



# Development of Nurse Competencies to Improve Dementia Care

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The rapid increase in the number of elders who need dementia care and the critical need for skilled care providers prompted Florida legislators to enact legislation to improve the care of these residents. One component of the new legislation mandated dementia training for long-term care staff and led to the development of dementia care competencies that would guide a competency-based curriculum to meet the demand for training. The competencies, methods used for development, and information regarding how to access these newly developed resources are described in this article. (*Geriatr Nurs* 2005;26:98-105)

**D**emographics related to the care of residents in long-term care (LTC) are providing the impetus to improve care in nursing homes for residents with dementia. At least 60% of all nursing home residents have some form of dementia,<sup>1</sup> and that number will continue to grow.<sup>2</sup> Consistent with this trend, the state of Florida legislature enacted major reforms in 2001 through Senate Bill 1202. The legislation established new nurse staffing levels, dementia training for staff, and tort reform.<sup>3</sup> Specifically, the legislature mandated that all nursing home staff members who have direct contact with residents receive 1 hour of required dementia care education and further, that clinical staff with direct patient contact receive 3 additional hours of dementia training (SB 1202, page 62, section 26).

The state of Florida allocated responsibility for the implementation of this new law to 2 state agencies—the Department of Elder Affairs (DOEA) to “prescribe training standards” by establishing a program to approve curriculum and certification of Alzheimer’s trainers and the Agency for Health Care Administration (AHCA) to monitor if nursing home staff received the required dementia training as proscribed by law. New rules, based on the language of SB1202, were promulgated by the DOEA, including a set of recommendations called “Training Guidelines

for the Special Care of Nursing Home Residents with Alzheimer’s Disease or Related Disorders (ADRD).” These rules required 1 hour of content to include an understanding of ADRD, characteristics of ADRD, and communicating with residents with ADRD, as well as 3 additional hours of content for direct-care staff to include information on behavior management, assistance with activities of daily living, activities for residents, stress management for the caregiver, family issues, resident environment, and ethical issues (Florida Administrative Code 58A-4.001. F.A.C.).

The state of Florida had a unique resource to help develop new materials to meet the training requirements. In 2000, recognizing the increasing number of elders in Florida and the need to educate health care providers about how to care for them, the state funded the Teaching Nursing Home (TNH) to “formulate, implement, advocate, and disseminate best practices.” Florida House Bill 1971 charged AHCA with the establishment of a Teaching Nursing Home Pilot Project “to improve and expand capacity of Florida’s healthcare system to respond to the medical, psychological, and social needs of the increasing population of frail older citizens. In 2001, as the TNH was establishing its structure and products, the Advisory Committee chose to develop a model curriculum to meet the new dementia training requirements. The TNH Steering Committee convened a statewide Advisory Committee of Dementia Care Experts,<sup>2</sup> who were given the charge for curriculum development. The Advisory Committee of Dementia Care Experts included representatives from AHCA, DOEA, the Alzheimer’s Association, Florida Association of Homes for the Aging (FAHA), Florida Health Care Association (FHCA), and the Department of Veteran’s Affairs (DVA), as well as from Florida’s leading universities and professional organizations. The committee’s responsibility was to create a model for development, dissemination, evaluation, and validation of the dementia training materials.

Two realities shaped the decision to focus the educational development efforts toward LPNs. In 2002 and 2003, LPNs averaged 0.9 hours of care per resident day in comparison to 0.6 hours of care from RN staff in Florida long-term care facilities.<sup>4</sup> LPNs are the largest group of licensed caregivers, and they provide the majority of licensed nursing care to long-term care residents. Furthermore, at the same time the Advisory Committee was deciding about the audience for the curriculum, the Florida Board of Nursing approved a rule change to expand LPNs' role to include direct supervision of long-term care paraprofessional staff if the LPN took an additional 30 hours of supervisory training. Thus, LPNs' role of caring for residents with dementia evolved to include supervision and mentoring of the most numerous nursing home workers, certified nursing assistants (CNAs), who were responsible for the day-to-day care of dementia residents. The Advisory Committee also realized that the LPN focus would be optimal for future repeated efforts; professional materials could be edited for the RN audience and simplified for CNAs.

