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Framework on core competences for physiotherapists and nurses working with older adults in Sri Lanka

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ABSTRACT

The population of Sri Lanka is rapidly aging, and there is a growing demand for healthcare professionals skilled in older adult's care. The CAPAGE project "Promoting academic and professional excellence in health care to meet the challenges of aging in Sri Lanka" is a transnational European Union co-funded project to enhance professional competences of health care professionals. The main objective of this study is to create a framework of core competences for physiotherapists and nurses working with older adults in Sri Lanka. Based on a recent literature review and a focus group analysis with experts, a competences framework will identify knowledge and skill-based competences required for health care professionals, specifically for physiotherapists and nurses, working with elderly. Main competences identified were: high-quality standards and team leadership (leader/expert); patient-centered practice, effective communication (communicator); interprofessional effective team collaboration and shared decision-making process (collaborator); coordination of care and healthcare management (organizer); health promotion, wellness and well-being (health and welfare advocate); evidence-based practice and lifelong learning and continuous professional development (scholar); professional and ethical standards and multi-dimensional approach and best practices (professional). This framework on competences can enable to update and improve knowledge, know-how, skills and mainly the conceptual approach in care and management of older adults, considering

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specific socio-economic and cultural aspects of Sri Lanka.

Keywords- Competences; Physiotherapy; Nursing; Older Adults; Sri Lanka.

INTRODUCTION

Life expectancy in Sri Lanka (SL) has increased over the past decades, leading to a demographic transition towards an aging population (Perera, 2015). This transformation has created challenges for the health care (HC) system, requiring a change in policy focus to address the needs of the older population (Asian Development Bank, 2019) and enhanced knowledge and skills for health professionals (Australian Institute for Social Research, 2009).

Physiotherapists and nurses are two of the health professions that, included in interdisciplinary teams, contribute to an active and healthy aging process. They are recognized as key players among HC providers. They participate in all levels of the HC process for older adults (i.e., prevention, primary care, and rehabilitation). The increasing disability with age, the changed pattern of aging-related health problems (mainly non-communicable diseases), requires specific competences of the different HC specialists (WHO, 2020).

Competences for adult's care are broader attributes that include knowledge, skills, social and methodological abilities in professional and personal development, covering cognitive, functional/technical areas, interpersonal skills, and values in health promotion, care, and rehabilitation (Woodruffe , 1993; European Union, 2014).

HC professionals, particularly physiotherapists and nurses, need specific competences in elderly HC, with continuous knowledge updating. A core competence framework can guide HC professionals, but also academics and students towards positive, active, and healthy aging of SL older adults. Public and private HC systems can use this tool to guide standards for physiotherapists and nurses, improving care for older people.

The main objective of this study, part of the CAPAGE project "Promoting academic and professional excellence in HC to meet the challenges of aging in Sri Lanka," is to create a framework of core competences for physiotherapists and nurses working with older adults in SL. It aims to identify competences and develop a modern, sustainable model for academic and professional education.

METHODS

The framework of core competences for physiotherapists and nurses working with older adults will be based on a literature review and a focus group with SL and European nursing and physiotherapy experts. The goal is to identify knowledge and skill-based competences required for HC professionals, specifically physiotherapists and nurses, working with older adults. A literature review will allow us to identify important publications, serving as a reference to create an initial competence framework draft, discussed, improved and validated through an expert focus group, updating and equalizing the knowledge base among the SL partner Health EU Institutions and re-establishment of the existing potential in HC practice with elderly in SL.

Literature Review

The investigation question for this review was: "What are the current evidence-based competences required for nurses and physiotherapists in providing optimal care for the older adults?". Only review papers published in the last 10 years in English, French, Spanish, Portuguese, Finnish, German, Sinhala, or Tamil were included. Papers in other languages, older publications, or those with different methodologies or populations were excluded. We used AI software and manual search in PubMed to identify papers. Selected articles were aggregated using Ryyan software. Data was extracted and organized into three groups (competences for health professionals, physiotherapists and nurses) then summarized in tables by author/year, country, and detailed competences.

Focus Group

A qualitative methodology (Streubert & Carpenter, 2013) was used to understand and validate the competences needed for nurses and physiotherapists working with older people, supported by a literature review. The focus group consisted of 10 experts (equal numbers of nurses and physiotherapists, and SL and European participants). Experts were appointed by CAPAGE project coordinators, invited via email, and provided with a confirmation letter, informed consent, and a socio-demographic questionnaire (Lucasey, 2000). Three project researchers participated: one moderator and two observers. Observers took notes (including non-verbal information) and the session was audio recorded with participant consent. The moderator led the discussion, promoting effective participation (Silva, Veloso & Keating, 2014). Participants socio-demographic data was analyzed using descriptive statistics.

