The face of gerontological nursing in Canada is evolving and changing in accordance with demographic imperatives and the growth of evidence-informed nursing knowledge. These standards are meant to reflect current knowledge and understanding of our discipline, and are, as a consequence, conditional, dynamic and subject to change because of the influence of social, cultural, economic and political environments of health care.

The Canadian Gerontological Nursing Association (CGNA) responds to evolving change as a partner in the health care system with older adults and recognizes that health is a provincial/territorial partnership with the federal government. CGNA is a special interest group of the Canadian Nurses Association and contributes to the health care system by:

- promoting high standards of gerontological nursing practice,
- providing education programs in gerontological nursing,
- participating in affairs that promote the health and wellness of older adults,
- enhancing networking opportunities for all nurses,
- conducting and promoting gerontological nursing research,
- participating in knowledge translation activities such as disseminating gerontological nursing research findings, and by
- advocating the views of CGNA to government, educational, professional, and other appropriate bodies.

The mission of CGNA is to address the health of older Canadians and the nurses who participate with them in health care. CGNA is a federation consisting of gerontological nursing groups from British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Prince Edward Island, Newfoundland and Labrador, and Nova Scotia. Individual members are also represented in Quebec, Ontario and the North West Territories.

The vision of CGNA is to promote excellence in gerontological nursing through leadership, knowledge, and scholarship.

Acknowledgment

The CGNA standards have a long history (See Appendix A). This work is a continuation of work that has been evolving since 1996. The current review and revision began with a membership request at the 2007 AGM, which was subsequently approved by the CGNA executive and board in the fall of 2008. The 2010 Canadian Gerontological Nursing Standards and Competencies is the culmination of effort received from many people. Many people must be acknowledged for their contributions. We begin with the Gerontological Nursing Standards working group (GNS-WkG). This group was established in March 2009. Membership for the GNS-WkG consisted of CGNA members and representatives from National Initiative for Care of the Elderly (NICE).

Working group members were:

**CGNA Provincial Presidents/Designates/Members**

- **Gloria Connolly and Sohani Welcher** – Nova Scotia
- **Heather Hutchinson** – British Columbia
- **Ruth Graham and Helle Tees** – Alberta
- **Dawn Winterhalt** – Saskatchewan
- **Dawn Fenton** – New Brunswick
- **Mary Mac Swain and Anna Enman** – Prince Edward Island
Annette Morgan – Newfoundland and Labrador  
Bonnie Hall - Ontario

National Initiative for Care of the Elderly (NICE) representatives

Dr. Kathy McGilton and Dr. Lorna Guse

We must also acknowledge the contributions of:

Canadian Nurses Association (CNA)

Lucie Vachon – Nurse Consultant, CNA Certification Program

International Collaborators

Dr Judith Hertz and Susan Carlson – President NGNA (United States)  
Dr. Gwi-Ryung Son Hong – KGNS (Korean Gerontological Nursing Society)

To ensure the relevance of the new standards and competencies an external review was conducted by inviting experts across the country to provide a critical analysis of the document content. We are grateful to the following external review panel:

External Review Panel
Deborah Vandewater – Nova Scotia  
Julie Langlois - Ontario  
Julie Doyon – British Columbia  
Carla Wells – Newfoundland and Labrador  
Lori Schindel-Martin - Ontario  
Anne Stephens - Ontario  
Mollie Cole - Alberta  
Kathleen Hunter - Alberta  
Lynn McCleary - Ontario

We would also like to recognize the contributions made by our research assistants, administrative support, and the guidance we received from current and previous CGNA executive members:
Mr. Richard Littleton: Graduate Student, University of Alberta  
Ms. Cheryl Silveira: Graduate Student, University of Toronto  
Ms. Sharon Leung: CGNA Administrative Manager – Malachite Management Services  
Ms. Beverley Laurila: CGNA President and other 2009-2010 executive members: Denise Levesque, Sandi Hirst, Cheryl Knight

Many people from across Canada have provided wisdom and insight to ensure that gerontological nursing is represented by a specialized body of knowledge. Thank you everyone.

