Abstract

One of the biggest challenges facing health and social care in the United Kingdom is the projected increase in the number of older people who require dementia care. The National Dementia Strategy (Department of Health, 2009) emphasizes the critical need for a skilled workforce in all aspects of dementia care. In the West Midlands, the Strategic Health Authority commissioned a project to develop a set of generic core competencies that would guide a competency based curriculum to meet the demands for improved dementia training and education. A systematic literature search was conducted to identify relevant frameworks to assist with this work. The core competency framework produced and the methods used for the development of the framework are presented and discussed.

Keywords competencies, dementia, development, framework, workforce

Background

Dementia care has become an important and urgent global issue, posing a major current and future challenge for health economies. There are estimates of 35.6 million people living with dementia worldwide in 2010 and this number will increase to 65.7 million by 2030 and 115.4 million by 2050 (Alzheimer’s Disease International, 2010). The Alzheimer’s Research Trust’s (2010) recent report suggests that there are currently 820,000 people in the UK with dementia, whilst 61,800 are estimated to live in the West Midlands region (Seamer, 2009). Dementia has a devastating effect on individuals with the condition, but it can also have a profound, negative impact on the family, carers and other relatives (Knapp et al., 2007). Dementia plans and strategies are being developed and implemented by a number of countries (Hardy, Benbow, & Kingston, 2010). The National Dementia Strategy for England was published in 2009 (Department of Health, 2009). Alongside this Strategy there is increasing awareness of the implications of changing population demography in the United Kingdom for dementia care (Alzheimer’s Society, 2007), and recognition that the health and social care costs to the economy of caring for people with dementia are a political issue (Alzheimer’s Research Trust, 2010; Lowin, Knapp, & McCrone, 2001). Dementia presents a challenge for services across the UK (and indeed across the world) as the population ages, both in terms of the increasing numbers of people who will require treatment, care and support, and in terms of the decreasing pool of people to draw on as informal carers with implications for workforce cost.

The dementia workforce underpins the care of people living with dementia and their families and this is emphasized in The National Dementia Strategy (Department of Health, 2009). Although only one of the 16 identified objectives in that Strategy directly concerns the workforce, ‘objective 13: an informed and effective workforce for people with dementia’ (p. 13), it is clear that the availability of a properly motivated, trained and resourced workforce is key to delivery of the Strategy as a whole and will determine whether or not the other objectives can be met. The document refers to the need for agreement on the core competencies required in dementia care (p. 65) and for curricula to be adapted in order to include these core competencies in both pre- and post-qualification training. It calls on Commissioners to specify what dementia training service providers are required to undertake, and goes on to state on page 66 that:

People with dementia and their carers need to be supported and cared for by a trained workforce, with the right knowledge, skills and understanding of dementia to offer the best quality care and support.

This presents a not inconsiderable challenge to service providers and also to providers of education, since people with dementia are cared for, supported and treated in a wide range of settings: in the health service this includes mental health services, acute hospital care, older people’s medical services, neurological services and others; in social services it includes domiciliary care, day centres, residential and nursing homes, among others; and in the community both services provide various forms of treatment and care to people with dementia and their families. To develop a competent and well-trained workforce will require inclusion of dementia training in basic training for all professional groups and in continuous professional and vocational development. The Strategy encourages health and social care agencies to work together in order to develop the workforce.

In the West Midlands, Saad, Smith and Rochfort (2008) produced a strategy document which predated The National Dementia Strategy and went a step further by including the following objective:

… minimum core standards of competency for dementia care will be used to underpin all education programmes for staff working alongside people with dementia.

Recognizing that a competency based dementia training is more likely to improve dementia care outcomes, rather than just an educational training void of competencies, the Workforce Deanery at NHS West Midlands commissioned the development of a set of generic core competencies applicable to the whole of the dementia workforce across health and social care. The initial process of competency development was considered crucial because this set of competencies was expected to address all the stages of the West Midlands Dementia Pathway. Thus, this process drove the content development and is the focus of this article.