Assuring ethical aspects and data protection (Moloneyet al., 2003), the session was held during CAPAGE Porto Face-to-face Meeting (in Tuesday 1st October 2024), in an approximately 90 minutes session, according to the saturation of the topics discussed; the session was recorded and later transcribed for content analysis. Thirteen participants, including one moderator, two observers and 10 experts were enrolled (Silva, Veloso & Keating, 2014). Data analysis was performed after manual transcription of the audio record, evaluated through qualitative content analysis (Mayring, 2000; Minayo, 2001).

Ethical considerations

The study was submitted to the Ethics Committee of the Santa Maria Health School – Porto, Portugal and approved with the code CE2024/05. An informed consent form was sent to all participants along with the socio-demographic questionnaire in digital format. The form contained information about the study objectives, study design and the guarantee of confidentiality. Data collection and processing was encrypted ensuring data protection and all ethical demands.

RESULTS

Literature Review

Initially through brainstorming the investigators identified 2 main documents regarding possible competences for health professionals working with older adults: the AGE Platform (2016) and the SIENHA project (2023). Then using AI, we searched for related publications associated with

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these papers, using *ResearchRabbit* software (https://www.researchrabbit.ai/); we also used *Consensus AI* (https://consensus.app/), using the research question (previous described) to identify further papers.

Finally, to identify the papers published after 2022 (data of the last major paper initially identified) we used the *Connected Papers AI* software (https://www.connectedpapers.com/); we also performed a *Pubmed* search using the following keywords: competences, framework, physiotherapy, physical therapy, nurse, nursing, health, older adults, ageing, aging, elderly, active aging and healthy aging (also for papers after 2022).

We included meta-analyses, systematic reviews, scoping reviews, integrative reviews, and literature review papers, based on predefined inclusion and exclusion criteria. The Ryyan platform was used to screen the retrieved papers. Two blind investigators initially screened by title and abstract; in case of conflict, a third investigator made the decision. If there was any doubt, the paper proceeded to full text analysis. A total of 214 papers were screened by title and abstract, and 14 papers were retained for full analysis. After screening, 5 studies were included in this review: 2 on overall competences, 2 on specific competences for nurses, and 1 for physiotherapists (Figure 1). To ease data presentation and discussion we aggregated the 2 main papers describing core competences; these are European project founded studies: the AGE Platform (2016) and the SIENHA project (2023). They both use adapted versions of the CanMEDS Framework (Frank et al., 2015) that define the main essential roles/dimensions in HC, facilitating the description, understanding and practical implementation in education