Sincerely,

Dr. Belinda Parke Co-Chair  
Dr. Diane Buchanan Co-Chair
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFACE ............................................................ 3</td>
</tr>
<tr>
<td>Acknowledgement ........................................................... 3</td>
</tr>
<tr>
<td>TABLE OF CONTENTS ........................................................................ 5</td>
</tr>
<tr>
<td>SECTION ONE ............................................................................... 6</td>
</tr>
<tr>
<td>Assumptions ............................................................................. 6</td>
</tr>
<tr>
<td>Beliefs about Gerontological Nursing ................................ 7</td>
</tr>
<tr>
<td>Conceptual Framework ................................................................ 7</td>
</tr>
<tr>
<td>SECTION TWO ............................................................................... 9</td>
</tr>
<tr>
<td>STANDARD I: PHYSIOLOGICAL HEALTH ........................................... 9</td>
</tr>
<tr>
<td>STANDARD II: OPTIMIZING FUNCTIONAL HEALTH .................................. 9</td>
</tr>
<tr>
<td>STANDARD III: RESPONSIVE CARE ................................................ 10</td>
</tr>
<tr>
<td>STANDARD IV: RELATIONSHIP CARE ................................................ 11</td>
</tr>
<tr>
<td>STANDARD V: HEALTH SYSTEM ..................................................... 12</td>
</tr>
<tr>
<td>STANDARD VI: SAFETY AND SECURITY ............................................... 12</td>
</tr>
<tr>
<td>REFERENCES .................................................................................. 13</td>
</tr>
<tr>
<td>APPENDIX A: HISTORY OF CGNA STANDARD DEVELOPMENT ......................... 14</td>
</tr>
<tr>
<td>APPENDIX B: GLOSSARY OF TERMS ................................................... 15</td>
</tr>
<tr>
<td>APPENDIX C: DEFINITIONS OF ROLES ............................................... 16</td>
</tr>
<tr>
<td>RESOURCES .................................................................................... 18</td>
</tr>
<tr>
<td>Bibliography list ....................................................................... 18</td>
</tr>
<tr>
<td>Internet sources ........................................................................ 20</td>
</tr>
</tbody>
</table>
SECTION ONE

Assumptions

Assumptions that underpin the Gerontological Nursing Standards:

1. Competencies are bound to the scope of practice held by different categories of nurses regulated by their Canadian jurisdiction. For example, Registered Nurses are regulated by each Canadian province and territory as set forth by the Canadian Nurses Association.

2. All gerontological nurses (Registered Nurses, Licensed and Registered Practical Nurses, and Registered Psychiatric Nurses) work within their regulated scope of practice.

3. Gerontological nursing practice standards are the minimum considerations taken by the gerontological nurse to facilitate the health of older people.

4. Gerontological nurses practice in a manner that incorporates normal age related changes in a socially constructed and culturally sensitive manner.

5. Gerontological nurses demonstrate leadership, and direct their attention toward promotion, prevention, maintenance, rehabilitation and the palliation of health related issues to address the functional needs, abilities, and expectations of older people and their family members.

6. Gerontological nurses practice in a variety of contexts but always adhere to a set of values that are included in the Canadian Nurses Association code of ethics.

7. The role of the gerontological nurse is influenced by a number of factors (e.g., legal dimensions, legislative authority, client rights, current social and political trends, growth of specialization and professional organizations that require inter-sectoral collaborations).

8. Gerontological nurses work in a variety of roles and in their practice apply theoretical knowledge of aging (e.g., Developmental theory, Erikson's stages of psychological development, critical age-related stress theory, relationship care theory).

9. Selected standards are in keeping with CNA Gerontological Certification requirement that specialty skill, knowledge, attitude, judgment, and behavior be represented in each standard and competency.

