

PERCEPTIONS OF PRACTITIONERS AND PRACTITIONER ORGANIZATIONS ABOUT GAPS AND REQUIRED COMPETENCIES FOR SENIORS' CARE AMONG HEALTH AND SOCIAL CARE GRADUATES AND WORKERS

NEEDS ASSESSMENT CONDUCTED FOR THE COUNCIL OF ONTARIO UNIVERSITIES

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EXECUTIVE SUMMARY—PRACTITIONER AND PRACTITIONER ORGANIZATION PERSPECTIVES

This needs assessment focuses on providers' perceptions of the preparedness of health and social care graduates and workers in terms of caring for seniors. It is one of five needs assessments commissioned by the Council of Ontario Universities in November, 2013, with funding from the Government of Ontario, in order to help identify priority areas for implementing the educational recommendations in Dr. Sinha's Report *Living Longer, Living Well*. Interim results of the needs assessments also supported stakeholder discussions at the "Better Aging: Ontario Education Summit" held on Feb. 13, 2014.¹

Dr. Sinha's Report, *Living Longer, Living Well*, identifies the need to enhance gerontological content in entry to practice and continuing professional development programs across health and social care professions, and to support and develop interprofessional education and collaboration amongst care providers regarding older adults. By examining the perspectives of practitioners and practitioner organizations that work with seniors regarding specific strengths and gaps in competencies of new and experienced providers, and what should be expected from new practitioners versus more experienced practitioners, this needs assessment seeks to provide additional information to help guide effective implementation of Dr. Sinha's recommendations.

The needs assessment covers seniors' care competencies in relation to the following professions: RNs (Registered Nurses), RPNs (Registered Practical Nurses), PSWs (Personal Support Workers), PTs (Physiotherapists), OTs (Occupational Therapists), MDs (Medical Doctors), RTs (Recreation Therapists), and SWs (Social Workers).

STRENGTHS IN KNOWLEDGE OR SKILLS IDENTIFIED IN ALL PROFESSIONS (EXPERIENCED AND NEW GRADUATES)

- people who work with seniors are there because they care
- health care professionals have a desire to learn more and want to make a difference
- there is a more collaborative inter-professional approach to care of seniors compared to the past

¹ Dr. Sinha is the Provincial Expert Lead for the Ontario Seniors Strategy. Dr. Sinha identified enhanced education and training of health and social care professionals who work with older adults as a key enabler of a seniors-friendly Ontario.

- there is a positive move from a physical/medical model towards a more person-centered, less task-oriented approach to seniors' care, with recognition that it is important to be attuned to what the client's norm is
- staff are more engaged and aware that knowledge of seniors' care is important compared to the past

GAPS IN KNOWLEDGE OR SKILLS IDENTIFIED IN ALL PROFESSIONS (EXPERIENCED AND NEW GRADUATES)

- how older adults differ from the rest of the population and normal versus abnormal aging
- the 3 Ds (dementia, delirium, depression), i.e., types, what they look like in practice, how they differ, prevention, effective interventions
- mental health, mental illness, and concurrent disorders (e.g., mental illness and substance abuse)
- consent, Health Care Consent Act, substitute decision-makers, and capacity assessment
- advanced care planning
- end of life palliative care
- communicating with seniors (particularly those with mental illness and communication deficits)
- assessing and managing complicated cases with co-morbidities
- comprehensive holistic assessment

GAPS IDENTIFIED FOR SOME SECTORS OR FOR SOME WORKER CATEGORIES BUT NOT ALL

- leadership and mentoring
- wound care
- managing violent behaviour and threats
- moving evidence into practice/quality improvement

Apart from the long-term care sector, where there is little to no capacity to train new providers, and the primary care sector, where respondents expected physicians to graduate with competence and progress to excellence, respondents recognized the need to mentor new graduates and did not expect the same level of competency as experienced workers would have.

KEY THEMES/PRIORITIES IDENTIFIED

- All health care professionals need to move toward a more person-centred, collaborative approach to seniors' care rather than working in silos.

- The gaps identified here should be used, along with published seniors' care competency frameworks, to prioritize continuing education efforts and to inform curricular enhancement decisions of college and university based educators.
- Gaps should be addressed, where possible, in entry-to-practice education, but continuing professional development also needs to be targeted.
- The new graduate needs to meet the same basic level of competency that an experience worker would, but would not have the depth of clinical and experiential knowledge.
- Mentorship is key to the success of the new graduate, and mechanisms to support mentorship of new graduates in seniors care were experienced positively, e.g., Nursing Graduate Guarantee and the Late Career Nurse Initiative both funded by MOHTLC.
- While education is a shared responsibility between the employee and employer, an expectation of life-long learning is important to instill early because health care is constantly changing.
- A variety of approaches to continuing education should be used, including partnership between community agencies.
- Courses on seniors' care should be offered with an emphasis on geriatric mental health.
- Gentle Persuasive Approaches and PIECES should be taught in the acute care sector.
- There should be more funding for continuing education in the long-term care sector, in order to address the gaps in competencies identified here.
- Ministry of Health and Long-Term Care and other Ministries should use their authority to identify priorities for training in order to fill gaps in competencies.
- Senior leadership in practice settings must set competency in senior's care as a priority, for example by:
 - Setting expectations of certain seniors' care competencies as part of the hiring decision or in other ways making it an incentive
 - Ensuring the work context supports best practice in seniors care

BACKGROUND

The 2012 report by Dr. Samir Sinha, *Living Longer, Living Well* [2], , identifies the importance of adequately trained and supported care professionals as a key enabler for improved seniors wellbeing.

Specifically, the *Living Longer, Living Well* (Sinha, 2012) report includes recommendations that the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges, and Universities should:

- require that core training programs for health and social care workers include “relevant content and clinical training opportunities in geriatrics” (Recommendation 130, p. 203)
- “support the preparedness of all current health and social care providers by encouraging the development of continuing professional education activities and certification programs focused on care of the older adult” (Recommendation 133, p. 203)
- “establish an educational accreditation standard for training in geriatrics and/or gerontology” for programs educating health and social care workers (Recommendation 131, p. 203)

To inform action on how these recommendations can best be implemented, this needs assessment investigated the perceptions, views, and expectations of health and social care providers and practitioner organizations who work with older adults in acute, primary, community/home care, and long-term care sectors, regarding what they believe to be the specific gaps in competency achievement amongst providers working with older adults, and what gerontological competencies should reasonably be expected of a new graduate and what from a more experienced practitioner.

SUMMARY: APPROACH AND METHODS

The two components of this needs assessment were a literature review and key informant interviews. The approach, methods, and results of each component are described in turn, followed by an analysis of the results of the needs assessment.

SUMMARY: LITERATURE REVIEW APPROACH AND METHODS

The purpose of this literature review was to determine managers’ and practitioners’ views on:

1. gaps and strengths in competencies for seniors’ care in the current workforce, and

2. expectations of new graduates and experienced workers.

SEARCH STRATEGY

Databases and appropriate search terms were discussed with a university librarian prior to conducting the search, to ensure the desired information would be captured. Relevant literature was identified by conducting a systematic search in the CINAHL, MEDLINE and Social Services Abstract databases. Articles that had cited the identified articles were also reviewed on the Web of Science database. Additional articles were identified by reviewing the reference lists of identified articles, by searching Google Scholar, and by searching Web sites of relevant organizations.

The search was limited to research publications. The entirety of the search is described in Appendix 1, including details on search terms, inclusion and exclusion criteria, limits applied, and search results.

SEARCH RESULTS

The literature search identified 23 articles, with one subsequently removed upon further evaluation, resulting in 22 sources that were reviewed.

SUMMARY: LITERATURE REVIEW RESULTS

While there was a limited quantity of relevant literature, research was retrieved pertaining to gaps in competency in senior care as identified by managers/administrators, physicians, and nurses (registered nurses, registered practical nurses, and personal support workers). After reviewing all of the sources retrieved, several areas of seniors' care were identified in the literatures as gaps in current competency. Each area is described in turn, below.

CLINICAL COMPETENCY GAPS

1. COMMUNICATION

Conveying information through exchanges with supervisors, coworkers, residents and family members is vital in seniors' care, to ensure that the quality of care being delivered is at the highest standards, highlighting the importance of the finding of communication being the most often identified gap in competence. Physicians in assisted living reported low confidence in the ability of staff to convey information adequately regarding acute events/problems of residents (Sloane et al., 2011); this is supported by a finding that administrators thought communication skills of nurses working in aging related services need to be better developed (Ma, 2005). In one study, focused on depression in older patients receiving homecare, the majority of nurses

(69.6%) reported not being confident (not at all/a little/somewhat confident) in their ability to effectively communicate information to physicians; physicians echoed this when more than 75% of the sample indicated that they found the information they received was inadequate to make decisions (Brown, Raue, Schulberg & Bruce, 2006). Nurses, however, also reported being inadequately informed, particularly on night-duty (Whittaker, Kernohan, Hasson, Howard & McLaughlin, 2006). Moreover, nurses reported an overall inadequacy of training for communication regarding dementia (Gandesha, Souza, Chaplin, & Hood, 2012) and palliative care (Hirakawa, Kuzuyam, & Uemua, 2009).