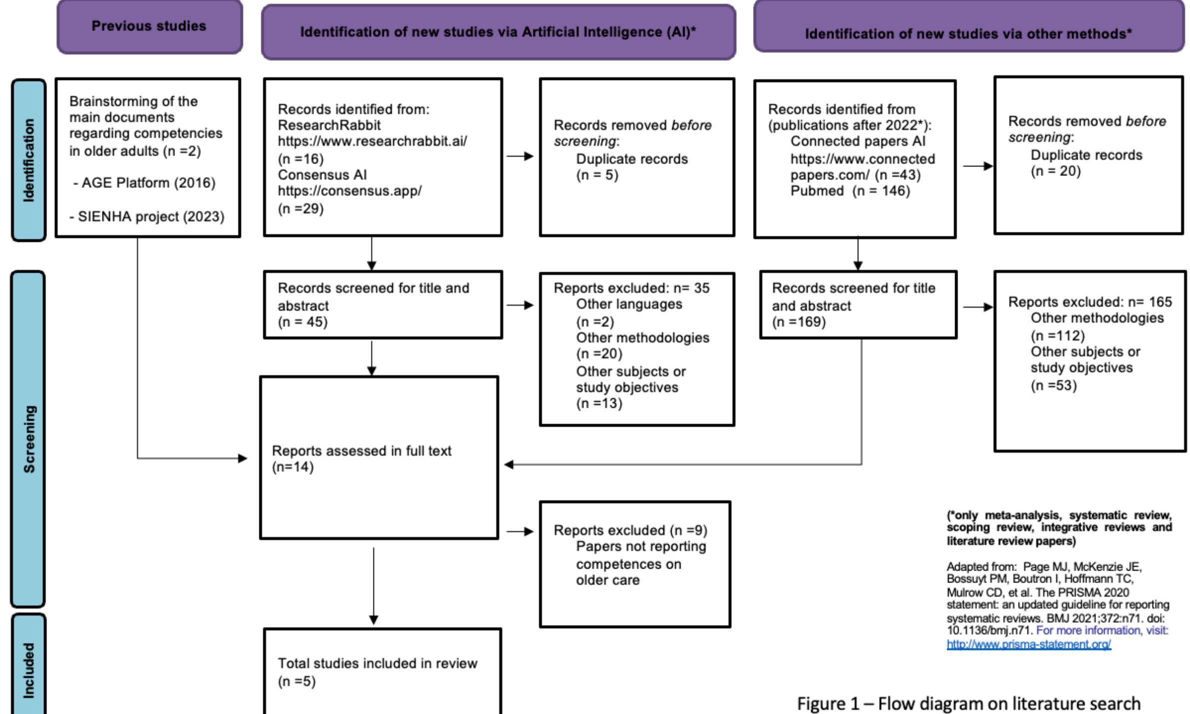

Figure 1 – Flow diagram on literature search

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and clinical practice: Expert/Leader, Communicator, Collaborator, Organizer, Health and welfare advocate and Scholar (table 1).

Study	Author/Year	Country	Competences Described
European Competences Framework for Health and Social Care Professionals Working with Older People	DijKman, B. Roodbol, P., Aho J., Achtschin-Sieger, S. Andrusszie-wicz, A. Coffey, A., Felsmann, M., Klein, R., Mikkonen, I., O-leksiw, K., Schoofs, G., Soares, C. & Sourtzi, P. / 2016	European Later Life Active Network (EL-LAN). Project funded by the European Commission. 26 partners from 25 countries in Europe.	**1. Expert:** a) Assessment: Conduct an appropriate assessment and collect data in a systematic way from the older person and, when necessary, from his/her family or caregivers about the physical and mental wellbeing, housing conditions, and social participation of the older person, as well as identifying his/her needs and wishes. b) Analysis and problem identification: Analyze and identify the problems and the risk factors for the older person and his/her family. Formulate a conclusion or, when applicable, a diagnosis. c) Planning: Develop a clear, timely, and appropriate individual plan with measurable objectives for the care and support of the older person and his/her family with a focus on optimum health, wellbeing, and quality of life. Use the techniques for shared decision making. d) Carry out interventions based on professional standards: Provide care, help, and support to the older person and his/her family to improve or prevent further decline in mental and physical wellbeing, housing, and living conditions and social participation. e) Evaluation: Re-evaluate and adjust service or care plans for the older person on a continuing basis. **2. Communicator:** a) Maintain relationships and effective communication: Form strong positive relationships with older persons and their families, based on empathy, trust, respect and reciprocity. Communicate in a clear and effective way considering older person's individuality, dignity, personal and social background, and needs. b) Empowerment: Promote capacities and resources in older people and their families own goals according to their needs and expectations. Improvement of the older person's autonomy, independence, wellbeing and quality of life. c) Coaching: Encourage, motivate and coach the older person and relevant others in relation to self-management, self-reliance and co-reliance. **3. Collaborator:** a) Integral cooperation and integrated services: Work effectively together with other professionals for integrated care and support. Multi- and inter-professional cooperation to achieve optimal support and care for the older persons with the goal of optimizing their health and wellbeing and quality of life in multiple locations. b) Informal care and support: Work together with older people's supportive families, informal caregivers and their social network to encourage appropriate informal care and support. **4. Organizer:** a) Planning and coordination of care and services: Plan, arrange, and coordinate the care and services provided by formal and informal health and social care workers, across different organizations, to provide the best-personalized care and support for the older person and their family. b) Program of care: Contribute to the organization of existing care and services Take an active part in developing, adapting and implementing long term policy actions relating to care and services for older people on a national, regional, local or organizational level. **5. Health and welfare advocate:** a) Collective prevention and health promotion. Advocate for health with, and on behalf, of older persons and their families, communities and organizations in order to improve health and wellbeing and build capacity for health promotion. b) Social map and social networks: Access and share information or resources with older persons, their families and their caregivers, regarding the social map, healthcare benefits, social support and public programs. **6. Scholar:** a) Expertise: Expand professional expertise for their own professional practice in relation to working with older people and their families. Spread relevant new evidence based research among fellow professionals and other professionals in health and social care services. b) Innovation of care and support: Interpret evidence based results of research and contribute to the development of knowledge and practical research. Implement and apply new insights, protocols, standards, procedures, and technologies with the aim of promoting the quality, efficiency and effectiveness of care and services provided to older people and their families. **7. Professional:** a) Professional ethics: Demonstrate commitment to best practices for the health and wellbeing of older people, their families and society through adhering to ethical standards and professional-led regulation. b) Professional commitment and personal awareness: Reflect on one's own actions and improve and innovate own professional behavior to the highest quality of care and support possible for older people and their families. Demonstrate commitment to the health and wellbeing of older people and their families, understanding cultural differences.
Handbook on Healthy Aging SIENHA	Strategic Innovative Educational Network for Healthy Aging, 2023	SIENHA Project Project funded by the European Commission. 7 European countries.	**1. Collaborator:** The professionals are able to work effectively with other professionals within and outside the health and social care profession to promote and support healthy aging throughout the lifespan. The professionals are able to work effectively with individuals and families to promote and support healthy aging throughout the lifespan. **2. Communicator:** The professionals are able to communicate effectively with individuals, families and stakeholders to establish strong positive relationships with them. The professionals are able to stimulate and encourage individuals, their families and stakeholders regarding healthy aging. The professionals are able to advise and support individuals, families and stakeholders regarding healthy aging / or self-management, self-reliance and co-reliance. **3. Health and welfare advocate:** The professionals are able to perform a person-centered assessment of an individual focusing on the determinants of healthy aging. The professionals are able to establish a plan together with the individual, their families and relevant stakeholders to promote and support healthy aging. The professionals are able to perform actions for the promotion of healthy aging in individuals. The professionals are able to evaluate and adjust the plan on a continuing basis.

