The Australian ‘Dementia Care Kit’ (Department of Health and Ageing 2006b) is a similar dementia-specific resource. These were useful resources but guidelines for their use were not included. There is an opportunity for competency frameworks to fill these gaps and articulate how care can be effectively delivered.

The Registered Nurses’ Association of Ontario (2003, 2004) in Canada developed a best practice ‘delirium, dementia and depression’ guideline. Nurses were encouraged to use the guideline to improve screening assessment and differential diagnosis of delirium, dementia and depression. The level of evidence attached to each of the recommendations and the guideline enabled registered nurses to be aware of the supporting evidence for each clinical practice. However, the authors explained that the guideline focuses on assessment and lacks an explanation of nursing practice (Registered Nurses’ Association of Ontario 2003, 2004).

The recommendations on care-giving strategies for older adults with delirium, dementia and depression, found in the brief summary from the National Guideline Clearinghouse (2007) from the USA, were similar in that they articulated the level of supporting evidence for each recommendation. Thirty-five recommendations were gathered and the degree and type of evidence for each was included. This resource contained useful information for gerontological nursing generally and, to some extent, dementia care specifically. It emphasised clinical issues, rather than issues relevant to assisting with daily living (National Guideline Clearinghouse 2007). This made it difficult to determine specific dementia nursing competencies from this source.

Alzheimer’s Australia (2007a,b) published detailed guides on delivering quality residential dementia care. They included a description of dementia care from management and practical/clinical perspectives. Evidence of healthcare workers’ and families’ experiences informed the content, enhancing its validity. The publication was designed to meet the needs of all residential care healthcare workers, including nurses, domestic and kitchen staff and gardeners. It is therefore difficult to extract relevant information for dementia nursing.

The Alzheimer’s Association (2005), in the USA also provided dementia care practice recommendations, which were developed from a comprehensive literature review and
interventions evaluated by expert panels. Similarly, the UK Alzheimer’s Society (2007) provided standards in dementia care, such as home care and person-centred care. The usefulness of these documents is limited because the qualifications, responsibilities and duties of nurses were not articulated. Therefore, these resources cannot be used readily to inform the content of a dementia nursing competency framework.

There were also resources outlining best practice for the care of people with dementia in acute care settings (Willick & Willick 2001, Archibald 2003, Greater Metropolitan Transition Taskforce 2003, Nay et al. 2003, Norman 2003, Royal College of Psychiatrists 2005, 2006, Health and Social Care Change Agent Team 2006, Silverstein & Maslow 2006). These resources are useful to inform the content of acute care dementia nursing competencies and ensure a dementia nursing competency framework is relevant across care settings.

Theme 5. Dementia: educational frameworks

Dementia education frameworks were also potentially useful resources. As discussed, dementia can be described as a gerontological, psychiatric or psychogeriatric speciality. Regardless of the arena where dementia is classified, topics surrounding dementia are necessarily broad because of its impact on many aspects of health. Dementia education programmes reflect this broad scope and the potentially wide-ranging audiences to reflect the different qualification levels of staff work when caring for people with dementia and their carers, including undergraduate and postgraduate degrees, vocational training and professional development activities.

Alzheimer’s Australia (2007c) provides competency-based accredited dementia training for support care workers using a model of Vocational Educational Training. The content focuses on three areas:
1. Effective communication
2. Meaningful activities

The programme aims to meet the needs of support care workers from care settings including family homes, community day care and residential homes (Alzheimer’s Australia 2006).

Organisations adopting competency terminology to articulate the duties and tasks of dementia care personnel structure their education programme differently from Alzheimer’s Australia (2007c). For example, the Oregon State Board of Nursing (2006) emphasises the number of curriculum hours to be completed, the work required within 11 domains of care and detail about the learning needed by support workers aiming for certification as dementia specialists.

Other organisations addressed the broad issue of aged care training in residential facilities (Oklahoma Department of Career and Technology Education 2003, Booth et al. 2005). Internationally, many aged care providers adopt ‘Dementia Care Mapping’ to structure the content and delivery of dementia education (Brooker 2005). In Australia, the Aged Care Standards and Accreditation Agency (2004) addressed the issue of dementia training through a course, ‘Demystifying Dementia’, consisting of six specialist modules. This development demonstrates a commitment to acknowledging the importance of dementia education in aged care facilities. In the USA, the Wayne State University (Curtin 2006) has a long established dementia education programme with a ‘Train the Trainer’ focus, consisting of five specialist modules (Table 6).

This material was useful to inform practitioner education regardless of practitioner level. The level of detail provided was insufficient to inform an in-depth model of dementia education for nurses working with people with dementia and their carers across settings and levels of practice.