This document has been prepared in collaboration with National Initiative for the Care of the Elderly (NICE), funded by the Networks of Centres of Excellence, Health Canada. NICE is an initiative focused on: the development and maintenance of optimal well-being of older adults, improving and enhancing education and training, and achieving high standards in the delivery of health and social care. As a corporate structure of NICE, the curriculum subcommittee identified core interprofessional competencies for undergraduates. The CGNA standards and NICE competencies were integrated to develop a comprehensive list of requirements for gerontological nurses. The gerontological nurse will assume multiple roles while working with older adults (e.g., clinician, collaborator) when implementing the standards and competencies. Refer to Glossary of Terms for key definitions (See Appendix B) and role definitions endorsed by CGNA (See Appendix C).
Beliefs about Gerontological Nursing

We believe each older person is unique. Each person has values, goals, strengths, limitations, rights and responsibilities. Each person develops within a society; and influences and is influenced by societal attitudes, culture, spiritual beliefs and the environment.

- We believe in the older person's right to dignity and privacy.
- We believe that the older person has abilities and limitations which influence expectations, life satisfaction and needs.
- We believe in the older person's right to make informed choices and we advocate for the fulfillment of those decisions.
- We believe that families and friends play a central role in the life of the older person.
- We believe that gerontological nursing is an area of specialization.
- We believe that gerontological nurses practice in collaboration with other team members.
- We believe that gerontological nursing care should reflect research and/or evidence-based practice.
- We believe that a conceptual framework is the foundation for gerontological nursing standards.
- We believe that registered nurses, and specifically gerontological nurses, practice in accordance with the provincial, territorial, and national standards of nursing practice and the Canadian Nurses Association Code of Ethics.
- We believe that the health care system, including gerontological nursing practice, supports client outcomes.

Conceptual Framework

Gerontological nursing is a dynamic interaction between the client and nurse to achieve health and wellbeing. The client and the nurse both contribute to the interaction. Clients bring their unique experiences, personal knowledge and expertise about themselves whereas nurses bring their specific body of knowledge of gerontology and geriatrics, their skills and the art and science of nursing. The historical and current social and cultural climates, political influence and values of the community and society also influence the interaction.

CLIENT

The client of Gerontological Nursing is the older person. Clients may also be families, groups, aggregates, or communities. Clients should be viewed within the biological, psychological, social, cultural, developmental and spiritual dimensions of a total life experience. The older person is a unique individual with values and beliefs, strengths and limitations, and rights and responsibilities. The definition of "an older person" varies from person to person, and culture to culture; therefore, the client of gerontological nursing is determined by the client's and society's definition of old age.
NURSING

Nursing is both an art and a science. It uses a unique body of knowledge to guide the professional practice of nurses. Nursing is based on a code of ethics. Professional nursing practice is based on provincial and federal standards of practice for clinicians, educators, researchers, and administrators.

Gerontological nursing adds a specialized and expanding body of knowledge of gerontology and geriatrics to general nursing practice. In gerontological nursing practice, nurses collaborate with clients to promote well-being, optimize functional abilities, and act as advocates for clients. Research findings are incorporated through the application of theory and evidence based nursing therapeutics to meet clients’ goals and expected outcomes. Gerontological nurses identify clinical questions and conduct research so that nursing practice continues to expand beyond the boundaries of tradition.
SECTION TWO

(Adapted from Iowa Intervention Project 1992; CGNA Standards 1996; Gerontological Nursing Association (Ontario) 2004; American Nurses Association, 2001; The John A Hartford Foundation Institute for Geriatric Nursing, 2000).

Practice standards describe the appropriate therapeutic health promotion, prevention, maintenance, rehabilitation or palliation activities of gerontological nurses to facilitate client health.

STANDARD I: PHYSIOLOGICAL HEALTH

Definition: Gerontological nurses assist clients to maintain homeostatic regulation through assessment and management of physiological care to minimize adverse events associated with medications, diagnostic or therapeutic procedures, nosocomial infections or environmental stressors.