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			The professionals are able to advocate for the promotion of healthy aging with, and on behalf of communities, populations and organizations. **4. Leader:** The professionals are able to articulate and act on both a personal vision on healthy aging as well as a common vision shared with others. The professionals are able to contribute to the quality of health and social care in the domain of healthy aging. The professionals are able to demonstrate leadership in the domain of healthy aging. **5. Professional:** The professionals are able to apply best practices and adhere to high ethical standards. The professionals are able to recognize and respond to societal expectations and knowledge gaps within the healthy aging domain. **6. Scholar:** The professionals are able to engage in the continuous enhancement of their professional activities through ongoing learning. The professionals are able to integrate best available evidence into practice. The professionals are able to contribute to the creation and dissemination of knowledge and practices applicable to health.

Table 1 -Studies describing competences for health professionals working with older persons.

One of the papers describing specific competences for nursing was the Tate et al., (2024) study; it is a scoping review that incorporates 8 literature sources, 4 of which were academic papers and 4 documents describing gerontological entry-to-practice standards and competences from national nursing associations (Canada and the United States). Dijkman et al., (2022), in a research design, with a needs analysis, a situational analysis, a trend analysis and a competence analysis created a competence framework that then was analyzed by a two-round Delphi study with a panel of Chinese and European experts (table 2).