Recognizing that a competency-based curriculum is more likely to improve care outcomes,<sup>5</sup> the TNH Advisory Committee, composed of nursing educators and experts in dementia care, met to develop dementia education competencies. This initial process of competency development was considered crucial; it drove the content development and is the focus of this article.

### Development of Competencies

Ballantyne and colleagues<sup>6</sup> stressed the need for the development of competency criteria that could ensure effective care provided by nurses working with the older adults. Zhang<sup>7</sup> defined nursing competencies as "sets of knowledge, skills, traits, motives and attitudes that are required for effective performance in a wide range of nursing activities" (p. 469). To begin the process of developing competencies, a literature search was conducted. Results indicated that although significant progress has been made toward the development of "best practices" for care of the older adult, little published material was available directed specifically toward LPN practice in LTC and the person with dementia.<sup>8</sup>

Competency-based education focuses on performance of measurable outcomes; the value of this approach is that one can measure outcomes by assessing differences in quality of care per-

formed by the care provider. In an attempt to implement the state mandate and improve care delivery in LTC, the task force focused on the development of competencies that would provide desired outcomes for the curriculum. A review of LPN curricula, National League for Nursing (NLN) publications, and Florida scope of practice for LPNs was completed, providing necessary direction to identify the appropriate level of knowledge, skills, and attitudes.

The task force identified a comprehensive level of dementia knowledge necessary to provide high-quality care. Members further delineated which of these content areas were basic to dementia care delivery and necessary to include in the initial hour of training and which would be included in the additional 3 hours of training mandated for direct care staff. Advanced competencies, such as identification and treatment of pain in dementia and end-of-life care, were identified but could not be included in the initial state-mandated training because of time constraints. It was decided that content with this focus could be developed at a later date, building on the basic knowledge mandated in the 4 training hours.

Another dilemma was how to integrate the state-mandated areas with the outcome competencies defined by the group and considered crucial to quality care. For example, the group had identified competencies related to the importance of the LTC environment well beyond the training guidelines promulgated by DOEA. The group recognized the importance of quality of life for persons with dementia as well as ethical content and chose to include these additional competencies. Negotiations involved a year-long process of competency development, presentation and feedback from an advisory committee, and development and continued refinement of content modules.

Taylor<sup>9</sup> identified 4 broad areas of nursing competencies—interpersonal, intellectual, technical, and moral—and stated that nurses often emphasized technical and intellectual competencies to the exclusion of interpersonal and moral competencies. The task force group concurred that it was important to include moral and interpersonal competencies, especially considering the care required for the vulnerable population experiencing dementia in nursing homes. The task force evaluated the competencies needed for dementia-specific care in long-term care, with a broad focus of including the

**Table 1.**  
**Domains for Nursing Competencies**

|               |   |
|---------------|---|
| Interpersonal | Establishing and maintaining caring relationships                             |
| Intellectual  | Reasoning to achieve valued goals   |
| Technical     | Manipulating equipment skillfully   |
| Moral         | Living is consistent with one's personal moral code and role responsibilities |

**Table 2.**  
**Nursing and Dementia Competencies**

| Dementia-Specific Competencies: Phase 1 Training |   | Nursing Competencies        |
|--|---|-----------------------------|
| Competency 1.1                                   | Understands the characteristics of dementia and the special needs of the person with dementia   | Intellectual, interpersonal |
| Competency 1.2                                   | Adapts communication to cognitive/emotional needs of the person with dementia   | Interpersonal               |
| Competency 2.1                                   | Demonstrates a working knowledge of dementia  | Intellectual                |
| Competency 2.2                                   | Recognizes, prevents, and manages distress behaviors including agitation, pacing, exit-seeking, combativeness, withdrawal, and repetitive vocalizations | Interpersonal, moral        |
| Competency 2.3                                   | Understands special needs of family and friends of persons with dementia  | Interpersonal, intellectual |
| Competency 2.4                                   | Promotes independence in activities of daily living   | Intellectual, interpersonal |
| Competency 2.5                                   | Promotes an optimal environment that will support resident autonomy and enhance capabilities  | Intellectual, interpersonal |
| Competency 2.6                                   | Recognizes ethical issues that arise in dementia care and incorporates these into care approaches   | Moral, intellectual         |