Defining competencies

Before going into the detailed explanation of the method we deemed it essential to define competencies so that there is a common understanding between the reader and the authors of this article. There have been various definitions for the term ‘competency’ such as:

The state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of one’s professional responsibilities. (Roach, 1992)

A more recent definition is that of Schwarz and Wojtczak (2002) who described competency as the possession of a reasonable level of pertinent knowledge and attainment of a diversity of appropriate skills that include interpersonal and technical components. Such knowledge and skills are necessary to complete the tasks that reflect the scope of professional practices.

We present here the development of a Core Competency Framework designed for the entire dementia workforce in the West Midlands.

Method

Identifying core competencies and skills

We identified potentially relevant frameworks, and sources of literature to aid the development of competencies and skills suitable for the dementia workforce. A systematic search was undertaken (see NHS Centre for Reviews and Dissemination, 2008) involving comprehensive searches of electronic databases, journals, books, citation tracking and internet searches (following links when appropriate) from 1999 to December 2009. The following terms were entered when searching the electronic resources listed below: ‘competency’, or ‘competencies’ in conjunction with ‘framework’, ‘dementia’, and ‘workforce’. Some supplementary terms were also used to facilitate the search such as ‘health and social care’ and ‘mental health’.

PubMed

CINAHL

Social Care Online

Ovid Nursing Collection

ProQuest Nursing and Allied Health Source

ISI Web of Knowledge

NHS Health and Social Care

Google Scholar

The relevant identified literature was inserted into an Endnote library where it was filtered for duplication. Eighteen competency frameworks were identified as being the most relevant to our purposes (Table 1). The search results indicated that even though considerable improvement has been made in developing ‘best practices’ for the care of older people, little published material and few frameworks were available dedicated explicitly to the dementia workforce and the individual with dementia and their carer.

Table

Table 1. Competency frameworks relevant to dementia workforce that assisted the competency framework development process

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The frameworks were thoroughly reviewed so as to identify generic competencies and skills that applied to the dementia field and could be used by the education providers for the provision of generic dementia training of the dementia workforce. The aim was to select generic skills and competencies that would serve every profession, grade and level within the dementia care workforce. All the competencies and skills that met these targets were adopted.

We placed the identified competencies in a hierarchy of relevance to dementia, i.e. ‘dementia specific’ or more ‘general’, in order to highlight the dementia focus of the framework as well as to facilitate its use for the education providers. Hence, on top of the hierarchy we placed the competencies that were more ‘dementia specific’, with the first being ‘knowledge/awareness of dementia and dementia related issues’, followed by competencies such as ‘understanding the behaviours of individuals with dementia’, or ‘enriching the life of individuals with dementia and their carers’. Competencies that were more ‘general’, i.e. suitable for the dementia workforce but could also be applicable to other areas of practice, such as ‘person centred care’, ‘staff development and self-care’ and ‘promoting best practice’ were placed at the end.

As a next step, a number of relevant skills were identified from the frameworks as well as from interviews with dementia training providers, users and carers and suggestions made by expert groups, such as the steering group and project discussion forum. These were divided into three categories, which were adopted from Bloom’s (1956) Taxonomy of educational objectives:

knowledge: skills that demonstrated awareness, knowledge and understanding of dementia and related issues;

technical: skills that demonstrated ability and/or actions (e.g. communication, support, empowerment, enabling);

attitude/behavioural skills: (e.g. sensitivity, empathy, compassion, helpfulness). Subsequently, all skills were arranged within each relevant competency following the same rationale with the competency order arrangement where applicable, that is placing the more ‘dementia specific’ skills higher within each competency.

During the competency framework development, feedback was sought from key experts working in various sectors that provide training for the dementia workforce, including higher and further education (i.e. universities and colleges), voluntary organizations (i.e. charities and other non-profit organizations) and hospital trusts (acute and mental health). Special support was provided by the project steering group and a project development forum dedicated to the project. A lay version of the framework was also used to obtain comments from users/carers (for more details on the aforementioned groups see full SHA report). All feedback and comments were taken into account throughout the development process.

Results

We developed a set of eight core competencies and 87 knowledge, technical and attitude/behavioural skills in total to serve every profession, grade and level of dementia workforce. These are set out in the Appendix 1.