Study	Author/Year	Country	Competences Described
Gerontological nursing competences: A scoping review.	Tate, K., Guney, S., Lai, C., Van Son, C., Kennedy, M., & Dahlke, S. (2024).	Canada /US	**Person-Centered Care:** Focuses on respecting and responding to the preferences, needs, and values of older adults. Involves collaboration with older adults and their families to promote health and well-being. **Relational and Cultural Competences:** Emphasizes the importance of building and maintaining therapeutic relationships with older adults. Includes understanding and respecting cultural differences and incorporating this understanding into care practices. **Professional Values:** Involves adhering to ethical principles, such as autonomy, dignity, and justice in the care of older adults. Nurses should advocate for older adults' rights and provide care that aligns with ethical standards. **Competences:** 1. **Assessment**: Collect pertinent data relative to the older adult's health. 2. **Diagnosis**: Analyze assessment data to determine diagnoses or issues. 3. **Outcomes Identification**: Identify expected outcomes for individualized plans. 4. **Planning**: Develop plans to attain measurable outcomes. 5. **Implementation**: Implement identified plans. 6. **Coordination of Care**: Coordinate care delivery across the healthcare continuum. 7. **Health Promotion**: Employ strategies to promote health and safe environments. 8. **Evaluation**: Evaluate progress toward goals and outcomes. 9. **Ethics**: Integrate ethical provisions in all practice areas. 10. **Cultural Humility and Inclusion**: Practice in a manner congruent with cultural diversity principles. 11. **Communication**: Communicate effectively in all practice areas. 12. **Collaboration**: Collaborate with older adults and stakeholders. 13. **Leadership**: Lead within the professional practice setting. 14. **Professional Development**: Seek knowledge reflecting current gerontological nursing practices. 15. **Evidence-Based Practice**: Integrate research findings into practice. 16. **Quality of Practice**: Contribute to quality nursing practice. 17. **Resource Utilization**: Use appropriate resources to provide evidence-based services. 18. **Environmental Health**: Practice in an environmentally safe manner. 19. **Holistic Patient Assessment**: Consider physical, psychological, social, and spiritual aspects. 20. **Planning Care**: Develop care plans based on comprehensive assessments. 21. **Implementation**: Provide and manage care plans. 22. **Evaluation**: Evaluate the effectiveness of care plans. 23. **Ethical Practice**: Ensure ethical standards in all practices. 24. **Leadership and Education**: Lead and educate within the gerontological nursing field. 25. **Interprofessional Collaboration**: Work collaboratively with other health professionals. 26. **Quality Improvement**: Engage in activities to improve care quality. 27. **Collaboration**: Work with older adults and their families to promote health and well-being. 28. **Resilience and Adaptation**: Foster resilience and adaptation in older adults. 29. **Optimization of Health**: Focus on optimizing health and well-being. 30. **Prevention**: Prevent illness and injury. 31. **Respect and Dignity**: Provide respectful, dignified, and culturally sensitive care. 32. **Relational Care**: Focus on relationships between older adults and their family/caregivers. 33. **Ethical Care**: Advocate for autonomy, inclusion, diversity, and collaborative decision-making. 34. **Evidence-Informed Care**: Address health assessments, chronic condition management, and end-of-life care. 35. **Aesthetic/Artful Care**: Enhance care environments and activities for cultural and creative expressions. 36. **Safe Care**: Ensure safety in various aspects including housing, food security, and abuse prevention. 37. **Socio-Politically Engaged Care**: Address ageism, care inequities, and advocate for older adults' needs.

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Study	Author/Year	Country	Competences Described
Developing a competence framework for gerontological nursing in China: a two-phase research design including a needs analysis and verification study	Dijkman, B. L., Hirjaba, M., Wang, W., Palovaara, M., Annen, M., Varik, M., Cui, Y., Li, J., van Slochteren, C., Jihong, W., Feiteng, C., Luo, Y., Chen, Y., & Paans, W. (2022).	China	**1. Providing gerontological care** The gerontological nurse comprehensively assesses, analyses, plans, implements and evaluates the care of older people. The gerontological nurse is able to utilize evidence-based knowledge and critical thinking when making decisions and providing person-centered and holistic care in different care settings. **a. Assessment:** Conduct a systematic, comprehensive gerontological assessment with input from the older people and, when necessary, from their families or caregivers. Inquire about the older people's physical and mental well-being, medical history, personal history, housing conditions, social participation and loneliness. Identify the needs, wishes and possibilities to increase older people's comfort. Assess the level of nursing needs. **b. Nursing diagnosis :**Analyze the data collected from the gerontological assessment and, through careful consideration, form a diagnosis using knowledge about healthy aging, geriatric syndromes and the most common health problems among older people. Identify the problems and risk factors for older people and their families. Diagnose the required nursing care using current theoretical and clinical