In the tertiary and higher education sector, there was a paucity of dementia education. In Australia and the UK, mapping exercises of nursing curricula content revealed an ad hoc and sparse inclusion of dementia education in undergraduate courses (Department of Health and Ageing 2006c, Pulsford et al. 2007). The NSW/ACT Dementia Training Study Centre addressed this by building on the work of the Queensland University of Technology (2004, 2007) to develop seven fully online multi-disciplinary modules for undergraduate healthcare students:
1. ‘What is Dementia’
2. ‘Recognising Dementia’
3. ‘Communication in Dementia Care’
4. ‘Care Partners and Families Across Dementia Care Settings’
5. ‘Younger Onset Dementia’
6. ‘Dementia within Culturally and Linguistically Diverse Communities’

Table 6 Summary of the five key modules in the ‘train the trainer’ dementia education programme

<table>
<thead>
<tr>
<th>Summary of five key dementia modules</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Putting the person first in dementia care</td>
</tr>
<tr>
<td>2. Environment</td>
</tr>
<tr>
<td>3. Assisting a person with dementia with activities of daily living</td>
</tr>
<tr>
<td>4. Mealtime and the person with dementia</td>
</tr>
<tr>
<td>5. Enhancing the bathing experience</td>
</tr>
</tbody>
</table>

Adapted from Wayne State University Training module: Managing difficult behaviors (Curtin 2006).
Postgraduate dementia care education now exists. These include Master of Sciences and professional development programmes in the UK (Age Concern 2010, University of Bradford 2010, University of Manchester 2010, University of Stirling 2010) and Master of Science and a postgraduate Graduate Certificate in Australia (University of Wollongong 2010). In Japan, the certified expert nurse accreditation standards in dementia care were revised (Japanese Nursing Association 2004) but without accompanying dementia-specific education.

Overall, these education programmes lack formal evaluations (Kuske et al. 2006). Thus, we cannot be sure which approach to dementia education works most effectively. The NSW/ACT Dementia Training Study Centre undergraduate dementia education resource included an online evaluation but without published findings. Other studies demonstrated how to implement dementia education programmes effectively to improve practice (McCallion et al. 1999, Bryans et al. 2003, Foreman & Gardner 2005, Traynor et al. 2005).

### Theme 6. Dementia: competency standards

Seven dementia nursing competency frameworks were accessed and reviewed for support care workers, enrolled nurses, specialist dementia nurses, registered practitioners from the multi-disciplinary team and organisational dementia competencies. Gaps identified from a review of these competency frameworks will inform the future development of dementia nursing competencies relevant across care settings and levels of practice.

The Michigan Dementia Coalition (2006) in the USA provided a guide for support care workers, including seven competencies representing the knowledge and skills for the role (Table 7). Twenty-nine subsidiary objectives precede each competence and explain what the support care workers need to achieve to demonstrate their competence in delivering dementia care. The well-organised content includes essential knowledge and skills for dementia care workers but does not differentiate between levels of competency for different roles of healthcare workers and their qualifications.

In Canada, the Calgary Regional Health Authority Dementia Network developed a dementia healthcare worker competency profile (Collins et al. 2000). The competency framework includes seven domains of competence and five attitudes workers require (Table 8). The report’s purpose is twofold: (i) administration by management and (ii) self-assessment and insight into a holistic approach to nursing competencies by addressing individual and organisational needs.

Williams et al. (2005) reported the development of dementia competency standards for enrolled nurses in the USA. They adapted an existing nursing competency framework for dementia care by adding four new domains within six of its relevant competencies (Table 9).

With further development, these enrolled nurse competencies have the potential for relevancy to registered nurses and support care workers.

Iliffe and Wilcock (2005) reported on a study used to develop generic skills in dementia care for the multi-disciplinary team. They identified twelve shared competencies in dementia care for medics, nurses and social workers. The competencies, also called ‘tasks’, were designed to describe the pathways of identification of dementia care needs, rather than explain competencies for all care. These competencies were relevant to the role practitioners fulfil when undertaking diagnosis and assessment of dementia care. This was a preliminary report and further work is required to understand the full potential of a multi-disciplinary dementia competency framework.

### Table 7 Summary of seven levels of direct care worker competencies

<table>
<thead>
<tr>
<th>Summary of direct care worker competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Knowledge of dementia disorders</td>
</tr>
<tr>
<td>2. Person-centred care</td>
</tr>
<tr>
<td>3. Care interactions</td>
</tr>
<tr>
<td>4. Enriching the person’s life</td>
</tr>
<tr>
<td>5. Understanding behaviours</td>
</tr>
<tr>
<td>6. Interacting with families</td>
</tr>
<tr>
<td>7. Direct care worker self-care</td>
</tr>
</tbody>
</table>

Adapted from Michigan Dementia Coalition (2006).