2. DEMENTIA CARE

Dementia care was another area often identified as a gap in competence. In a National Audit of Dementia in the United Kingdom, more than 50% of physicians and more than two thirds of nurses perceived they had insufficient competence and training in dementia care and awareness (Gandesha et al., 2012). Thirteen areas of competence were evaluated. Health care aides thought their training was inadequate in 9 of 13 areas. Both physicians and nurses were concerned about their ability to deal with challenging behaviors, while nurses were also concerned about how to assess capacity and recognize pain. Dementia care was identified in several other studies where practitioners were asked to self-assess areas where improvement in competence is required (Hasson & Arnetz, 2008; Hirakawa, Kuzuyam, & Umera, 2009; Josefsson, Sonde & Robins Wahlin, 2007; 2008).

3. MENTAL ILLNESS

Competency regarding mental illness was also assessed as being less than adequate overall, with both home care nurses and nursing home staff identifying a lack of knowledge regarding psychiatric illnesses and psychological disturbances (Hasson & Arnetz, 2008; Josefsson et al., 2007) and inability to meet mental health and cognitive needs (Gronoos & Perala, 2008). Related to inadequate knowledge, misconceptions regarding older adults and mental health were identified (Hsu, Moyle, Creedy & Venturato, 2005). In addition, lack of knowledge of services available to assist with the mental health of seniors and their care was identified as a problem (Gronoos & Perala, 2008).

4. PALLIATIVE CARE

Palliative care was another area that was identified as a gap in competence on several occasions, both at an individual practitioner level (Ford & McInerney, 2011; Gandesha et al., 2012; Raudonis, Kyba & Kinsey, 2002), as well as at an organizational level (Lees, Hill, & Coles, 2006). Deficits in knowledge regarding palliative care were evident at all worker categories in one study on aged-care workers, with 25% of the study sample reporting that they had received

zero hours of training in the area (Ford & McInerney, 2011). In particular, there was a lack of knowledge regarding the philosophy and principles of palliative care and a lack of understanding of the overall approach (Ford & McInerney, 2011; Raudonis et al., 2002).

5. URINARY INCONTINENCE

The results of our literature review also point to a gaps in competence related to urinary incontinence. Two studies demonstrated that when tested on their knowledge in this area, registered nurses receive satisfactory scores, with nursing assistants scoring somewhat lower (Lin, Wang, Lin, & Chiang, 2012; Saxer, de Bie, Dassen, & Halfens, 2008). While attitudes towards urinary incontinence care are seen as positive, deficits in competence in delivering the care were found in both staff groups (Lin et al., 2012; Saxer et al., 2008). These findings were supported by a study of knowledge and practice of advanced practice nurses who thought their knowledge was adequate but did not feel confident in their assessment/diagnostic skills and management/treatment skills related to urinary incontinence (Keilman & Dunn, 2010).

ADDITIONAL CLINICAL COMPETENCY GAPS

In addition to the competence gaps pertaining to clinical practices described above, several other areas were identified in the literature. Areas where senior care practitioners indicated that competence needed to be addressed and further developed included:

- falls and falls prevention (Josefsson et al., 2007; 2008; Lees et al., 2006)
- pain management (Hirakawa et al., 2009; Raudonis et al., 2002; Whittaker et al., 2006)
- diabetes care (Ford & McInerney, 2011; Josefsson et al., 2008; Lees et al., 2006)
- wound treatment (Josefsson et al., 2008)

OTHER COMPETENCY GAPS

While the majority of the literature focuses primarily on the need for competence development for clinical practices, several other areas were also identified in the literature:

- dealing with violence and threats from older adults (Badger & Mullan, 2003; Gandesha et al., 2012; Hasson & Arnetz, 2008; Lees et al., 2006)
- healthy aging and well-being (Gronoos & Perala, 2008; Hasson & Arnetz, 2008; Lees et al., 2006; Ma, 2005)

- moving evidence into practice (From, Nordstrom, Wilde-Larsson, & Johansson, 2013; Gronoos & Perala, 2008; Josefsson et al., 2007)
- leadership and mentoring (Hasson & Arnetz, 2008; Josefsson et al., 2007; 2008; Ma, 2005)
- laws and guidelines pertaining to senior care (Gronoos & Perala, 2008; Hasson & Arnetz, 2008)
- computer and technology skills (Gronoos & Perala, 2008; Hasson & Arnetz, 2008; Josefsson et al., 2007; 2008)

EXPECTATIONS OF NEW GRADUATES VS. EXPERIENCED PRACTITIONERS

Literature was limited regarding expectations of new graduates vs. experienced practitioners working in seniors' care, as these two cohorts of practitioners were not treated separately in the research. While several sources were located regarding new graduate competence, they often centered on education and the need for certain areas of gerontological care to be better included in the curriculum (Kaasalainen et al., 2006), which was not the focus of this needs assessment. No sources were retrieved regarding an evaluation or assessment of competence of new graduates currently working in senior care.

EXPECTATIONS OF SOCIAL CARE AND SOCIAL SERVICE WORKERS

As evidenced from the preceding summary, much of the identified literature was focused on health professions; little information was found pertaining specifically to competence in senior care of social and social service workers in our search. This may be due to perceptions of limited information on commonly accepted, gerontological knowledge-based skills or competencies for social workers (Naito-Chan, Damron-Rodriguez, & Simmons, 2004).

METHODOLOGICAL ISSUES IN LITERATURE

All of the retrieved sources used a cross-sectional design to capture information about competence, which is appropriate as data was being collected from a specific population – senior care practitioners – at one specific point in time. Of note, however, is that the majority of studies used self-report measures, in that practitioners were asked about their own views of gaps in their competence regarding senior care. This may have impacted the findings due to social desirability, the participant's feelings about the subject at the time the questionnaire was completed, and recall bias. Only two studies included a component where one group of practitioners was asked to evaluate another's current competence (Ma, 2005; Sloane et al.,

2011). In addition to the self-report format, there was no tool that was consistently employed to evaluate the competency of practitioners in senior care, limiting generalizability.

CONCLUSIONS FROM LITERATURE REVIEW

The literature demonstrates a substantial need for competence development among all practitioners who work with seniors in a variety of care settings, particularly hospitals, home care, and long-term care settings. Gaps identified in several studies, include communication, dementia care, mental illness, palliative care, and urinary incontinence. Several other gaps concerning clinical practices and administrative skills have also been identified in the literature. The literature regarding competence gaps in competencies for seniors' care, however, is limited.

SUMMARY: KEY INFORMANT INTERVIEWS APPROACH AND METHODS

Key informant interviews were conducted by Lynn McCleary and Lorie Luinstra-Toohey. Focus groups were considered but were deemed not feasible due to tight timelines and the challenge of scheduling focus groups to suit participants' schedules within these timelines.

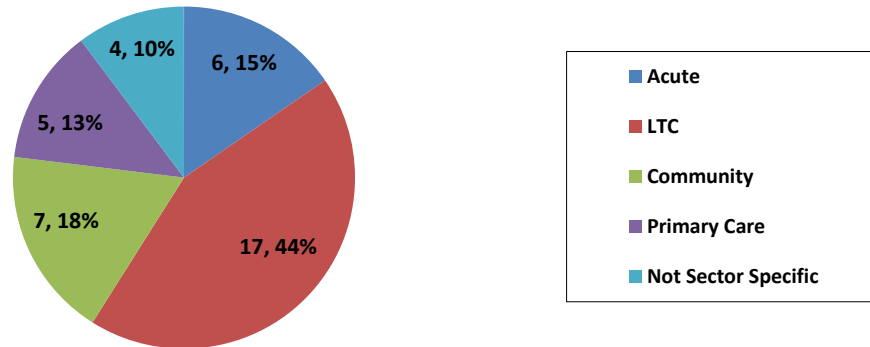
Key informants were identified through personal contacts or were suggested by others working in the geriatric field. Once identified, a mutually agreeable time was set for the interview to be completed. The interview guide is provided in Appendix 2.

Interviews lasted between 10 and 45 minutes (mean 22 minutes). Written notes were taken during interviews. Most interviews were audio recorded. Detailed notes were made after each interview, based on the initial written notes and the audio recordings.

A total of 39 interviews were conducted in January and February 2014. The goal was to gain the perspective of people who supervise or directly work with health care providers caring for seniors. Key informants represented the acute care, long-term care, home care and primary care sectors. Some of the interviewees crossed several of these sectors and were therefore not allocated to a specific sector when summarizing the data. See Figure 1 for a detailed breakdown of the sample. Interviewees included directors, managers, supervisors, and physicians in health and social service organizations linked to primary care, Community Care Access Centres, home care, long-term care, retirement homes, seniors' housing, or acute care. In addition, several Psychogeriatric Resource Consultants (PRCs) and Long Term Care Best Practice Coordinators (who do knowledge translation work in the long-term care sector) provided their insights. Health care provider organizations including the Ontario Long Term Care Association (OLTCA), Ontario Hospital Association (OHA) and Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) were also contacted to obtain information from their staff about

perceived gaps and expectations.