knowledge of the nursing process. **c. Planning:** Develop a clear, timely and appropriate plan for person-centered nursing care with a focus on recovery, optimal health, well-being and quality of life for older people and their families. Use practice- and evidence-based interventions. If possible, include the use of technology for the benefit of the patient and family members. Use appropriate techniques for shared decision-making. **d. Implementation of nursing interventions:** Provide accurate implementation of the care plan and perform the nursing interventions based on professional nursing standards in different care settings such as home care, hospital care, long-term care and hospice care. Guarantee person-centered and holistic care. **e. Evaluation:** Evaluate and adjust care plans for older people on a continuing basis with the purpose of providing optimal nursing care for older people and their families. **2. Communication and collaboration** To provide person-centered care, the gerontological nurse communicates and collaborates with older people, family members, other informal caregivers and other professionals in health and social care. The nurse is able to use Information and Communication Technology (ICT) properly for this purpose. **a. Person-centered communication and empowerment:** Form strong, positive professional relationships with older people based on empathy, trust, respect and reciprocity. Communicate in a clear and effective way considering older people's individuality, sociocultural backgrounds, health problems and needs. Collaborate with patients, use shared decision-making and empower older people to take responsibility for their own health and comfort. **b. Collaborate with family members and informal caregivers:** Work together with older people's supportive families, informal caregivers and social networks to encourage appropriate informal care and support. Be aware of older patients who suffer from loneliness and family members who suffer from caregiver burden. **c. Collaborate with nursing colleagues and the multidisciplinary team:** Work effectively together with other professionals for integrated care and support. Encourage multi- and interprofessional cooperation to achieve optimal support and care for older people. Pursue the goal of optimizing their health, well-being and quality of life in multiple areas. **3. Organization of gerontological nursing care** The nurse plans and coordinates safe, high-quality person-centered care for older people. The nurse is involved in quality assurance activities and contributes to the innovation of care for older people; this includes the use of suitable technical applications in care. **a. Planning and coordination of care and services:** Plan, arrange and coordinate the care and services provided by nurses and other formal or informal health and social care workers across different organizations to provide the best personalized care and support for older people and their families. Ensure continuity of care. **b. Innovation and technology:** Use innovative ideas, theories and methods to improve gerontological nursing practice. This process includes the use of technological applications. **c. Quality management:** Initiate, monitor and participate in quality management activities to provide safe, high-quality person-centered nursing care for older people. Establish assessment mechanisms and processes for continuous quality improvement. **4. Health promotion** The gerontological nurse is able to prevent further functional decline and promote healthy aging and a healthy lifestyle. The nurse helps older people and their families find comprehensive person-centered solutions within the entire healthcare system. **a. Plan person-centered health promotion:** Identify early risk factors that can impact the functional ability of older people. Plan holistic and person-centered health promotion interventions. **b. Perform health promotion interventions:** Work closely together in partnerships with patients, informal caregivers and other healthcare professionals to promote a healthy lifestyle and to work towards the improved self-care of older people. **5. Evidence-based nursing and lifelong learning** The gerontological nurse uses evidence-based practices and lifelong learning activities to provide the best care for older people and their families. **a. Lifelong learning and professional development:** Increase knowledge, understanding and skills in gerontological nursing through continuous education and professional development. Demonstrate commitment to lifelong learning. **b. Evidence-based practice:** Use and support the implementation of evidence-based nursing's theory and methodology in gerontological care. **c. Training and coaching:** Participate as a teacher and coach in education and training activities about gerontological nursing for staff, students and teachers. Strengthen the competences of nursing staff in gerontological nursing. **6. Professional behavior** The gerontological nurse shows a professional attitude, is aware of professional guidelines and is committed to providing appropriate person-centered care for older people and their families. **a. Professional ethics:** Provide nursing care for older people in accordance with professional and personal ethics, legal guidelines and cultural sensitivities. **b. Professional commitment and personal awareness:** Demonstrate commitment to providing appropriate gerontological nursing care for older people and their families. Be aware of personal values and assumptions