Our consultations identified that a comprehensive level of dementia knowledge and understanding is necessary to provide a high quality of dementia care. The ability to understand the behaviours of individuals with dementia, and the ability to enrich their lives by increasing their quality of life and giving individuals more choices and support were also deemed to be paramount competencies for the dementia workforce, as supported in other competency frameworks. Interaction with individuals with dementia, and interaction with carers and family members, were both selected as essential competencies. They were distinguished from one another in order to keep the balance of care and ensure that none of the parties involved (i.e. individuals with dementia, carers, significant others) would be at risk of under care, as carers’ and families’ needs and feelings are often underestimated or overlooked. Person centred care has been suggested to be synonymous with good quality care (Morton, 1999). Brooker (2003) offers a contemporary definition of person-centred care, suggesting that it includes four major elements:

Valuing people with dementia and those who care for them (V);

Treating people as individuals (I);

Looking at the world from the perspective of the person with dementia (P);

A positive social environment in which the person living with dementia can experience relative well-being (S).

Our core competency framework fits well into Brooker’s (2003) theory, which is presented as an equation: PCC (person-centred care) = V + I + P + S (p. 216). The person-centred element was considered to be a fundamental element of the approach to dementia care and it was made explicit in the competency framework by placing person-centred care as a separate competency. Nevertheless, all the four dimensions (VIPS) of Brooker’s theory are clearly evident throughout the entire framework (see Appendix 1). Dementia worker personal development and self care, an important competency for every worker that can enrich substantially the quality of service provision, is often missed in general educational training. The final competency included in the framework was that of promoting best practice, an essential awareness of policies and legislation, as well as an ability to practise at an ethical level, respect diversity and equality issues and use a rigorous evidence base.

Discussion

This framework covers most elements of generic core competencies and skills essential to the dementia care workforce. Competencies and skills are designed as such aiming to provide a good skill set in a broad context, applicable within all workforce levels. For instance, diagnosis of dementia suggests a general awareness of dementia and its features, not a clinical diagnosis of the condition. A few studies that support our work are presented here as examples, and in no way do they offer an extensive review of the literature. A study by Grant, Kane, Potthoff and Ryden (1996), comparing stress and burnout of dementia staff on special care and traditional units, reported that staff knowledge, abilities and resources best predicted staff stress reduction; this study supports our decision to place the competency of knowledge/understanding at the top of the framework. This fits with other findings: Kovach and Krejci (1998) found that employees themselves recognized knowledge as a significant factor in improving dementia care. Dementia workers’ personal development and self care are perhaps a neglected aspect of workers’ skillsets: Grant et al. (1996) compared stress and burnout amongst dementia staff on special care units and traditional units and confirmed the value of training in reducing staff stress. Numerous chronic and intermittent staff and carer stressors have been reported, ranging from patient-related, such as patient aggression (Rodney, 2000) to work-related psychosocial factors (Testad, Mikkelsen, Ballard, & Aarsland, 2010). The latter study shifts the emphasis to organizational characteristics, leadership especially, as being responsible for the health and well-being of care staff, suggesting that improving the work conditions and organizational aspects will reduce staff related stress and lead to better staff performance. Coping with stress and burnout, whether it is work or patient related is an important skill which if taught to the dementia staff and/or carers will enable them to feel well and provide better quality of dementia care.

Nevertheless, the newly developed framework needs to be further tested in practice, in order to assess and evaluate its effectiveness and overall significance within dementia care. The involvement of education and service commissioners and providers will be the key to successful implementation. Although a detailed implementation strategy is yet to be developed, the framework should be expected to be placed as a core in various dementia training courses and induction programmes; it is a tool which can be used to assess the competencies and skills of the existing staff that currently provide dementia care within the NHS or to develop training programmes for them. One possibility would be for staff to self-assess themselves using the competency framework and then use their assessment as a training needs analysis to inform their personal development plan. The framework could also be incorporated into appraisal processes or used in 360° feedback to identify areas for development. Another possibility is for organizations to use the framework to scope the skills of their workforce and use the findings to develop a workforce education strategy.