FIGURE 1: KEY INFORMANT SAMPLE BY SECTOR (N = 39)



Note: LTC can be further broken down into LTC homes (n=15) and Retirement homes/seniors' housing (n=2); Community informants included CCAC (n=3) and Home Care (n=4).

The 39 key informants were able to comment on seniors' care competencies in relation to the following health care providers:

- RN (Registered Nurse)
- RPN (Registered Practical Nurse)
- PSW (Personal Support Worker)
- PT (Physiotherapist)
- OT (Occupational Therapist)
- MD (Medical Doctor)
- SW (Social Worker)

Sixty-three percent of informants commented on nurses (RN, RPN); 26% commented on physicians. Between 23% and 37% of informants felt confident to speak about one or more of the following: recreation therapists, social workers, physiotherapists, occupational therapists, and personal support workers.

Content analysis was achieved by sorting responses by the five main questions in the interview guide. Responses were compared to identify similarities and differences. Themes were readily apparent. Responses are summarized by sector and, within sector, by worker category. Note

that in the summary of results section, where only one informant reported a particular finding, this is explicitly stated. Unless specifically stated otherwise, all other findings were reported by more than one informant.

SUMMARY: KEY INFORMANT INTERVIEWS RESULTS

1. STRENGTHS IN THE CURRENT WORKFORCE

We asked informants about strengths they see in the current workforce with respect to competence for seniors' care. The following strengths were reported by one or more informants across all sectors:

- it is evident that people who work with seniors are there because they care
- health care professionals have a desire to learn more and want to make a difference
- there is a more collaborative inter-professional approach to care of seniors
- there is a positive move from a physical/medical model towards a more person-centered, less task-oriented approach to seniors' care, with recognition that it is important to be attuned to what the client's norm is
- staff are more engaged and more aware that knowledge of seniors' care is important

Details of reported strengths by sector are described below.

ACUTE CARE SECTOR

The key informants reported that people in the current acute care workforce are there because they care. The biggest strength is that they want to learn about gerontology and want to make a difference. One informant further indicated that providers had a good knowledge base of disease processes and knowing when and how to make community referrals.

Informants commented that there is interest among the health professions in wanting to build knowledge and strengthen skills in the area of seniors' care. Staff is reported to be more engaged and there is an awareness that knowledge regarding seniors' care is important in all areas including acute care.

Another strength in acute care was improved ability to work in collaboration for seniors' care, with input from an inter-professional team rather than working in silos.

Several informants commented on improvements among general internists and hospitalists in acute care. Compared to 10 or 15 years ago, they were seen as having more awareness of and

recognition of the importance of geriatric care. They were seen as very well versed in seniors' care issues – but working in a context does not support best practice.

LONG-TERM CARE SECTOR

A frequent comment by informants in the long-term care sector relates to the passion the current workforce has for seniors' care. Staff members are caring, compassionate, and have a sense of ownership and pride in their work. Informants reported seeing more staff members knowing about dementia care from training in Gentle Persuasive Approaches, U-First, or PIECES (dementia care education and training programs) or having an interest in getting this training.

One participant further stated that strengths in the current workforce are: time management skills and awareness that they are unable to do everything as indicated in the Long-Term Care Homes Act. The current workforce was seen as having a lot of experiential knowledge and ability to recognize that a resident is “not well” (even if they do not know the diagnosis or reason for a problem). Awareness of the triggers that set off resident behaviours was also seen as a strength.

Several informants mentioned the positive move toward person-centered care versus the physical/medical model. The result is less task-focused care. In addition, informants indicated that there is more collaboration – a team focus – as disciplines increasingly work together.

One informant indicated that nurses do a great job with respect to documentation and attending to the basic nursing needs such as pain management, monitoring, and physical needs.

COMMUNITY SECTOR

Interviewees in the community sector indicated that home health care staff are interested in seniors and want to do their best. One informant stated that “staff in the community are committed to caring for people; to come to work every day and to accept people's behaviour.” They are open to learning more. One informant noted that staff are good at assessing safety and the need for additional community services or health professionals.

Participants identified that the ability of staff in the community to flag cognitive impairment and to manage responsive behaviours has greatly improved. In addition, there is recognition of the importance of keeping people in their own homes as long as possible.

One community interviewee reported that staff (particularly physiotherapists and occupational therapists) are often able to see clients very quickly after a CCAC referral and assess their functional needs in their home environment.

The CCAC interview participants identified that CCAC coordinators have become better at recognizing medication issues, handling acute and emergent situations, and making complicated service plans. There is also an understanding of their important role in the LTC application process as it relates to capacity assessment.

PRIMARY CARE SECTOR

Several of the primary care interviewees reported that the move to integrate inter-professional health care providers into primary care is positive. This is particularly true in relation to the family health team and chronic disease management, as identified by one key informant. Primary care physicians were seen as having improved knowledge about dementia, compared to 10 years ago. However, we heard that while there have been improvements, there is considerable variation among more experienced primary care physicians, depending on whether or not they have received continuing education about seniors' care and dementia.

2. GAPS IN COMPETENCY FOR SENIORS' CARE IN THE CURRENT WORKFORCE

Informants were asked about gaps in competency for seniors' care in the current workforce. They were asked to distinguish between the various categories of health and social care providers. In several cases, the same issues were seen as strengths and gaps – indicating variations in practice or an acknowledgement that competencies have improved but not to the point that meets expectations.

The following gaps in knowledge and/or practical skills (among experienced workers and new graduates) were noted by one or more participants across all sectors and across multiple worker categories:

- how older adults differ from the rest of the population
- normal versus abnormal aging
- the 3 Ds (dementia, delirium, depression), types, what they look like in practice, how they differ, prevention, effective interventions
- mental health and concurrent disorders (e.g., mental illness and substance abuse)
- complicated cases with co-morbidities
- consent, the Health Care Consent Act, substitute decision-makers, and capacity assessment
- advanced care planning

- end of life palliative care
- comprehensive/holistic assessment
- communicating with seniors (particularly those with mental illness and communication deficits)

Details of perceived gaps by sector are described below.

ACUTE CARE SECTOR

Informants in the acute care sector frequently told us that there is a gap in understanding of the different types of dementia; what dementia and delirium look like in practice; what the difference is between them and ways to intervene effectively.

Several key informants reported that in acute care, the atypical presentation of illness in seniors is mistakenly seen as normal due to aging. Informants said that they see staff managing the acute clinical concern with little focus on how to handle the behavioural component. Related to this, informants indicated that there is a knowledge gap as it relates to complicated cases with co-morbidities – there is a gap in ability to “put it all together” with frail and failing seniors or frail seniors with complex health and social needs. Related to complexity, we heard that reconciling medications is a challenge.

Not knowing what you don’t know was identified as a gap, meaning that there is a tendency for health professionals to think that because they work with older adults all the time, they know all that they need to know.

An acute care informant summarized her concerns by stating that there is a lack of awareness of how the hospital environment and the interventions provided impact a senior’s functional ability. The acute care system is short on time, which often makes it easier for the health care provider to do the task for the senior rather than assist them where they are struggling. This action feeds into the functional decline of the senior while in hospital. This acknowledgement that how care is organized influences practice gaps was echoed by informants who spoke about physician practice in acute care, saying that it is not just practitioner competence but system pressures in acute care (e.g., to get people out of hospital and limited time).

Making provisions for family support and attending to other social impacts was also identified as a gap. This may be related to gaps in knowledge about dementia, consent and capacity, and palliative and end of life care. Managing transitions from hospital and adequately communicating with community health care providers was also identified as a practice gap.

Many informants believe that there is a systemic lack of knowledge in the long-term care sector regarding consent (and the Health Care Consent Act), substitute decision-makers, and capacity assessment. They reported that there are also gaps in competencies in relation to advanced care planning and end of life palliative care.

Informants identified that there is a lack of understanding about how older adults differ from the rest of the population, the differences between normal versus abnormal aging and about geriatric mental health. Concerns were reported about a lack of knowledge among all professionals regarding the 3 Ds (dementia, delirium, depression) and concurrent disorders (i.e., mental illness and substance abuse). Informants identified that staff should have an understanding of dementia, recognize what it looks like or how it manifests, be able to communicate with clients with dementia, understand the different symptoms, and how that affects the intervention(s) they use. Also, one informant reported that there was a gap in understanding what depression looks like in an older adult and an awareness of how a client's personal history contributes to their behaviour.

Informants in this sector identified that health care providers lack competencies for holistic assessments and putting together information they gather in the case of a complex senior client. A number of informants expressed concern regarding the stigma of aging and related lack of understanding of healthy aging versus unhealthy aging. They also reported that there is a need to focus on person-centered care versus "this is an older adult, therefore this is to be expected."

With respect to social work, one informant commented on a recent trend in the interest of social workers to work with the senior's population, but with limited education about seniors. As a result, not all social workers have a solid foundation of understanding the intricacies, losses, specific psychosocial concerns, and needs of seniors.