Note: These categories (excluding the technical category) provided a framework from which to organize the competencies that were developed (see [Table 1](#)).

intellectual skills required in the state mandate and the additional moral and interpersonal skills the group considered important to quality of care. For example, one of the state-mandated content areas was “managing problem behaviors.” Members of the task force decided to shift the focus to person-centered

care that involved responding to the needs of the resident rather than focusing on the problem for the staff. This philosophy is consistent with the national Alzheimer’s Association approach to care.<sup>10</sup> Taylor<sup>9</sup> defined the competencies as abilities in a variety of domains (see [Table 1](#)).

## **Table 3.** **Competencies**

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### **Phase 1. 1 Hour of Training**

#### **Competency 1: Understands the characteristics of a dementing illness and the special needs of the person with dementia**

##### Knowledge, skills, attitudes:

- Defines dementia as decreasing brain function including memory problems, loss of some thinking and communication skills, and changes in personality
- Contrasts dementia with cognitive changes of normal aging and delirium
- Describes the early, middle, and late phases of dementia
- Recognizes and incorporates into the dementia care plan that quality of life is a realistic goal
- Interprets individual responses, mood, and other feedback as meaningful
- Seeks to create a homelike and comfortable environment
- Seeks a wide range of resources, such as community volunteers in daily care, whenever possible
- Uses individual's preferences and social history in daily practice

#### **Competency 2: Adapts communication to cognitive/emotional needs of the person with dementia**

##### Knowledge, skills, attitudes:

- Explains changes in communication skills that occur during progression of dementia
- Describes the relationship between communication and distress behaviors
- Demonstrates strategies for effective verbal and nonverbal communication
- Uses touch to gain person's attention
- Uses simple sentences
- Presents 1 idea at a time
- Asks 1 question at a time
- Avoids negatively worded statements
- Breaks down tasks
- Gives simple choices
- Identifies nonverbal expressions of physical discomfort and pain
- Demonstrates communication skills and strategies for managing disruptive, aggressive, or other problem behavior
- Listens and responds to emotional message
- Uses verbal redirection
- Uses written and visual cues
- Allows time to respond
- Avoids asking "why," arguing, correcting misinformation, confrontation
- Avoids raising voice
- Avoids sarcasm with person with dementia
- Demonstrates desired action
- Reacts appropriately to negative communication by individual with dementia
- Avoids responding to negative language by individual with dementia
- Uses redirection
- Reinforces (own) positive (caregiver) self-image using techniques such as positive self-talk
- Discusses cultural differences in individuals with dementia and how to appropriately adapt communication strategies
- Includes emotion-focused communication strategies in interactions with individuals
- Gives recognition
- Expresses positive regard
- Uses verbal encouragers
- Explores incomplete expressions of ideas

### **Table 3.** **Competencies (continued)**

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- Adopts an attitude of respect for individuality and dignity of the person with dementia
- Uses individual's name in communication
- Approaches individual in a calm, unhurried manner
- Avoids confrontation and arguments in communication

#### **Phase 2: 2–4 Hours of Training**

##### **Competency 1: Demonstrates a working knowledge of dementia**

###### Knowledge, skills, attitudes:

- Lists several diseases or conditions that may cause dementia
- Identifies polypharmacy, depression, and other conditions that may result in symptoms of dementia
- Describes how the disease progresses, as well as its symptoms, behaviors, and challenges associated with each stage.
- Discusses current research findings, including the research on cause, prevention, cure, and the recommended diagnostic process

##### **Competency 2: Recognizes, prevents, and manages distress behaviors including agitation, pacing, exit-seeking, combativeness, withdrawal, and repetitive vocalizations**