Table 2 - Studies describing competences for nurses working with older persons.

Specific competences for physiotherapist are described by the Academy of Geriatric Physical Therapy (American Physical Therapy Association, 2014). The paper was published in the Journal of Physiotherapy Education; it is a document describing entry-to-practice standards and competences for physiotherapists in older adults (table 3).

Study	Author/Year	Country	Competences Described
Essential Competences in the Care of Older Adults at the Completion of the	Academy of Geriatric Physical Therapy, American Physical Therapy	USA	**1: Health Promotion and Safety** a) Advocate to older adults and their caregivers about interventions and behaviors that promote physical and mental health, nutrition, function, safety, social interactions, independence, and quality of life. b) Identify and inform older adults and their caregivers about evidence-based approaches to screening, immunizations, health promotion, and disease prevention.

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Entry-Level Physical Therapist Professional Program of Study	Association (2014)		c) Assess specific risks and barriers to older adult safety, including falls, elder mistreatment, and other risks in community, home, and care environments d) Recognize the principles and practices of safe, appropriate, and effective medication use in older adults. e) Apply knowledge of the indications and contraindications for, risks of, and alternatives to the use of physical and pharmacological restraints with older adults. **2: Evaluation and Assessment** a) Define the purpose and components of an interdisciplinary, comprehensive geriatric assessment and the roles individual disciplines play in conducting and interpreting a comprehensive geriatric assessment. b) Apply knowledge of the biological, physical, cognitive, psychological, and social changes commonly associated with aging. c) Choose, administer, and interpret a validated and reliable tool/instrument appropriate for use with a given older adult to assess a) cognition, b) mood, c) physical function, d) nutrition and e) pain. d) Demonstrate knowledge of the signs and symptoms of delirium and whom to notify if an older adult exhibits these signs and symptoms. e) Develop verbal and nonverbal communication strategies to overcome potential sensory, language, and cognitive limitations in older adults. **3: Care Planning and Coordination** Across the Care Spectrum (Including End-of- Life Care) a) Develop treatment plans based on best evidence and on person-centered and person-directed care goals. b) Evaluate clinical situations where standard treatment recommendations, based on best evidence, should be modified with regard to older adults' preferences & treatment/care goals, life expectancy, co-morbid conditions, and/or functional status. c) Develop advanced care plans based on older adults' preferences and treatment/care goals, and their physical, psychological, social, and spiritual needs. d) Recognize the need for continuity of treatment and communication across the spectrum of services and during transitions between care settings, utilizing information technology where appropriate and available. **4: Interdisciplinary and Team Care** a) Distinguish among, refer to, and/or consult with any of the multiple healthcare professionals and providers who work with older adults, to achieve positive outcomes. b) Communicate and collaborate with older adults, their caregivers, healthcare professionals, and direct care workers to incorporate discipline-specific information into overall team care planning and implementation. **5: Caregiver Support** a) Assess caregiver knowledge and expectations of the impact of advanced age and disease on health needs, risks, and the unique manifestations and treatment of health conditions. b) Assist caregivers to identify, access, and utilize specialized products, professional services, and support groups that can assist with care-giving responsibilities and reduce caregiver burden. c) Know how to access and explain the availability and effectiveness of resources for older adults and caregivers that help them [the patient] meet personal goals, maximize function, maintain independence, and live in their preferred and/or least restrictive environment. d) Evaluate the continued appropriateness of care plans and services based on older adults' and caregivers' changes in age, health status, and function; assist caregivers in altering plans and actions as needed. **6: Healthcare Systems and Benefits** a) Serve as an advocate for older adults and caregivers within various healthcare systems and settings. b) Know how to access, and share with older adults and their caregivers, information about the healthcare benefits of programs such as Medicare, Medicaid, Veteran's Services, Social Security, and other public programs. c) Provide information to older adults and their caregivers about the continuum of long-term care services and support - such as community resources, home care, assisted living facilities, hospitals, nursing facilities, sub-acute care facilities, and hospice care.

Table 3 - Study describing competences for physiotherapists working with older persons.

Focus Group

The 10 experts had a mean (SD) age of 36.5 (7.19) years, and 8 (80%) were women. Participants were from all 10 universities (4 European and 6 Sri Lankan HEIs) in the CAPAGE consortium. Seven (70%) had a doctorate, and 3 (30%) had a master's degree, with an average of 10.33 (7.24) years of experience in older adult care. To develop the competency dimensions of this initial framework, we used the recommendation from Royal College CanMEDS Project, CanMEDS Roles (Frank, Snell & Sherbino, 2015), adapting it has previously been performed in AGE Platform (2016) and in SIENHA project (2023), two of the most important documents previously identified in the literature review.

Although we initially identified the possibility to divide them into specific nurses and physiotherapists competences, after analysis and discussion we decided to present the results by general competences; regarding the data obtained in the literature review the experts expressed that the main domains should be transversal to both physiotherapists and nurses working with older adults, so that the framework could be applied to both professional groups.

The draft framework was built through theoretical-scientific foundations and consensus methods, including Pre-Analysis, Exploration of Material, and Treatment of

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Results (Stewart et al., 2007). The final framework reflects expert proposals for each role/category, aligned with the SL national context. Participants agreed on the relevance of the seven proposed roles and emphasized the need for contextual adjustments to fit regional and institutional realities.

Concerns were raised about the feasibility of applying these competences in Sri Lanka's HC system, citing challenges such as the lack of specialized health services, working conditions, heavy workloads, and insufficient training opportunities. Ethical principles, including respect for cultural diversity, religious beliefs, and patient dignity, were emphasized as essential aspects of professional practice.

A major issue discussed was the lack of communication skills when working with older persons, particularly the need for HC professionals to listen actively. They highlighted the need for better integration of communication and listening skills in everyday practice, althought considering time constraints available for HC workers in SL.

Leadership in interdisciplinary teams was also discussed, with the need to both physiotherapists and nurses assuming leadership position and incorporate policy decision teams, although they recognized the difficulties of non-medical professionals taking on leadership roles effectively in SL services.

The framework aligns with SL qualification standards (SLQF, 2015) at levels 5 and 6, ensuring consistency across curricula. Learning outcomes include theoretical knowledge, practical application, communication, teamwork, leadership, creativity, problem-solving, managerial skills, information management, networking, adaptability, professionalism, and lifelong learning.