From a nursing perspective, informants identified that health assessments tend to be focused on physical aspects of the resident and less on cognitive or mental health aspects of the resident. They thought that nurses should be able to do a basic cognitive screening and identify risks. With respect to RPNs, one informant also noted a gap in general assessment skills. One informant identified gaps in the nursing skills needed for high acuity residents (as the health care system transforms and LTC has more residents with acute and complex illness). This includes IV starts and monitoring, feeding tubes, and complex dressings. The challenge was seen as one of 'skilling up' the current workforce.

Informants also cited a gap in nurses' competencies and ability to manage family expectations and collaborate with families. Informants indicated that competencies around leadership,

coaching, mentorship and supervisory skills are lacking in long-term care for RNs and RPNs. Nurses are reportedly not prepared to manage staff and deal with team issues such as insubordination.

According to informants, PSWs in the workforce are inadequately prepared in their education. Informants emphasized the importance of this in context of the fact that PSWs provide the majority of care in this sector. Informants thought that there were gaps in knowledge related to gerontology, dementia, pathophysiology, turning and positioning patients, communication skills, and documentation.

Gaps were not identified for physiotherapists; informants thought they were well prepared for the long-term care setting. Competence of recreation therapists in the workforce was seen to vary depending on their education, with those with a background in community college seen as better prepared. However, one informant commented on the inability of recreation therapy graduates to develop a goal for a client and to identify the interventions necessary to meet that goal.

One informant thought that an important gap in seniors' care relates to new residents and physicians writing prescriptions with doses that are not appropriate for the geriatric client.

Several informants commented that each discipline tends to work in their own area, that is, in silos, but they need to work together. A need was identified to educate all professions on each profession's perspectives and values.

COMMUNITY SECTOR

In the community sector, several informants commented on practitioners' lack of knowledge about normal aging versus abnormal aging, and about disease processes related to aging. Informants identified a lack of knowledge or ability to use simple screening tools for basic assessment.

In general, the 3 Ds (delirium, dementia, and depression) were seen by informants to be poorly recognized.

Capacity assessment and understanding the role of Power of Attorney and substitute decision maker was also a gap. Informants noted a tendency to involve family in decision making when the older client is capable of making their own decisions. Related to this, informants commented on a lack of understanding of the role of the patient in decision-making and that patient-centered goals drive the plan of care. Several informants reported that health care professionals come with a medical model/task oriented focus and not a holistic approach to the whole person.

Two informants identified that for the most part, providers are not comfortable talking about sexuality with older adults.

Several participants commented on the need to work better with other community partners. There tend to be silos rather than looking at the community resources and how providers can work well together to provide the best care to support a client to stay in their home.

One informant thought that physiotherapists and occupational therapists were clinically prepared but did not have a comfort level communicating and working with clients with dementia or clients struggling with communication deficits.

PRIMARY CARE SECTOR

Informants about the primary care sector frequently spoke about how the system drives the care provided; noting that gaps may be due to problems with competencies, the way the system is designed, or a combination of both. For example, several participants commented on practice gaps for physician home visits and palliative care. This was seen to be related to comfort with practice, lifestyle choices, knowledge about palliative care, and financial incentives (once the quota for home visits is reached, the practice stops). Decreasing likelihood of making home visits was seen to lead to gaps in care, with emergency departments unnecessarily used.

Informants said that all disciplines lack training on inter-professional collaboration; informants emphasized the importance of this gap.

Informants reported that few health care professionals have adequate competency for dementia care, mental health and mental illness, complex chronic conditions, and end of life care.

Lack of knowledge regarding capacity and competence was also cited by primary care informants.

3. STRENGTHS AND GAPS BY HEALTH AND SOCIAL CARE WORKER CATEGORY

Narrowing the focus to specific categories of health and social care workers, informants commented on strengths and gaps in competencies as indicated below. Note, that many of the gaps and strengths by sector described above were seen as cutting across worker categories. These are not necessarily mentioned again below. The following summary focuses on gaps or strengths that were identified by informants as relevant to a particular worker category. As was evident in the preceding summaries, informants were more expansive about what they perceived to be gaps than they were about strengths.

PERSONAL SUPPORT WORKERS

Strengths:

- really know the client
- are motivated to learn in the workplace
- are expected to have a large number and broad range of competencies

Gaps:

- knowledge re: importance of turning and positioning
- documentation skills and understanding of the importance of communicating client changes
- communication skills specific to seniors
- understanding of pathophysiology
- organizational skills
- knowledge of screening tools

REGISTERED PRACTICAL NURSES

Strengths:

- are expected to have a large number and broad range of competencies

Gaps:

- assessment skills, i.e., holistic assessment, as well as cognitive, pain, and others
- supervisory skills (overseeing PSWs)
- value for/recognition of the role of PSWs
- knowledge related to RAI tools

REGISTERED NURSES

Strengths:

- documentation and meeting basic nursing needs such as pain management, monitoring, physical needs, are strengths

Gaps:

- leadership, coaching and mentorship skills
- skills for high acuity seniors in long-term care, e.g., intravenous, complex dressings, feeding tubes
- knowledge related to RAI tools
- assessment skills i.e. holistic; cognitive; pain
- skills for working with families and managing their expectations
- recognition of the role of PSWs

RECREATION THERAPISTS

Gaps:

- assessment skills
- setting client goals and planning necessary interventions to meet those goals
- dementia specific approaches
- understanding of documentation software, care plans, and coding relative to long-term care

CCAC COORDINATORS

Strengths:

- capacity and suitability assessment for long-term care home
- understanding antecedents of behaviours and triggers
- recognizing medication issues and medication reconciliation
- making complicated service plans – managing acute and emergent situations

- RAI assessment
- creating service plans to keep people at home
- plans for wound care and complicated wounds

Gaps:

- being truly patient centred (associated with being paternalistic and not accepting client decisions to live at risk)
- understanding capacity for decision making and recognizing importance of patient choice
- cognitive assessment

SOCIAL WORKERS

- specific strengths and gaps not identified, it was noted by informants that social workers are showing more interest in working in geriatrics

PHYSICIANS

Strengths:

- improved knowledge and recognition of importance of geriatric principles
- interested in continuing education about dementia

Gaps:

- prescribing doses not appropriate for the geriatric client (more so among new physicians)
- practice can vary depending on the system, for example, financial incentives may impact decisions on the care provided
- managing complexity and frailty

PHYSIOTHERAPISTS

Strengths:

- tend to have good clinical skills

Gaps:

- communicating with seniors, particularly those with communication deficits or dementia

4. GAPS IN COMPETENCIES OF NEW GRADUATES

Informants' opinions about gaps in competencies of new graduates are described below, by sector.

ACUTE CARE SECTOR

Multiple informants reported that they believe there is not a lot of gerontology, geriatrics, or seniors' care content in curriculums. However, one interviewee noted the changing focus to person-centred care fits well with the senior's population. Another informant identified that education is not standardized and that education standards do not set content requirements for seniors' care competencies.

One interviewee indicated that new graduates lack understanding of geriatric syndromes, assessment, and the ability to integrate assessment information with an understanding of aging. Similarly, another informant noted that new graduates have so many tasks in front of them that they often do not know how to prioritize their care.

Another acute care informant stated that it is important to recognize that the new graduate will adapt positively or negatively depending on the culture of the organization they are joining. If they enter an organization that does not use best practice, that will influence their performance.

LONG-TERM CARE SECTOR

Informants in the long-term care sector reported that graduates come with a real spirit of inquiry and are quick to pick up new things. However, they were seen to lack good assessment skills, practical experience, and an understanding of the importance of documentation and how documentation impacts funding and the client (particularly PSWs). New health professionals were viewed as lacking knowledge about dementia care (e.g., knowledge they could obtain through Gentle Persuasive Approaches (GPA) and PIECES dementia care training). However, one informant noted having worked with some new graduates who had learned about PIECES. Informants thought that new graduates understood the basics but struggled with complexity.

One informant reported that new graduates lack knowledge regarding consent and capacity, who our seniors are, as well as the practice principles of other disciplines. Several informants noted a need for more ability to work within an inter-professional team.

Two informants indicated that all staff (new graduates and experienced staff) should have a background in project management, change strategies, and quality improvement methodology. This is necessary to fulfill a mandate in long-term care to have interdisciplinary committees for improving practice (e.g., continence, wound care, and falls prevention committees).

Informants reported seeing PSW graduates as inadequately prepared; lacking knowledge in a number of areas (as described previously for PSWs in the workforce). An informant also noted that personal support worker graduates lack experience with how to address various conditions and behaviours such as dementia and aggression. Informants recognized that these competencies were difficult to achieve in the short timeframe of PSW education.

Communicating with an older adult was noted as a gap by one informant. New graduates are unsure how and what to say. A tendency to use endearments, which were viewed as disrespectful, was noted.

An informant thought that recreation therapy graduates were lacking needed knowledge of Montessori methods for dementia care.

Physician informants noted that most graduating family physicians do not have any practice experience in long-term care.