As a specialty, Gerontological Nurses address:

• Bodily systems (e.g., Neurological status, Respiratory status, Integument, Thermoregulation, Cardiovascular status)
• Acute illness and chronic health conditions
• Electrolyte and acid base balance
• Medication management
• Bowel and bladder functions

This requires competence (skill, knowledge, attitude, judgment, and behaviors) in the following:

• Understanding and consideration of normal age related physiological changes.
• Analyzing, selecting, and administering valid, reliable assessment/diagnostic/screening tools.
• Completing a nursing history and physical examination when there is a change in health status, setting, or medical condition (e.g. peri/post operative status, acute illness and chronic health conditions).
• Supporting nutrition/fluid balance (e.g. difficulty with chewing and swallowing, alterations in hunger and thirst, inability to self-feed and capacity of others to feed) in consideration of older adult abilities and wishes.
• Identifying older adults’ use of prescription medications, over-the-counter medications, herbal remedies and complementary and alternative therapy; and using established criteria for assessment and management of polypharmacy.
• Identifying factors associated with increased risks specific to physiological complications (i.e. cardiovascular disease, renal disease, diabetes, thromboembolic disease and neuropsychiatric disorders) and recommending a management plan that minimizes the risks for adverse outcomes. Collaborating with others to include complementary and integrative health care practices on health promotion and symptom management for older adults.
• Identifying and managing bowel and genital urinary functions with most appropriate intervention (e.g. prompting approaches to voiding, implementing regular toileting, selecting appropriate adaptation devices, avoiding catheterizations,).

STANDARD II: OPTIMIZING FUNCTIONAL HEALTH

Definition: Gerontological nurses promote older adults to optimize functional health that includes an integration of abilities that involve physical, cognitive, psychological, social, and spiritual status (AACN & Hartford, 2000).

As a specialty, Gerontological Nurses address:

• Geriatric syndromes
• Mobility requirements
• Rest/sleep, activity and exercise
• Nutritional support
• Physical comfort
• Independence in different living environments and arrangements
This requires competence (skill, knowledge, attitude, judgment, and behaviors) in the following:

- Recognizing and utilizing assessment approaches that specifically address geriatric syndromes (e.g., falls, incontinence, delirium, deconditioning, frailty, pressure ulcers) common to care needs of older adults.
- Managing geriatric syndromes common to older adults, and the complex interaction of acute and chronic co-morbid conditions common to older adults (e.g., cancer, depression, hip fracture, influenza and stroke).
- Assesses to distinguish the clinical presentations of delirium, dementia, and depression (3D’s) using validated and reliable screening tools and involving the inter-disciplinary team in care planning and management.
- Implementing falls prevention protocols, employing a valid and reliable measure of fall risk assessment, and by promoting least restraint approaches in injury prevention programs.
- Applying evidence-based standards/best practice guidelines to promote health promotions activities (e.g., rest/sleep, activity and exercise in older adults).
- Performing assessment of older adults through the use of valid and reliable tools in the domains of physical health and illness conditions, functional ability, cognitive ability, mental health, and psychological function including social support system and life course changes.
- Recognizing vulnerability and risk for adverse outcomes related to aging and social changes, while also reinforcing strengths and abilities.
- Planning appropriate intervention to promote function in response to change in activities of daily living (ADL) and instrumental activities of daily living (IADL).
- Completing pain assessment and management as a crucial component of health care, which includes the implications of depression, anxiety, fear, fatigue, and cognition.
- Completing pain assessment for cognitively impaired clients using valid and reliable self-report instruments and/or observations of client behaviors (e.g., agitation, withdrawal, vocalizations, and facial response/grimaces) and intervening as appropriate.

- Assessing endurance capacities of older adults in supportive living arrangements, including appropriate use of technology and assistive devices to promote and maintain optimal function, independence and safety.