The key questions regarding the framework are ‘Can it help to improve the skills and knowledge of the dementia workforce and if so in what way?’ Our framework was developed for generic competencies and for different professionals working in a variety of contexts within dementia care requiring varying skill levels to fulfil their roles. An example of an agency which has tried to disaggregate skill/competency levels is the Admiral Nurse Competency Framework produced by fordementia (now called Dementia UK) which gives a range of competencies categorized as intermediate, advanced and expert (Traynor & Dewing, 2003). These levels would not be directly applicable to a generic competency framework. One of the next steps in our development work is to look at how to categorize competency levels in order that the framework can be used for a range of professions and for dementia care workers who have no professional qualification, as well as across work contexts including those which are dementia specific and those which are not (e.g. acute care settings). Work areas where staff is employed specifically to work with people with dementia and their families (e.g. older people’s mental health, specialist residential and nursing homes etc) could usefully be classed as areas where staff require specialist or advanced levels of dementia skills and knowledge. Those settings where staff members are employed to work with a variety of other conditions, but some of their service users may co-incidentally have a dementia might usefully be regarded as requiring a generic or basic level of skills and knowledge regarding dementia. In addition, there is likely to be a need for an intermediate level of skills and knowledge in settings where staff members are employed to work with a variety of other conditions but a large proportion of their service users will also have a co-morbid dementia (e.g. geriatric medical settings, stroke and physical rehabilitation services). Behavioural and psychological symptoms of dementia (BPSD) are likely to be a priority topic at this intermediate level. Thus the framework could be used to map the skills by level required by different groups working in the health and social care workforce. The resulting mapping could form a basis for provider organizations to develop workforce educational and training strategies; for education and training providers to review and develop their curricula, targeting them appropriately at the skills needed by different staff groups; for commissioners of education to assess and ensure the quality of educational and training courses; and for commissioners of dementia services to ensure that providers of those services utilise an appropriately trained workforce.

What difference might this schema (Table 2) make to services? An underlying issue is whether skill development changes practice and this is another area for future research. Dementia training courses could indicate to commissioners and students which competencies they aim to provide and at what level. Students could rate themselves (or be rated by colleagues and/or users/carers) prior to undertaking a course, and then again on completion of a course, to assess how their skill set has developed, and whether the skills which the course aims to provide have changed. Service audits and feedback from service users and their families might be valuable in assessing whether and how services have changed after curricular modification and workforce skill development.

Table

Table 2. Examples of dementia skills levels required by various sectors

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Finally, our future research plans include appraising our newly developed dementia framework against the NHS Knowledge and Skills Framework (KSF; Department of Health, 2004a). An initial analysis would suggest that both KSF and our dementia framework are generic, simple and practicable to implement, designed to facilitate and support the effective learning and the development of the NHS workforce. Also, they both promote equality and diversity of all staff:

… with every member of staff using the same framework, having all the same opportunities for learning and development and having the same structured approach to learning, development and review. (Department of Health, 2004b, p. 3)

It is noteworthy, that the KSF has greatly contributed to our framework development process, in that we have drawn from it various competencies and skills and adapted them accordingly to fit our objectives.

Conclusions

We have identified a set of core competencies applicable to all staff working with people with dementia across all stages of the dementia pathway. Different staff working in different environments will require dedicated training specific to their needs, and the competency framework could be used in a number of ways including the following: to identify skills for further development; to commission and develop education and training courses aimed at the skills required by different groups in the dementia workforce; and to quality assure the courses used for the workforce.

We believe that the competency framework:

is rigorous in that it encompasses all vital aspects of core competencies and skills (i.e. knowledge, technical and attitude/behavioural) that are essential in dementia care, and it proficiently addresses all the different stages of the Dementia Care Pathway. These points, along with the fact that this framework is aimed at the whole workforce rather than specific professions within dementia care (e.g. nursing) are clear advantages compared to other coexisting dementia competency frameworks;

is practical and easy to implement and evaluate;

provides a means to equip the dementia workforce with skills and qualities which are vital in optimal interactions with the vulnerable populations of individuals with dementia and their carers;

has the potential to improve quality of care, support and empowerment of people with dementia as envisaged by the National Dementia Strategy (Department of Health, 2009).

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