COMMUNITY SECTOR

In the community sector, one informant identified that new graduates have similar gaps to the experienced worker but communication challenges are probably more noticeable with new graduates. Informants thought that gaps varied depending on the upper year clinical placement experiences of new graduates. Informants thought that new graduates needed more hands on experience, i.e., in home care, long-term care, and retirement home settings.

Informants reported that new graduates are open to learning. One interviewee indicated that new graduates are very flexible and able to self-identify that they need more education. In general, informants thought that new graduates seem to have more theory but do not have sufficient practical experience.

One informant noted that some graduates have knowledge about dementia care, particularly PIECES, but thought this probably depends on where they were educated.

Informants indicated that new graduates in the community need mentorship. Informants noted that new graduates lack the knowledge of community resources and how to navigate the system. In addition, they are less familiar with patient rights with regard to choice. As one informant put it, new graduates “tend to want to take control and make everything better.”

PRIMARY CARE SECTOR

An informant from the primary care sector reported that new graduates need more field experience working with seniors. They also need to start learning to work together in a team approach as early as possible in their training.

One informant highlighted communication skills and comfort with difficult situations (e.g., advanced care planning, resuscitation) were difficult for new graduates.

In general, informants were positive about the preparation of new family physicians, seeing new family physicians having more knowledge and competencies for seniors’ care than more experienced family physicians (who completed their residency before enhancements to the residency training programs). In particular, improvements were noted in ability to recognize and manage dementia. However, gaps were noted in ability to screen, recognize, and manage mental illnesses, such as depression.

5. EXPECTATIONS OF NEW GRADUATES AND EXPERIENCED WORKERS

Participants were asked whether expectations of competencies should be different for new graduates compared to more experienced workers. Their responses are described below, by sector. For the most part, informants thought that it was reasonable to expect minimum competencies from a new graduate and more competencies from more experienced workers. Furthermore, with a few exceptions, it was common for informants to believe that new graduates need mentorship in the first few months (at least) of their job to achieve expected competence.

ACUTE CARE SECTOR

Informants in the acute care sector thought that there should be a basic competency level that applies to both new graduates and experienced staff. When setting the expected standard, one informant indicated that the focus should be on what is required from the patient’s perspective. New graduates were seen as needing basic skills, the principles and foundation of geriatric or seniors’ care, and knowing how to apply those principles. It was seen as unrealistic to think that everything can be taught prior to graduation particularly as some graduates will go on to practice in settings outside the senior’s population. Expertise from practice was valued; as

one informant worded it “all the education students receive while in school doesn’t have the same meaning until they put it into practice.”

Several informants thought that health care providers with working experience should have more competence; as stated by one informant, “a greater repertoire of understanding different strategies.”

One informant noted that a new graduate needs time and experience before being able to take on the caseload that an experienced health care provider can do. There was recognition of a need for mentorship of new graduates.

LONG-TERM CARE SECTOR

Informants in the long-term care sector thought new graduates should graduate with core competencies. However, as one informant put it “the new grad is coming out of school with the newest theoretical framework, the newest/latest and greatest best practice but may not be able to put it into practice.” With this in mind, informants thought there is a need to have some leeway and difference in expectation – but a minimum standard is required. As one informant noted “the experienced worker ... (is) expected to have the ability to do assessments, put information together and have a good outcome for the client. A new graduate should be able to identify that something is different and then go down a path of a full assessment and refer the client to other resources as needed.” Informants noted that mentorship is important to their success. There was agreement in an opinion that competency grows with experience.

While most informants thought that a minimum standard should apply to both a new graduate and an experienced worker, they reported that the system does not recognize this difference. As a long-term care informant saw it, a nursing home is paid the same for a new graduate or an experienced staff member, thus, the nursing home needs the same productivity from new graduates and experienced staff. One participant concluded that mentorship was impossible, thus, new graduates were seen as needing to come prepared with fairly advanced competencies (e.g., for nurses to be able to provide clinical care for complex and acute residents, manage and supervise staff, manage budgets and Ministry documentation and reporting requirements, and conduct quality assurance projects).

From a physician perspective, one informant noted that there has been some discussion on setting competencies for physicians working in LTC. “The fear is that if mandatory competencies are set, people already in the field may leave. It is tough to get the balance as these are competencies you need to have in order to do the job.”

COMMUNITY SECTOR

A basic level of competency was expected by most informants; the new graduate will learn the nuances the longer they work. One informant in the community sector noted that there is an expectation that more experienced workers will have a comfort level for home care but this is less so for the new graduate. Similarly, other participants commented that new graduates in the community need support and mentorship to be able to function in the community setting – knowing who to call, who can help, support with interviewing etc.

As one informant indicated, there is an expectation that new graduates are able to screen for common conditions of aging – regardless of discipline (including PSWs). This informant thought that PSWs should be taught screening tools because you do not need to be a professional to administer them – they would need help with what to do afterwards.

Informants in this sector thought that it was not reasonable to have the same expectations, since new graduates have not been exposed to the same experiences as a health care professional who has been working for a while.

PRIMARY CARE SECTOR

Primary care informants felt that new graduates (particularly physicians) should have the same competency as experienced graduates. As an informant stated, if a physician is sued, the law considers the level of training (credentials/qualifications), not the years of experience.

Informants said that minimum knowledge and professionalism is needed at graduation but learning continues after graduation in real work situations. The new graduate needs enough knowledge and skills to take care of patients and then becomes excellent over time.

6. PREFERRED APPROACHES TO BRIDGING THE GAPS

Informants were asked about where health and social service workers should learn about seniors' care and about barriers to continuing education and professional development. Responses are summarized below by sector.

ACUTE CARE SECTOR

PREFERRED APPROACHES

According to informants in the acute care sector, the core curriculum in entry to practice education should focus on best practice guidelines (e.g., RNAO best practice guidelines on delirium, dementia, and depression; Gentle Persuasive Approaches dementia care). It was recommended that Gentle Persuasive Approaches dementia care should be taught to students

and hospital staff. Informants thought that education about aging should start from day one and build as the student moves through their education and eventually into practice.

One informant noted that there is a need to set expectations around the knowledge for seniors' care in entry-to-practice education and for employers; that is, this not 'nice to know' but 'need to know.' This informant stated: "You wouldn't put a person in ICU without additional training and orientation but yet with respect to senior's care, we constantly do this."

Informants thought education for seniors' care competencies needs to be provided by the employer in part. They noted that there is an expectation for life-long learning as it is the responsibility of health professionals to maintain their competency. Informants noted that health care professionals can access education at work, colleges, workshops, and webinars. One informant suggested that it could also be part of the competencies required for continued licensure by the various professional regulatory colleges.

BARRIERS

Cost was cited by informants as a barrier to continuing education. This includes the cost to the individual. However, they noted that there is also a cost to quality care and risk from an organizational perspective if staff is not provided with seniors' care education.

One informant noted that unless an employer organization really values seniors' care, the money for education is squeezed out by other competing specialties or initiatives. In other words, if education is a priority, the money will be available. One informant reported that their hospital is dedicating funding for all nurses to spend 2 days a month with an advanced practice nurse and with colleagues from across the hospital dedicated to gerontological nursing practice. This informant commented: "if we only do things and educate the way we've always done it...that's our barrier. It's finding new ways that are meaningful to practice and to the outcome of the older patient."

Informants from the north reported that barriers related to expense and distance are decreasing with access to online resources. They reported that there is a wealth of educational resources available – webinars, journals, research networks, and more. The volume itself, however, may seem overwhelming and present a barrier to continuing education. One participant noted that it is also important that the continuing education be appealing to the individual and connected to clinical knowledge.

One informant told us that people's time is a barrier. Another participant indicated that often nurses want to do the education on paid time only.

Resistance to learning was noted as a barrier, with informants noting to be effective, people need to be open to learning. One informant noted that, “There’s the resistance, i.e., that if you are showing me something new...you are telling me I’m not doing a good job.”

One informant said that understanding and recognition of need for learning is also a barrier. That is, seniors’ care is not even on people’s radar. As mentioned previously, practitioners not knowing what they don’t know or assuming that they have needed competence because they work with seniors is a barrier. Related to this is a lack of recognition of the relevance of specialized knowledge for seniors’ care to acute care. Linking the importance of this knowledge to patient care outcomes and to staff safety was seen as a way to engage staff. Lack of recognition of this at the management level was also seen as a barrier to moving education forward.

LONG-TERM CARE SECTOR

Informants in the long-term care sector thought that seniors’ care education should happen primarily in entry-to-practice education. This sentiment is nicely summarized by one informant who said, “New graduates need to come to the table armed with knowledge of who are our seniors and where they are at.” Informants noted that increased competency will come with experience; as long as new graduates have the necessary knowledge, skill will come with experience.

PREFERRED APPROACHES

Overall, informants in the long-term care sector thought that what is needed is a mix of formal and informal education (self-directed and employer provided education). They thought that it was not reasonable to expect that all education be done on the employee’s time. Most informants thought that there is a shared responsibility between the employer and employee, recognizing that there are a lot of educational resources that are easy to access.