###### Knowledge, skills, attitudes:

- Recognizes antecedents and consequences for distress behaviors
- Monitors, documents, and reports to team the time, place, and circumstances accompanying distress behaviors
- Looks for patterns that reveal potential causes (correlates vs. triggers) of distress
- Monitors, documents, and reports to team staff responses to residents' distress behaviors and residents' responses to consequences
- In collaboration with interdisciplinary team and family, plans prevention or modification strategies and addresses residents' needs
- Under the direction of a registered nurse, teaches and supervises nursing assistants regarding their responses to dementia-related behaviors
- Assists in the design and implementation of care plan
- Cooperates in modification of care plan
- Teaches and supervises nursing assistants in reporting behaviors
- Under the direction of a registered nurse, teaches and implements recommended staff stress-relieving strategies such as social support
- Promotes quality of life and mental health consistent with resident's individual history and preferences through:
  - pet therapy
  - music therapy
  - structured activities
  - family photos and/or tape recordings
  - physical exercise
- Describes the risks associated with wandering, pacing, and exit-seeking
- Identifies and addresses mental health issues appropriately
- Identifies and reports symptoms of psychological distress, acute confusion, or depression
- Describes the effects of pain, illness, limited mobility, and sensory loss on behavior
- Discusses the use, effects, side effects, and undesirable effects of medications used in memory loss
- Discusses the use, effects, side effects, and undesirable effects of medications used to manage symptoms of dementia
- Understands the use and misuse of restraints

### **Table 3.** **Competencies (continued)**

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#### **Competency 3: Understands special needs of family and friends of persons with dementia**

Knowledge, skills, attitudes:

- Discusses the psychological needs and stress of family members including
  - stages of grief, anger, concern, and guilt
  - cultural differences in expressions of grief, anger, concern, guilt
  - how to respond to family expression of these needs and stresses
- Identifies and reports family member needs, problems, and concerns to the team
- Plans with team strategies to address family issues and includes family input
- Supervises nursing assistants regarding their responses to families' concerns
- Includes family members in planning care and devising strategies as a means to provide quality care
- Incorporates resident's philosophy and values in an individualized care plan

#### **Competency 4: Promote independence in activities of daily living**

Knowledge, skills, attitudes:

- Incorporates an approach to remaining capabilities and capitalizes on individual's potential for rehabilitation
- Breaks tasks down to manageable components
- Promotes independence in activities of daily living
- Looks for appropriate process as outcome in chosen activities rather than successful product
- Encourages direct care staff in "doing with" rather than "doing for" approach to activities of daily living
- Allows for personal choices and preferences using past history and other family information

#### **Competency 5: Promotes an optimal environment**

Knowledge, skills, attitudes:

- Maintains safety and security of residents
- Monitors environmental stimuli
- Provides information as to date, day, season, and weather
- Ensures needed auditory and visual aids and mobility and memory aids
- Increases lighting to prevent shadows
- Identifies and responds to individual's feelings and fosters their expression
- Reduces isolation through group activities, through family, friend, and community visits, and intergenerational experiences
- In collaboration with other departments and consultants, promotes physical, social, and mental health
- Avoids overhead paging
- Promotes social interaction among individuals with dementia as well as staff members
- Uses simple designs and colors
- Avoids mirrors in hallways or common rooms
- Provides sheltered freedom
- Initiates appropriate conversation to maintain abilities
- Provides opportunity for productivity
- Decreases background noise (e.g., TV, radio)
- While maintaining resident confidentiality, posts signs as reminders; puts labels on family photos, uses other written cues
- Promotes constancy and predictability through a consistent and individualized routine, familiar caregivers, and appropriate activities

### **Table 3.** **Competencies (continued)**

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#### **Competency 6: Recognizes ethical issues that arise in dementia care and incorporates these into care approaches**

##### Knowledge, skills, and attitudes:

- Articulates an awareness of issues such as privacy, honesty, and autonomy in the daily care of persons with dementia
- Identifies common ethical conflicts that may arise when caring for residents with dementia
- Discusses ethical decision-making process using problem-based learning
- Recognizes variability in family and cultures in making ethical decisions
- Identifies the resources available for resolving ethical dilemmas