STANDARD III:
RESPONSIVE CARE

Definition: Gerontological nurses provide responsive care that facilitates and empowers client independence through life course changes. A responsive care approach recognizes that certain behaviors are not necessarily related solely to pathology, but instead may be related to circumstances within the physical or social environment surrounding well older persons and those with dementia, and maybe an expression of unmet need (Wiersman & Dupuis, 2007).

As a specialty, Gerontological Nurses address:

- Behavior and cognitive therapy
- Communication challenges
- Educational needs
- Coping and grieving
- Psychological comfort
- Advanced care planning

This requires competence (skill, knowledge, attitude, judgment, and behaviors) in the following:

- Recognizing that all behavior has cultural meaning and viewing behavior within contextual issues that are specific to aging (e.g., in an attempt to communicate, dementia situations, aphasia in stroke, depression due to loss of long term partner).
- Recognizing changes (e.g. sensory, cognitive) that affect communication with older adults and using communication strategies to meet client’s needs for optimal communication ability.
- Assessing barriers (e.g. drug interactions, dementia, delirium, disease states, depression) that impact clients’ understanding of information, ability to follow directions and make needs known, and demonstrating familiarity with adaptive devices (e.g. hearing aid, listenator).
• Assessing with appropriate clinically relevant tools such as: mental status (e.g. Mini Mental Status Examination-MMSE), delirium (e.g. Confusion Assessment Method-CAM) and depression (e.g. Geriatric Depression Scale-GDS).

• Addressing health-related learning needs and developing, implementing and evaluating learning plans to accommodate changing cognitive and sensory changes (e.g., font and letter size; additional learning time to process information; ambient light adjustments).

• Supporting those who are dealing with dying, death and grief of a loved one.

• Promoting quality end-of-life care for older adults, including pain and symptom management, advanced care planning, and support of families.

STANDARD IV:
RELATIONSHIP CARE

Definition: Gerontological nurses develop and preserve therapeutic relationship care. Relationship-centered care is an approach that recognizes the importance and uniqueness of each health care participant’s relationship with every other, and considers these relationships to be central in supporting high quality care, a high-quality work environment, and superior organizational performance (Saffron, Miller & Beckman, 2006).

As a specialty, Gerontological Nurses address:

• Therapeutic nurse client and family relations
• Interprofessional relationships
• Health and welfare of family members
• Consistent care needs
• Respect client preferences
• Ethical issues

This requires competence ((skill, knowledge, attitude, judgment, and behaviors) in the following:

• Assuring participation of older adults and their families in decision making (e.g. advance care planning, health care proxy, informed consent, elder abuse reporting, legal guardianship, wills, and Do-Not-Resuscitate orders).

• Assessing family knowledge, skills, and needs, and their level of stress in providing care to older adults and collaborating toward best outcomes.

• Assessing family knowledge and skills to draw on their own abilities and resources for self-care and health promotion.

• Facilitating communication between families and older adults’ transition across and between home, hospital, home care services, and nursing home utilizing communication technologies (e.g. tele-health, computer, digital speakers, and adaptive devices).

• Assisting family caregivers to reduce their stress levels and maintain their own mental and physical health.

• Facilitating and recognizing the benefits of interprofessional care in linking older adults and their families to community organizations, policy makers, and the public to meet the needs and issues of the growing aging population.

• Promoting team problem-solving, decision making and intra-professional collaboration by jointly assessing outcomes of care; planning interventions; implementing new strategies; evaluating the impact on older adults, families and team members; facilitating continuity of care; and developing new and innovative working relationships.

• Using decision-making tool resources, communication strategies, and making appropriate referrals, in collaboration with interdisciplinary members, in order to provide counseling related to the needs and abilities of older adults and their families in making complex decisions that arise with aging.

• Communicating effectively, respectfully, and compassionately with older adults and their families (e.g., considering special features of cognitive impairment, ageism, hearing impairments, and literacy).

• Facilitating in collaboration with interprofessional resources, group interventions with older adults and their families (e.g. bereavement groups, reminiscence groups).