Informants noted that as the workplace is always changing; thus, lifelong education is needed. One informant commented that belonging to a professional organization is important for staying current. Several informants indicated that nurses should take responsibility for their own professional development. One informant suggested that employers could set job expectations about education and certification required of new hires – this would then translate into interested applicants obtaining those certifications.

One informant noted that the Ministry of Health and Long-Term Care is putting considerable resources into making it possible for people to learn about seniors’ care (e.g., RNAO guidelines, Psychogeriatric Resource Consultants, Alzheimer’s Society, Advocacy Centre, pain and symptom

management consultants, webinars, online resources). This means that the opportunity for health and social care workers to learn and grow regarding seniors' care is greater now than in the past.

Informants believed that education that would benefit point of care staff is often provided to managers and clinical leaders, not point of care staff who would benefit from it.

An observation was made that most of what unregulated professionals learn is through the workplace. Registered staff, on the other hand, seek out formal continuing education. Another informant commented that the best learning happens through dialogue in a group.

BARRIERS

Several informants noted that lack of awareness of the resources that are available can be a barrier. Time and money were barriers identified by many of the informants. Organization costs include paid time for staff, backfill (paying staff to fill in while other staff attend education), and registration fees for courses. There is not a lot of money in education for employers to educate staff unless there are special initiatives.

A participant noted that homes have mandatory education they must provide (mandated in the Long-Term Care Home Act Regulations), which does not leave time or resources for important learning about seniors' care and for the increased acuity of long-term care home residents.

A physician informant noted that barriers to continuing education for physicians include multiple competing demands for time; and the need to be up to date on so many clinical issues (e.g., diabetes, cancer care, CHF, and more).

An informant from the north indicated that there is a dire shortage of staff in the north (i.e., nursing, allied health professionals). Backfill is a struggle, particularly if there is not enough casual staff to cover for the training.

One informant commented that another barrier to continuing education is an often held belief that it is the responsibility of the workplace to provide education, possibly related to union contracts and unions. Burnout was a barrier noted by one informant.

One informant indicated that some staff attend training but then cannot get approval to implement it.

COMMUNITY SECTOR

PREFERRED APPROACHES

Informants noted that it is a shared responsibility between the employer and the employee to pursue educational opportunities. The agency holds some responsibility to support or provide employee training. However, as health care providers, employees should have a focus on life-long learning. Several informants noted that mentorship post-graduation is helpful. In addition, a suggestion was made by one informant that organizations should include seniors' care in their orientation for new employees.

One informant commented that the employer may provide in-services and just in time education at the point of care – staff may not have used some skills for a long time or ever – so there is a need for education at the point of care.

A number of informants noted that a collaborative approach to education is important – partnering with other community agencies and the Alzheimer's Society.

BARRIERS

Informants in the community sector identified finances as a barrier to continuing education. One informant noted that workshops can be expensive. Front line staff need to pick and choose what is best for their ongoing education. Employers provide varying amounts of support for these.

Informants reported that there are budget constraints from an organizational perspective as well. Providing short in-services is one option for the employer to minimize backfill costs. Another informant noted that while there is a cost for training, there may be savings to the system by providing education, for example through reductions in length of stay or avoidance of hospitalization.

Informants noted that time can be a barrier. One participant identified that finding a work-life balance that includes taking courses on weekends or evenings is difficult for employees. In addition, there are so many changes happening in health care that it is difficult to stay on top of all of them.

One informant indicated that another barrier to continuing education is having an awareness of what is available. In addition, another informant suggested that stereotyping related to seniors can create a barrier.

PRIMARY CARE SECTOR

One informant noted that post graduation is when much of the learning occurs – once new graduates are in the real work setting. The importance of regulatory college requirements for continuing education to maintain licensure was noted by informants.

PREFERRED APPROACHES

The majority of informants commented that workshops and conferences are good places for learning. One informant suggested that it would be great if continuing education were funded perhaps by licensing bodies or the Ministry. As noted by one informant, there are many options for education particularly for physicians through professional organizations and colleges.

BARRIERS

From the perspective of a primary care informant, the barriers to continuing education include time, money for course registration, and money for travel. Lack of interest was also noted as barrier. It was thought that there is not the same level of interest in pursuing education related to seniors compared to other topics.

Given the changing demographics, and the complexity of seniors' care, all key informants felt that this was an important area to address.

ANALYSIS

The results of the literature review and key informant interviews support the recommendations made in the report *Living Longer, Living Well* (Sinha, 2012). The literature review and key informant interviews revealed similar findings about practitioners' views of gaps in competencies among the current workforce and new graduate health and social care workers.

The key informant interviews revealed that there are similar gaps in seniors' care competencies among both new graduates and experienced workers. This was true across all sectors and across all professions.

The gaps in competencies for seniors' care among Ontario health and social service workers identified in the key informant interviews all fall in the category of core competencies for seniors' care. As described in the Canadian National Initiative for Care of the Elderly (NICE) *Core Interprofessional Competencies for Gerontology* (nd), "A core competency is a fundamental knowledge, ability or expertise in a specific subject area or skill set" (p. 1). As a key informant noted, the expectations are about competencies that are 'need to know' not 'nice to know'; the

competencies are the fundamental knowledge, skills, and abilities needed to provide seniors' care.

The National Initiative for Care of the Elderly *Core Interprofessional Competencies for Gerontology* (nd), identify competencies for seniors' care in the categories of: (1) clinician; (2) communicator; (3) collaborator; (4) supervisor/leader; (5) advocate; (6) scholar; (7) professional; (8) educator; and (9) health system (staff) member. The key informants identified competency gaps in all nine categories. This reinforces the need to consider a breadth of competencies when planning curriculum for entry-to-practice and continuing professional development.

The following gaps in knowledge or skills were identified in all professions (experienced and new graduates), with similar findings in the literature:

- how older adults differ from the rest of the population and normal versus abnormal aging
- the 3 Ds (dementia, delirium, depression), i.e., types, what they look like in practice, how they differ, prevention, effective interventions
- mental health, mental illness, and concurrent disorders (e.g., mental illness and substance abuse)
- consent, Health Care Consent Act, substitute decision-makers, and capacity assessment
- advanced care planning
- end of life palliative care
- communicating with seniors (particularly those with mental illness and communication deficits)

The following gaps were identified in the key informant interviews but not in the literature:

- assessing and managing complicated cases with co-morbidities
- comprehensive holistic assessment

Some of the gaps identified in the literature were also identified by informants for sectors or for some worker categories but not across all sectors. This may be because most of the literature focused on nurses, where the interviews were not focused on a particular worker category. These gaps, noted in the literature and by some informants include:

- leadership and mentoring
- wound care
- managing violent behaviour and threats
- moving evidence into practice/quality improvement

Other gaps identified in the literature but not in the needs assessment were competencies related to urinary incontinence, pain management, falls and fall prevention, diabetes care, and computer and technology skills.

Informants identified many of the same competency gaps for experienced workers and workers at the entry-to-practice. Informants identified a need to address competency gaps both within entry-to-practice education and within the current workforce. For the most part, informants thought gaps should be addressed, wherever possible, in entry-to-practice education. They thought that courses and placements related to seniors' care should be mandatory in undergraduate training. The gaps identified here should be used, along with published seniors' care competency frameworks, to prioritize continuing education efforts and to inform curricular enhancement decisions of college and university based educators.

Key informants noted that opportunities for practical application of knowledge are important for increasing competency levels. A common theme was that, for the benefit of the client, all health care professionals need to move toward a more person-centred, collaborative approach to seniors' care rather than working in silos. Informants saw that while this move is happening, it is important that new graduates and the current workforce recognize that client-centred goals determine the care plan for the client.

Overall, informants' expectations of a new graduate differ from expectations of an experienced worker. However, the majority thought the new graduate needs to meet the same basic level of competency that an experience worker would. This was particularly so in the long-term care sector, where, reasoning that their work setting does not recognize the difference between a new graduate and health care professional who has been working for some time, several informants concluded that the employer needs both new and experienced workers to do the same job with the same competence.

It was frequently noted that increased competence comes with experience and that mentorship is key to the success of the new graduate. For experienced workers and new graduates, their client experiences, student clinical and practicum placements, and work experiences influence the gaps they demonstrate in seniors' care. The depth of clinical and experiential knowledge was seen as the primary difference between the new graduate and

experienced worker. Results of the key informant interviews indicate a need to support mentorship of new graduates. This can be addressed by extending formal programs such as the Nursing Graduate Guarantee (Health Force Ontario, 2013) for RN and RPN graduates to other worker categories. Some informants in the long-term care sector noted that filling these new graduate guarantee positions was challenging. They noted that the Late Career Nurse Initiative (Health Force Ontario, 2013) was a more effective approach to supporting mentorship of new nurses.

A challenge noted by informants was how to 'skill up' the current workforce so they are more knowledgeable regarding seniors' care. Informants thought that continuing education should focus on the gaps they identified. They noted that there are a lot of educational resources available. While education was seen as a shared responsibility between the employee and employer, informants believed that an expectation of life-long learning is important to instill early because health care is constantly changing. Informants were in favor of a variety of approaches to continuing education, including partnership between community agencies.