##### **Advanced Competencies**

- To prevent excess disability, incorporates an approach to support remaining capabilities and capitalizes on potential for rehabilitation
- Identifies physical discomfort, pain, fatigue, dehydration, hunger
- Identifies verbal and nonverbal pain and discomfort, reports changes in cognitive function, anticipates individual's needs to prevent pain, fatigue, dehydration, and hunger and assists with plan to address same
- Understands the end-of-life issues facing residents, staff, families, and guardians related to dementing illness
- Explains the complex and terminal nature of providing care for persons with advanced, progressive dementia
- Incorporates palliative care principles into planning, supervision, and delivery of care
- Discusses the concept and implementation of an Advance Directive

Dementia-specific competencies were prioritized for each phase of state-mandated training. Phase 1 (1 hour of training) included an overview of dementia and communication issues. Phase 2 included more detailed content on dementia and its treatment, related behavioral changes, the role of the family, and ethical issues. Time constraints of the state-mandated training necessitated creating advanced competencies for other content that the task force considered important but could not be included in either phase 1 or phase 2 (see [Table 2](#)).

The task force constructed a draft of the LPN competencies, as well as a diagram depicting the progression from core to advanced competencies within a novice-to-expert framework. The draft was distributed to the Advisory Committee members for review and in a face-to-face meeting; each competency was discussed along with questions and comments from LPNs at the TNH who reviewed earlier drafts. Suggestions from the wider group were incorporated, and consensus was reached. The revised document was distributed by e-mail for comments and revisions.

At the end of 2001, the final version was ready to be used for the development of the curriculum.

Although core competencies will change as knowledge and skills in dementia care advance, the list in [Table 3](#) represents the current consensus of the TNH Steering Committee. The proposed phases of training for LPN competencies is organized to reflect training that might occur in 1- and 3-hour sessions in compliance with the dementia training mandate of SB1202.

With the projected increases in the number of elders with dementia in nursing homes and the rapidly growing dementia population in the LTC system in Florida, it was imperative to ensure that Florida's nursing home care providers were prepared to care for these residents. The Florida legislature signed into law SB 1202 in 2001 to begin the process of improving dementia care.<sup>3</sup> Legislation passed in 2002 requires the same 4-hour mandatory dementia training for hospice and adult day care personnel and recognizes the pressing need to train all staff who work with community living elders to be competent in dementia care.

The competencies for dementia care and the curriculum based on those competencies are currently available through the TNH online educational site GeriU ([www.GeriU.org](http://www.GeriU.org)). GeriU is the first online geriatric university dedicated specifically to the provision of accurate and timely information on the care of older patients for health care providers. Although these educational resources were developed with State of Florida funding for Florida nurses, by accessing this Web site, any health care provider can use the dementia education learning modules without cost. The learning modules are available from the "Public Content" link at the GeriU Web site. From there, the learner will be directed to a link to Florida's Teaching Nursing Home Program. The instructional activities titled "Nursing Home Alzheimer's Disease and Related Disorders Training for LPNs" include learning modules divided into 2 sections representing basic and more advanced training. The basic modules ("Understanding Dementia" and "Communication") provide an overview of dementia, quality of life, person-centered care, types of communication, and accommodations to improve communication with cognitively impaired residents. There are 5 modules that make up the second phase of the program ("Distress Behavior," "Loved Ones," "Activities of Daily Living," "Environment," and "Ethics"). Each module begins with a set of objectives, followed by learning activities, practice exercises, and resources for further information. Modules are presented as computer-based interactive learning that can be completed independently.

A complete description of the training materials and the curriculum is beyond the scope of this article; it will be the subject of a forthcoming paper.<sup>11</sup> The results of a preliminary evaluation of the program are reported elsewhere.<sup>12</sup> With its high concentration of older residents, Florida is positioned to develop models of care and education for long-term care providers. This article has described the process we used to develop not only the most comprehensive competencies to guide staff training but also the need to establish buy-in from all of the constituents who provide and would benefit from this training.

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