• Appreciating the influence of attitudes, roles, language, culture, race, religion, gender, and lifestyle on how families and assistive personnel provide long-term care.

• Assessing and respecting need for intimacy, sexual orientation, and gender identity.
• Mediating situations of conflict between older adults and their family members by balancing client autonomy and safety decisions.

• Understanding the principles of capacity, informed consent and ensuring procedures for voluntary consent or proxy decision making that arise from aging issues.

STANDARD V:
HEALTH SYSTEM

Definition: Gerontological nurses are aware of economic and political influences by providing or facilitating care that supports access to and benefit from the health care delivery system. Systems to support and sustain practice changes should be in place, including ongoing education, policies and procedures and job descriptions (Crandall, White, Schuldheis & Talerico, 2007).

As a specialty, Gerontological Nurses address:

• Environmental support services for the delivery of care
• Inter-relationships between client/family and the healthcare system
• Advocating for the client and healthcare system

This requires competence (skill, knowledge, attitude, judgment, and behaviors) in the following:

• Analyzing the effectiveness of community resources in assisting older adults and their families to retain personal goals, maximize function, maintain independence, and live in the least restrictive environment.

• Identifying and evaluating the accessibility, availability, and affordability of health care for older adults to promote their goals; maximizing function, desired level of autonomy and independence and their living in the least restrictive environment.

• Forming partnerships with older adults, their families and communities, to achieve mutually agreed upon health outcomes and transition through the system.

• Identifying gaps, barriers, and fragmentation in the health care system and applying evaluation and research findings to improve the health care system in achieving intended outcomes for older adults and their families.

• Representing the older adult as requested and when the older adult is not able to advocate for self in discussions of care, preferences for care and decisions related to care within the health care team and the organization.

• Respecting and promoting older adults’ rights to dignity and self-determination within the context of the law and safety concerns.

• Identifying that older adults may be at risk in relation to their right to privacy and information.

• Advocating for health care services that will enhance care within the organization and society.

STANDARD VI:
SAFETY AND SECURITY

Definition: Gerontological nurses are responsible for assessing the client and the environment for hazards that threaten safety, as well as planning and intervening appropriately to maintain a safe environment (Potter & Perry, 2009).

As a specialty, Gerontological Nurses address:

• Risk reduction and monitoring of risk over time
• Self-care (immunizations, accident prevention)
• Advocating for the older person and family

This requires competence (skill, knowledge, attitude, judgment, and behaviors) in the following:

• Intervening to eliminate or minimize the use of physical, chemical, and environmental restraints (e.g. alternate strategies to prevent falls, to prevent treatment interference, and to manage agitated and/or combative behavior).

• Using established criteria to identify elder abuse and follow standards of care to recognize and report mistreatment (e.g., physical, financial, sexual, neglect, emotional, and social).

• Preventing or reducing common risk factors that contribute to functional decline, impaired quality of life, and excess disability in older adults.
• Performing interventions (i.e. screening, immunization, risk-assessment) to promote health and optimal care, enhance quality of life, prevent disease, injury and excess disability, maximize function, maintain desired level of autonomy and independence, promote rehabilitation, and provide palliative care to older adults.

• Facilitating older adults’ active participation in all aspects of their own health care (i.e. access to information, right to self determination, right to live at risk, access to information and privacy).

REFERENCES


APPENDIX A
History Of CGNA Standard Development

Before 1989, although individual provincial associations of Gerontological Nursing had developed standards, the Canadian Gerontological Nursing Association Standards had not yet been established. In 1989, at the Annual Meeting, CGNA members accepted the Gerontological Nursing Association (Ontario) Standards of Gerontological Nursing (1987) as the Canadian Gerontological Nursing Association National Standards. A mechanism for ongoing examination of the CGNA standards was to be developed and reported at the 1991 Annual Meeting. A Standards Task Force was appointed by the executive to make recommendations for changes to ensure the standards reflected National Gerontological nursing practice. Using the CNA Standards of Nursing Practice as a framework, a new Draft of Canadian Gerontological Nursing Standards was proposed at the 1991 annual meeting by the task force.