The barriers to professional development identified by the informants include the following:

- money (employee ability to pay; organizations budget to support or provide education; other competing demands within the organization for education dollars; replacement costs; education on paid time or not)
- time (to do the training; to access the training; multiple competing demands; work-life balance)
- interest and engagement (i.e., do not see the link to client care and staff safety; not seen as important)
- legislation (LTC regulations mandatory education not leaving time and resources for other education, Ministry of Health and Long-Term Care seen as not recognizing that training has not kept up with acuity in LTC)
- lack of knowledge of the available resources
- volume of resources available – too many to choose from
- staffing (backfill needs)
- distance to travel (particularly in the North, although technology is having a positive impact)

- resistance (i.e., “if you are showing me something new, you are telling me I’m not doing a good job” as well as resistance to change)
- understanding and awareness of importance and lack of knowledge
- leadership (i.e., need to set an expectation that seniors’ care is important organizationally)

A consistently noted strength in the health and social care workforce, across sectors, is caring, commitment, and interest in learning. Although lack of interest or engagement in learning about seniors’ care – and resistance when education is perceived to be coupled with criticism of current practice – were noted as barriers to achieving enhanced seniors’ care competencies, this interest in learning and commitment to care can be leveraged in education initiatives.

Informants recommended creating courses on seniors’ care with an emphasis on geriatric mental health.

An approach for workforce education for seniors’ care competencies should take into account the variation in needs and resources for education across sectors. For example, dementia care education approaches such as Gentle Persuasive Approaches and PIECES were highlighted as strengths in the long-term care sector, while need for these education approaches was noted as a need in the acute care sector. Long-term care legislation means that employers in this sector expend considerable resources on mandated education, leaving limited funding to address the competency gaps identified in this needs assessment. There may be more resources for such education within other sectors.

Some informants reported that incentives in the system drive how people practice and the kind of education they receive. For example, a Ministry of Health and Long-Term Care priority for wound care was reported by a CCAC informant to result in focused education on this topic and improved competencies.

Finally, informants said that it is critical that senior leadership in practice settings set competency in senior’s care as a priority. This is needed for a successful shift in competency and practice. An example of this would be setting expectations of certain seniors’ care competencies as part of the hiring decision. This may provide an incentive for some workers to seek out continuing education. Another example is informants’ examples of how the work context, not just worker knowledge and skills, drives practice. To the extent that senior leaders influence the ways that the work context supports best practices, translating enhanced competencies in the workforce into improved seniors’ care will be achieved.

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APPENDIX 1: LITERATURE SEARCH DETAILS

Databases Used: Medline via OVID, CINAHL, and Social Services Abstract

Limits Applied: 2000-present

Reviewed articles when search resulted in less than 60 articles as per librarians recommendation

TABLE 1A

Criteria for Articles

Inclusion Criteria	Exclusion Criteria
Research literature	Opinion pieces
Grey literature	
Focus on seniors care	Focus on other areas of healthcare (i.e. pediatrics, obstetrics etc....)
English language	Other than English

Search Terms Used:

1. Gerontological nursing OR Geriatric nursing
2. Gerontologic care
3. Health services for the aged
4. Clinical competence
5. Geriatrics
6. Nursing skill
7. Practice patterns
8. Administrative personnel
9. Personnel management
10. New graduates
11. Professional knowledge
12. Quality of care

TABLE 1B

Database Review of CINAHL, Medline via OVID, and Social Services Abstract

CINAHL					
Search History	Search Terms	Subheadings	# Retrieved	# Met Inclusion Criteria	List of Articles ID #
S1	Gerontologic nursing	Standards, manpower	115	-	
S2	Gerontologic care	Standards	197	-	
S3	Health services for the aged	Standards, manpower	170	-	
S4	Clinical competence	Standards, manpower	1624	-	
S5	Geriatrics	Standards, manpower	84	-	
S6	Nursing skill	Standard, manpower	12	0	
S7	Practice patterns	Standards, manpower	289	-	
S8	Administrative personnel	Standards	32	0	
S9	Personnel management	Standards	49	1	1
S10	New graduates	-	889	-	
S11	Professional knowledge	Standards, manpower	18	-	
S12	S1 OR S2 OR S3 OR S5	N/A	550	-	
S13	S12 AND S4	N/A	6	0	
S14	S4 AND S10	N/A	0	0	
<i>Searches are not producing much; broadened search terms to include all subheadings</i>					
S15	Clinical competence	All subheadings included	14,802	-	
S16	Gerontologic nursing	All subheadings included	6437	-	
S17	Gerontologic care	All subheadings included	10,745	-	
S18	Geriatrics	All subheadings included	2111	-	
S19	Health services for the aged	All subheadings included	2671	-	
S20	Administrative personnel	All subheadings included	5731	-	
S21	Nursing skills	All subheadings included	1963	-	

S22	Professional knowledge	All subheadings included	2416	-	
S23	S16 OR S17 OR S18 OR S19	-	20617	-	
S24	S23 AND S15		251	-	
S25	S24	Quality of nursing care	15	1	2
S26	S24	Nursing home personnel	11	1	3
S27	S24	Attitude of health personnel	9	2	4, 5
S28	S24	Health care delivery	5	1	6

MEDLINE via OVID					
Search History	Search Terms	Subheadings	# Retrieved	# Met Inclusion Criteria	List of Articles ID #
S1	Geriatric nursing	Standards, manpower, organization & administration	1907	-	
S2	Geriatrics	Standards, manpower, organization & administration	774	-	
S3	Health services for the aged	Standards, manpower, organization & administration	3151	-	
S4	Clinical competence	Standards	10517	-	
S5	Nursing care	Standards, manpower, organization & administration	2474	-	
S6	Professional practice	Standards, manpower, organization & administration	1469	-	
S7	Students, nursing		0	-	
S8	Administrative personnel	Standards, manpower, organization & administration	343	-	
S9	Health knowledge, attitudes, and practice		55040	-	
S10	Professional competence	Standards	2733	-	
S11	S1 OR S2 OR S3		5350	-	
S12	S11 AND S4		101	-	
S13	S12	Attitudes of health personnel	42	7; Extracted 5 as 2 were previously retrieved	7, 8, 9, 10, 11

S14	S11 AND S10		11	0	
S15	S11 AND S5		33	0	
S16	S11 AND S4 AND S8		0	-	
S17	S11 AND S4 AND S9		20	4; Previously retrieved	
S18	Needs assessment	Standards	267	-	
S19	S11 AND S18		8	0	

Social Services Abstract					
Search History	Search Terms	Subject	# Retrieved	# Met Inclusion Criteria	List of Articles ID #
S1	Gerontological nursing		374	-	
S2	Gerontological care		999	-	
S3	Geriatrics		884	-	
S4	Health services for the aged		2170	-	
S5	Clinical competence		191	-	
S6	Professional competence		417	-	
S7	Needs assessment		2144	-	
S8	Administrative personnel		18	0	
S9	Students, nursing		142	-	
S10	Perception		6531	-	
S11	S1 OR S2 OR S3 OR S4		3925	-	
S12	S11 AND S5		7	0	
S13	S11 AND S6		8	1	12
S14	S11 AND S7		143	-	

TABLE 1C

Reference List Review Results

<i>Articles Identified from Reference List Review of Retrieved Articles</i>		
Article Retrieved From (ID)	Number Retrieved	List of Articles ID #
From et al., 2013 (2)	2	13, 14
Hasson & Arnetz, 2008 (3)	2	15, 16, 17

TABLE 1D

Web of Science Citation Review

Chart Article ID	Reference	# of times cited	# of retrieved articles	List of Articles ID #
1	Kendall, V. (2000). Are you achieving the required standard? <i>Nursing & Residential Care</i> , 2(1), 8-11.	0	-	
2	From, I., Nordstron, G., Wilde-Larsson, B., & Johansson, I. (2013). Caregivers in older peoples' care: Perception of quality of care, working conditions, competence and personal health. <i>Scandanavian Journal of Caring Science</i> , 27(3), 704-714.	0	-	
3	Hasson, H., Arnetz, J.E. (2008). Nursing staff competence, work strain, stress and satisfaction in elderly care: A comparison of home based care and nursing homes. <i>Journal of Clinical Nursing</i> , 17(4), 468-481.	26	0	
4	Gandesha, A., Souza, R., Chaplin, R., & Hood, C. (2012). Adequacy of training in dementia care for acute hospital staff. <i>Nursing Older People</i> , 24(4), 26-31.	Not in database	-	