### Table 8 Summary of seven dementia care support worker competencies

<table>
<thead>
<tr>
<th>Summary of dementia care support worker competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nature of dementia</td>
</tr>
<tr>
<td>2. Altered behaviour</td>
</tr>
<tr>
<td>3. Communication strategies</td>
</tr>
<tr>
<td>4. Person in the environment</td>
</tr>
<tr>
<td>5. Activities of daily living</td>
</tr>
<tr>
<td>6. Partnership with families</td>
</tr>
<tr>
<td>7. Palliative care</td>
</tr>
</tbody>
</table>

Adapted from (Collins et al. 2000).

### Table 8 Summary of dementia care support worker attitudes

<table>
<thead>
<tr>
<th>Summary of dementia care support worker attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respect towards the individual and family</td>
</tr>
<tr>
<td>2. Respect for the personhood (the unique individual)</td>
</tr>
<tr>
<td>3. Patience combined with gentleness</td>
</tr>
<tr>
<td>4. Flexibility and resourcefulness</td>
</tr>
<tr>
<td>5. Compassion for the whole person</td>
</tr>
<tr>
<td>6. Optimism for the present</td>
</tr>
</tbody>
</table>

Adapted from (Collins et al. 2000).
Another study explored a competency framework for specialist dementia community practitioners, known as ‘Admiral Nurses’ (Traynor & Dewing 2003). The content of the competencies reflects the role of nurses working as specialists and its applicability to non-specialists requires reviewing. This specialist competency framework includes eight core competencies (Table 11).

Similar to two UK approaches (National Health Service Scotland 2003, Marshall et al. 2006) outlined earlier, this framework includes details about nurses working in specialty roles progressing through levels of competence. The levels identified were:

1. Intermediate
2. Advanced

This competency framework has the potential for relevance across levels of practice.

The Mississippi Department of Mental Health (Cleave & Jackson 2006) has added a unique dimension to dementia competency by operationalising it using a systems perspective, including an organisational dementia competence. The main components of the Mississippi state plan for dementia are:

1. Family support
2. Dementia competency
3. Public awareness
4. Best practices.

These dementia competencies focused not on care itself but on an organisation’s attitudes towards dementia care. The publication described a dementia competent organisation. This perspective could be usefully combined with those drawn from the dementia standards and educational programmes, with guidance for an organisational dementia competency framework.

Synthesis: Ten dementia care competencies across five levels of practice

A synthesis of the findings from this literature review was undertaken, and a proposal is made to create a competency framework of 10 dementia competencies: (i) Understanding Dementia; (ii) Recognising Dementia; (iii) Effective Communication; (iv) Assisting with Daily Living Activities; (v) Promoting a Positive Environment; (vi) Ethical and Person-Centred Care; (vii) Therapeutic Work (Interventions); (viii) Responding to the needs of Family Carers; (ix) Preventative Work and Health Promotion and (x) Special Needs Groups and five levels of practice at which to evaluate competence: (i) Novice; (ii) Beginner; (iii) Competent; (iv) Proficient and (v) Expert. An empirical study is required to test the relevance of these competencies across care settings, disciplines and levels of practice.
Discussion

Of the 164 resources accessed for this review, 59 were relevant to dementia nursing competencies across care settings and levels of practice. These ranged from generalist and mental health competency frameworks to gerontological education and competency frameworks and dementia education, standards and competencies. The review demonstrated the lack of clinical specificity in many generalist competency frameworks published by regulatory bodies and a lack of conviction to address the key health issue of dementia within the context and role expectations of enrolled and registered nurses (Nursing and Midwifery Council 2004, Australian Nursing and Midwifery Council 2006a,b). By contrast, regulatory bodies for healthcare workers across the world have identified dementia as an important healthcare issue among their client group and are working towards ensuring dementia training is mandatory. An example of this was the Aged Care Standards and Accreditation Agency (2004), which produced its ‘Demystifying Dementia’ training resource.

No sources addressed the need to develop a competency framework across levels of practice. Some articulated a range of competencies within one level of practice (National Health Service Scotland 2003, Traynor & Dewing 2003) but none described competencies across different levels of practice, that is, for support care workers, enrolled nurses or registered nurses. Each competency framework addressed specific groups of practitioners. Thus, existing competencies need further development to ensure their relevancy across levels of practice. The content of these competencies is similar but more detail is required to articulate differences in competence between groups of practitioners. Three frameworks articulated levels of practice to demonstrate how practitioners with increasing expertise care differently for people with dementia and their carers (National Health Service Scotland 2003, Traynor & Dewing 2003, Dewing & Traynor 2005, Marshall et al. 2006). These models will inform the content of future competency frameworks across levels of practice. All these frameworks included Benner’s (1984) ‘novice to expert’ continuum (Benner 1984) to articulate different levels of competence.