A conceptual framework provides the foundation upon which the unique boundaries of gerontological nursing can be identified through standard statements. M. McGee RN, PhD (Nursing) developed a Conceptual Framework for Gerontological Nursing (1991, 1994). Dr. McGee offered her work to the Standards Task Force. The membership of the CGNA endorsed the revised conceptual framework through a mail survey in 1994. The CGNA Conceptual Framework does not preclude the use of other frameworks. It supports the concept of pluralism in theory. More than 50% of the membership responded positively to the first draft of the conceptual framework.

Further development of the draft standards continued until the 1993 Annual Meeting, when the membership requested more input into the process of standards’ development prior to acceptance. A new task force was formed by the executive to prepare a second draft statement on National Standards to be presented at the 1995 Annual Meeting.

To quote from the first task force report:

“As the specialty of gerontological nursing evolves and CGNA continues its commitment to the promotion of quality nursing care for older individuals, there will be a need for ongoing refinement of these standards and further delineation of the scope, levels and specificity and uniqueness of the practice of gerontological nursing.”

Standards continued to evolve and are built upon the work of those many individuals who assisted with the former provincial standards and drafts of our Canadian Standards. Standards Task Force Members appointed in 1989 were: Barbara Brown, Chairperson; Hebina Hood; Cheryl McCulloch; and Dorothy Wasson. Standards Task Force Members appointed in 1991: Sandi Hirst, Chairperson; Nancy Bol; and Betty Riberio.

In 1993, Deb Vandewater and team presented a set of standards to the membership. The membership recommended a new direction for the standards. The executive appointed Bonnie Hall, Julie Doyon, Carla Wells, and Jean Benton. In order to include the members in the process, surveys were distributed through provincial presidents or their delegates to better reflect the views of nurses across Canada. Focus groups were organized at the Biennial conferences to discuss the content of the standards. The Standards were published in 1996.

In 2001, Bonnie Hall recommended a review of the standards. Members at the biennial meeting recommended continuing with the 1996 Standards. In 2007, the membership identified a need to review and refine the existing standards to reflect the current and future Gerontological nursing practice in Canada.
APPENDIX B
Glossary Of Terms

For the purpose of these standards, we distinguish curriculum, objectives, competence, competencies, and core competency. These definitions are drawn from numerous resources that include: National Initiative for the Care of the Elderly (NICE), Canadian Nurses Association (CNA), and the College and Association of Registered Nurses of Alberta (CARNA) Continuing Competence Program:

*Curriculum* is the means by which educational institutions achieve planned objectives and competencies. This includes resources, formats and venues.

A *Learning Objective* is the knowledge, skill, or attitude that should result from the delivery of curriculum. Learning objectives may be broad and inclusive.

*Competence* is the ability to apply knowledge, skill, abilities, and judgment needed for safe gerontological nursing practice in any setting or roles denoted below.

*Competencies* are gerontologically specific knowledge, skill, attitude, judgment, and behavior, which is reflected in the content of each standard to ensure that safe and ethical nursing care is provided to older people and their significant family members or caregivers.

A *Core Competency* is a discrete ability derived from a learning objective. A Core competency is a minimum expectation. Ideally, it should be observable in the context of real application.

*Evidence Based Practice/Best Practice Guidelines* recognizes that evidence-based practice incorporates knowledge generation, synthesis, transfer and adoption. In providing care to older adults, the best results will be achieved through integration of current research, clinical expertise, older adult needs/preferences and available resources.