5	Ma, A. (2005). Importance and adequacy of practice competencies for care professionals in aging-related fields: Chinese administrator's perspective. <i>Gerontology & Geriatrics Education</i> , 26(2), 17-34.	Not in database	-	
6	Slone, P.D., Zimmerman, S., Perez, R., Reed, D., Harris-Wallace, B., Khandelwal, C., Beeber, A.S., Madeline, M.C., & Schumacher, J. (2011). Physician perspectives on medical care delivery in assisted living. <i>Journal of the American Geriatrics Society</i> , 59(12), 2326-2331.	3	0	
7	Saxer, S., de Bie, R., Dassen, T., & Halfens, R. (2008). Nurses' knowledge and practice about urinary incontinence in nursing home care. <i>Nurse Education Today</i> , 28, 926-934.	4	2	18, 19
8	Gronroos, E., & Perala, M.L. (2008). Self-reported competence of home nursing staff in Finland. <i>Journal of Advanced Nursing</i> , 64(1), 27-37.	5	0	
9	Brown, E., Raue, P., Schulberg, H., & Bruce, M. (2006). Clinical competencies: Caring for late-life depression in home care patients. <i>Journal of Gerontological</i> , 10-14.	Not in database	-	
10	Kaasalainen, S., Baxter, P., Schindel Martin, L., Prentice, D., Rivers, S., D'Hondt, A., Ploeg, J., Coker, E., Montemuro, M., Hammers, J., & Roberts, E. (2006). Are new RN graduates prepared for gerontological nursing practice? Current perceptions and future directions. <i>Perspectives</i> , 30(1), 4-10.	Not in database	-	
11	Lees, L., Hill, C., & Coles, T. (2006). Without prejudice: Results and realisation of a training needs audit in nursing homes. <i>Nursing Older People</i> , 18(4), 19-27.	Not in database	-	
12	Naito-Chan, E., Damron-Rodriguez, J., & Simmons, J. (2005). Identifying competencies for geriatric social work practice. <i>Journal of Gerontological Social Work</i> , 43(4), 59-78.	Not in database	-	
13	Josefsson, K., Sonde, L., & Robins Wahlin, T.B. (2007). Registered nurses' education and their views on competence development in municipal elderly care in Sweden: A questionnaire survey. <i>International Journal of Nursing Studies</i> , 44, 245-258.	8	0	

14	Josefsson, K., Sonde, L., & Robins Wahlin, T.B. (2008). Competence development of registered nurses in municipal elderly care in Sweden: A questionnaire survey. <i>International Journal of Nursing Studies, 45</i> , 428-441.	5	0	
15	Badger, F. & Mullan, B. (2003). Aggressive and violent incidents: Perceptions of training and support among staff caring for older people and people with head injury. <i>Journal of Clinical Nursing, 13</i> , 526-533.	21	0	
16	Raudonis, B., Kyba, F., & Kinsey, T. (2002). Long-term care nurses: Knowledge of end-of-life care. <i>Geriatrics Nurse, 23</i> , 296-300.	18		20, 21, 22, 23

Note: Articles that cited the articles listed above – searched by article title

TABLE 1E

List of Articles

ID #	Reference
1	Kendall, V. (2000). Are you achieving the required standard? <i>Nursing & Residential Care</i> , 2(1), 8-11.
2	From, I., Nordstron, G., Wilde-Larsson, B., & Johansson, I. (2013). Caregivers in older peoples' care: Perception of quality of care, working conditions, competence and personal health. <i>Scandanavian Journal of Caring Science</i> , 27(3), 704-714.
3	Hasson, H., Arnetz, J.E. (2008). Nursing staff competence, work strain, stress and satisfication in elderly care: A comparison of home based care and nursing homes. <i>Journal of Clinical Nursing</i> , 17(4), 468-481.
4	Gandesha, A., Souza, R., Chaplin, R., & Hood, C. (2012). Adequacy of training in dementia care for acute hospital staff. <i>Nursing Older People</i> , 24(4), 26-31.
5	Ma, A. (2005). Importance and adequacy of practice competencies for care professionals in aging-related fields: Chinese administrator's perspective. <i>Gerontology & Geriatrics Education</i> , 26(2), 17-34.
6	Slone, P.D., Zimmerman, S., Perez, R., Reed, D., Harris-Wallace, B., Khandelwal, C., Beeber, A.S., Madeline, M.C., & Schumacher, J. (2011). Physician perspectives on medical care delivery in assisted living. <i>Journal of the American Geriatrics Society</i> , 59(12), 2326-2331.
7	Saxer, S., de Bie, R., Dassen, T., & Halfens, R. (2008). Nurses' knowledge and practice about urinary incontinence in nursing home care. <i>Nurse Education Today</i> , 28, 926-934.
8	Gronroos, E., & Perala, M.L. (2008). Self-reported competence of home nursing staff in Finland. <i>Journal of Advanced Nursing</i> , 64(1), 27-37.
9	Brown, E., Raue, P., Schulberg, H., & Bruce, M. (2006). Clinical competencies: Caring for late-life depression in home care patients. <i>Journal of Gerontological</i> , 10-14.
10	Kaasalainen, S., Baxter, P., Schindel Martin, L., Prentice, D., Rivers, S., D'Hondt, A., Ploeg, J., Coker, E., Montemuro, M., Hammers, J., & Roberts, E. (2006). Are new RN graduates prepared for gerontological nursing practice? Current perceptions and future directions. <i>Perspectives</i> , 30(1), 4-10.
11	Lees, L., Hill, C., & Coles, T. (2006). Without prejudice: Results and realisation of a training needs audit in nursing homes. <i>Nursing Older People</i> , 18(4), 19-27.
12	Naito-Chan, E., Damron-Rodriguez, J., & Simmons, J. (2005). Identifying competencies for geriatric social work practice. <i>Journal of Gerontological Social Work</i> , 43(4), 59-78.
13	Josefsson, K., Sonde, L., & Robins Wahlin, T.B.(2007). Registered nurses' education and their views on competence development in municipal elderly care in Sweden: A questionnaire survey. <i>International Journal of Nursing Studies</i> , 44,

	245-258.
14	Josefsson, K., Sonde, L., & Robins Wahlin, T.B. (2008). Competence development of registered nurses in municipal elderly care in Sweden: A questionnaire survey. <i>International Journal of Nursing Studies, 45</i> , 428-441.
15	Badger, F. & Mullan, B. (2003). Aggressive and violent incidents: Perceptions of training and support among staff caring for older people and people with head injury. <i>Journal of Clinical Nursing, 13</i> , 526-533.
16	Raudonis, B., Kyba, F., & Kinsey, T. (2002). Long-term care nurses: Knowledge of end-of-life care. <i>Geriatrics Nurse, 23</i> , 296-300.
17	Hsu, M.C., Moyle, W., Creedy, D., Venturato, L. (2005). An investigation of aged care mental health knowledge of Queensland aged care nurses. <i>International Journal of Mental Health Nursing, 14</i> , 16-23
18	Lin, S.Y., Wang, R.H., Lin, C.C., & Chiang, H.Y. (2012). Competence to provide urinary incontinence care in Taiwan's nursing homes: Perceptions of nurses and nurse assistants. <i>Journal of Wound Ostomy and Continence Nursing, 39</i> (2), 187-193.
19	Keilman, L., & Dunn, K. (2010). Knowledge, attitudes, and perceptions of advanced practice nurses regarding urinary incontinence in older adult women. <i>Research and Theory for Nursing Practice: An International Journal, 24</i> (4), 260-279.
20	Choi, M., Lee, J., Kim, S., Kim, D., & Hokon, K. (2012). Nurses' knowledge about end-of-life care: Where are we? <i>The Journal of Continuing Education in Nursing, 43</i> (8), 379-384.
21	Ford, R. & McInerney, F. (2011). An evaluation of aged-care workers' knowledge of and attitudes toward the palliative approach. <i>Research in Gerontological Nursing, 4</i> (4), 251-259.
22	Hirakawa, Y., Kuzuyam N., & Uemura, K. (2009). Opinion survey of nursing or caring staff at long-term care facilities about end-of-life care provision and staff education. <i>Archives of Gerontology and Geriatrics, 49</i> , 43-48.
23	Whittaker, E., Kernohan, W.G., Hasson, F., Howard, V., & McLaughlin, D. (2006). The palliative care education needs of nursing home staff. <i>Nurse Education Today, 26</i> , 501-510.

APPENDIX 2: INTERVIEW GUIDE

1. First, could you please tell me, what kind of gaps do you think there are in terms of competency for seniors care among current providers? *(probe for information that is specific to the profession they represent – probe for information about differences across professions if relevant.) (probe for specifics on what they see lacking)(probe for examples/evidence/ reasons for their opinion)*
2. Could you please tell me about where you see the strengths are in the current workforce in terms of competency for seniors care? *(probe for details about what they see current workers doing well – and specific to profession if possible)*
3. Thinking about new graduates, do you think there are any gaps in terms of their competency for seniors care? *(probe for specifics in terms of the competencies, examples, and for which profession their opinion applies to) (probe for evidence – implications)*
4. Do you think expectations of competencies should be different between experienced practitioners and new graduates? In what way? *Probe for details and for differences across professions.*
5. To what extent do you think that achieving competencies for seniors care should happen in entry-to-practice education (before a student graduates)? What should happen after graduation? Where should health and social service workers learn about seniors care (e.g., employer provided education, community college continuing education, conferences, ...). What are barriers to continuing education and professional development?