The content of the competency frameworks varied. Some reflected a broader understanding of the needs of people with dementia and their carers than others did. Importantly, two frameworks explicitly addressed the role of practitioners in considering how to meet potentially competing needs of people with dementia and their carers (National Health Service Scotland 2003, Traynor & Dewing 2003, Dewing & Traynor 2005, Williams et al. 2005). Some frameworks reflected a functional model of dementia care, with the competencies merely focusing on activities of daily living, such as nutrition and personal hygiene needs (Curtin 2006).

By contrast, two frameworks articulated the need for practitioners to demonstrate how to address, effectively, the ethical issues that people with people dementia and their carers face (Traynor & Dewing 2003, Dewing & Traynor 2005, Williams et al. 2005). This draws an important distinction between the different competency frameworks, because those that were more useful reflected the complex nature of dementia care. No competency specifically mentioned how practitioners work with people with dementia to assess and provide intervention for the behavioural and psychological symptoms of dementia or unmet need. This is particularly relevant when developing competencies for specialist practitioners working in dementia care. Another area of deficiency, in Australia and internationally, was the specific competencies to address the special needs group and an explicit acknowledgement of the complex knowledge, skills and attitudes required to deliver services effectively to these groups of people with dementia and their carers.

Some competency frameworks included insight into multidisciplinary competency frameworks (National Mental Health Education and Training Advisory Group, National Education and Training Initiative and National Mental Health Strategy 2002, Department of Health 2006). Precise definitions of specific dementia competencies will enhance this work. These sources came mainly from the field of mental health, where the most effective explanation of competency frameworks relevant across care settings, levels of practice and disciplines occurred. The next phase of this study is to undertake empirical research to clearly articulate competencies across care settings and the different roles of healthcare practitioners and support workers in providing dementia care services.

Potential limitations of the review

The current state of knowledge in the dementia care field inevitably results in a literature review such as this relying on grey literature sources. Much of the published work in allied health fields remains limited to clinical articles and focuses on reflections of best practice rather than rigorous evaluation studies. It is therefore difficult to know what quality mechanisms were used to develop the content of the competency frameworks and to have certainty about the validity of their content. This lack of rigour leads to the conclusion that further empirical work is required to generate a competency framework for nurses which has relevancy across care settings and levels of practice.
Conclusions and relevance for clinical practice

The findings of this review demonstrated that Australia is one of the few countries to address the health issue of dementia by adopting it as a National Health Priority (Department of Health and Ageing 2005). The UK has followed with the launch of its Dementia Strategy (Department of Health 2009). Japan (Japanese Nursing Association 2005) and the UK (National Health Service Scotland 2003, Department of Health 2006, Marshall et al. 2006) were the only two countries to integrate dementia competencies in generalist frameworks as minimum standards for practitioners. These countries were trying to ensure their healthcare systems are contemporaneous and address the needs of people with dementia and carers across care settings by staff working at different levels of practice.

A review of the resources accessed demonstrated the potential to develop dementia competent organisations (Cleave & Jackson 2006) and a multi-disciplinary dementia competency framework (lliffe & Wilcock 2005). These two approaches show the potential to address dementia competency from a systems perspective and ensure a holistic approach to meet the needs of people with dementia and their carers. These approaches acknowledge the social disability model of dementia and the importance of the multi-disciplinary health and social care team in meeting the needs of people with dementia and their carers. Ignoring the interconnectedness of organisational culture and the multi-disciplinary team on quality-of-life issues is one reason the needs of people with dementia and their carers often remain unmet.

These studies were in their infancy and conclusions at this stage were only tentative. It is the intention of the authors of this paper to lead an empirical study and develop a dementia competency framework, based on inductively derived research evidence, to reflect the role of organisational culture and multi-disciplinary working.

This will provide the foundation from which practitioners, working across care settings and levels of practice, can demonstrate their capability in working with people with dementia and their carers (Erant 1994, Watson et al. 2002). Frameworks that successfully reflected the complex nature of dementia care were the most useful in informing the future development of a dementia competency framework across levels of practice and care settings (Traynor & Dewing 2003, Dewing & Traynor 2005, Williams et al. 2005). The model of care approach adopted by a gerontological nursing competency framework will be used to inform the dementia competency framework (National Health Service Scotland 2003). As such, the competency framework we will develop will more accurately respond to the public’s need to be assured that the capability of practitioners, in our example dementia specialists, is defined by what their clients ask of them (Erant 1994).

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Contributions

Study design: VT, PC; data collection and analysis: KI, VT and manuscript preparation: VT, KI, PC.

Conflict of interest

None.

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