Gerontological nursing *knowledge transfer (KT)* is understood to involve an analysis of evidence that is transformed into reliable information. This evidence is acquired from multiple sources and disciplines, and then analyzed and synthesized to produce appropriate nursing interventions that can be disseminated and exchanged between older people and gerontological nurses to improve health care systems. KT activity is also intended to improve the quality of life of older Canadians and their families.
APPENDIX C
Definitions Of Roles

Gerontological nurses assume a variety of roles in their pursuit of the health and wellbeing of older people. To fulfill the standards of practice outlined in this document the following roles (NICE, 2009) represent gerontological nurse activities in Canadian society:

**Clinician:** The clinician practices safely, ethically and effectively along a continuum of care in situations of health and illness in a variety of health care environments. The care of older adults is based on evidence and “best practice” guidelines. The foundation of knowledge is an understanding of the relationships among age-related physical, functional, cognitive and psychosocial changes; and risk factors emanating from lifestyle, pathology and the environment. The clinician’s clinical focus includes other disciplines and members of the health care team, and family members, as appropriate.

**Communicator:** The communicator communicates effectively and respectfully with older adults and their families, and with other disciplines and members of the health care team. The foundation of knowledge is an understanding of communication strategies, interviewing and counseling techniques and conflict resolution skills.

**Collaborator:** The collaborator effectively works with other disciplines and the health care team to promote optimal care and quality of life, and maximize function for older adults. The foundation of knowledge is an understanding of group dynamics and partnerships, and an appreciation of the contributions of other disciplines in the health care team.

**Supervisor/Leader:** Based on collaborative process, the manager makes decisions to delegate, guide and direct the care of older adults through other health care personnel as well as providing expertise in decision-making within the organization to promote optimal care and quality of life, and maximize function of older adults. The foundation of knowledge is an understanding of time management, organizational structure and function, and the delegation and decision-making processes.

**Advocate:** The advocate initiates and takes opportunities to advocate on behalf of older adults and their families to advance the development and establishment of needed services and programs that contribute to the optimal care and quality of life, and maximize function of older adults. The foundation of knowledge is an understanding of the concepts of advocacy and social action.

**Scholar:** 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 adult. The foundation of knowledge is an understanding of established knowledge as a basis for practice, and current gaps in knowledge, and an appreciation that new knowledge is needed and must be implemented as a basis for improved practice and care. Research and knowledge translation endeavors fundamental to the pursuit of scholarly activities.
**Professional:** The professional is committed to promote optimal care and quality of life, and maximize function for older adults through knowledge and respectful practice, professional regulation and adherence to standards of practice. The foundation of knowledge is an awareness of one's own values and assumptions in interactions with older adults and the larger context of provincial/territorial/federal legislation that defines scope of practice.

**Educator:** The educator educates older adults and their family, providing information on prevention, health promotion, and management of conditions that will optimize health and quality of life, and maximize function. The educator also educates nurses, students, other members of the health care team. The foundation of knowledge is an understanding of teaching and learning theory, principles and strategies.

**Health System (Staff) Member:** The context of care is the health care system and the care to older adults and their families is provided within the availability, accessibility and affordability of programs and services. The member provides maximum opportunities and choices for older adults and their families within the larger health care system to promote optimal health and quality of life, and maximum function of older adults with an effective and efficient use of the system. The foundation of knowledge is an understanding of the health care system structure and function, and the relationships among policy, service provision and service use.
RESOURCES
Bibliography List


Registered Nurses of Ontario (RNAO) (2004). *Nursing Best Practice Guidelines: Caregiving Strategies for Older Adults with Delirium, Dementia, and Depression*. Toronto, ON. Registered Nurses of Ontario.
Royal College of Nursing. (2004). *Nursing Assessment and Older People: A Royal College of Nursing Toolikit* London, RCN.


Internet Sources


J.W. Crane Memorial Library http://www.deerlodge.mb.ca/crane_library

National Initiative for the Care of the Elderly (NICE) http://www.nicenet.ca

The Hospital Elder Life Program (HELP) http://elderlife.med.yale.edu/

The Ontario Network for the Prevention of Elder Abuse (ONPEA) http://www.opnea.org

The Registered Nurses’ Association of Ontario (RNAO) http://www.rnao.org/

Submitted by Dawn Fenton, New Brunswick