The focus group provided valuable insights for adapting the framework to ensure its relevance and applicability to HC professionals in SL in a flexible, context-sensitive way. It emphasizes the importance of cultural and ethical dimensions, adjustment to national HC dynamics, and improving access to essential curricula for competences still lacking in physiotherapy and nursing professionals working with older persons. The final framework is presented in Table 4, with a model/infographic perspective in Figure 2.

Roles/Categories	Expert/Leader	Communicator	Collaborator	Organizer	Health and welfare advocate	Scholar	Professional
General Competences for Physiotherapists and Nurses in older adult heath care in Sri Lanka	Be able to "lead" and be responsible for the **process of health care** of the older adult. Be capable of **assuming the leadership** of an interdisciplinary collaborative team in older adult's care (according to each specific context). Participate in the process of assessment/evaluation, analysis, diagnosis, intervention and re-assessment of the older adult, using the best updated available knowledge.	Be able to communicate with different stakeholders in the health care process (older adults, family, caregivers, other professionals, stakeholders). Apply patient-**centered practices** and establish appropriate therapeutic relationships, focusing on the empowerment, self-management and coaching of older adults. Use **effective communication**,	Be able to establish **effective collaboration** with the different stakeholders of the heath care process (older adults, families, caregivers, social services, other professionals, stakeholders). Use integral collaboration, involving the older adult in the **shared decision-making process**, respecting their preferences, needs and values. **Interprofessional team collaboration**, within integrated service care, for	Be able to **plan and coordinate** the process of health care of the older adult. Understand the **national, regional, local and organizational levels of health care** for older adults (e.g., public, private, non-governmental organizations). Ensure **quality management** and continuous improvement, innovation and research in health care. Identify **resources availability**, planning different settings and levels of care (e.g. specific treatment	Implement and coordinate **health promotion, wellness and well-being** programs and care of the older adults, contributing to healthy aging and longevity of populations. Act on disease prevention in a **patient-centered approach for positive and active aging,** promoting health literacy and positive behavioral changes. Optimize older adults' health, promoting their **independence, function**	Be updated in recent research, evidence, guidelines and **best practices in aging care**. **Evidence-based practice** on older adults according to the best evidence available. Have the **ability and opportunity to train in different** specific older adults' contexts and clinical settings. Engage and participate in **academic, research and community activities** in older adult's care. Have the commitment for **lifelong learning and**	Promote and disseminate **ethical standards and legal aspects** developing the best practices and conduct available in the field of older adult's care. Perform evidence-**based practice** but also patient-centered care, in a multi-dimensional approach. Respect **older adults' dignity and autonomy**, understanding their **preferences, needs and values**. Engage and participate in academic, professional and patients (national and international) **organizations and associations on older adult's care and healthy aging**. Possess the best

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	Use valid, updated tools, instruments and outcome measures for data collection during all the health care process. Possess the best and updated knowledge and skills on **physiological and pathological changes in older adults** and the specific care skills in prevention, treatment, care and rehabilitation of age-related conditions.	incorporating **empathy and active-listening strategies,** considering the older adults' primary concerns, priorities, and preferences. Possess the best and updated knowledge and skills on **specific communication aspects** with older adults regarding their specific needs and specificities (e.g. cultural, social and spiritual diversity of the Sri Lanka context)	effective teamwork. Facilitate, plan, manage and evaluate all care possibilities, with the interdisciplinary team, family and persons involved, ensuring the optimal health care coordination. Possess the best and updated knowledge and skills on **interprofessional competences and possibilities of collaboration and cooperation** between all professionals involved in health care of older adults.	options, transitions, discharge); identify both material and human needs (e.g. specific material demands for specific older adult's care; ratio health professional/older adult). Possess the best and updated knowledge and skills in the **coordination of care, national and international guidelines possibilities and different health care settings** according to the older adults' needs (e.g. aging in place, housing options, community management, home care, hospital care).	**and quality of life.** Promote opportunities to influence **local and national policies** on older adults' care availability and management. Possess the best and updated knowledge and skills on healthy aging, understanding major **health determinants** and how to positively influence them in the different stages of life (e.g. early aging, palliative care, end-of-life care).	**continuous professional enhancement and development** of the best and updated knowledge and skills in health care of the older adult.	and updated knowledge and skills to recognize and respond to **physical, psychological, social and spiritual needs** of the older person.
Minimum Sri Lanka Qualification Framework Level 5 or 6 (SLQF, 2015)							
Learning outcomes to be developed in each competency							
Theorical knowledge	Practical knowledge and application	Communication	Teamwork and leadership	Creativity and problem solving	Managerial and entrepreneurship	Information usage and management	Networking and social skills

Table 4 - Validated framework on core competences for HC professionals working with older adults in SL.

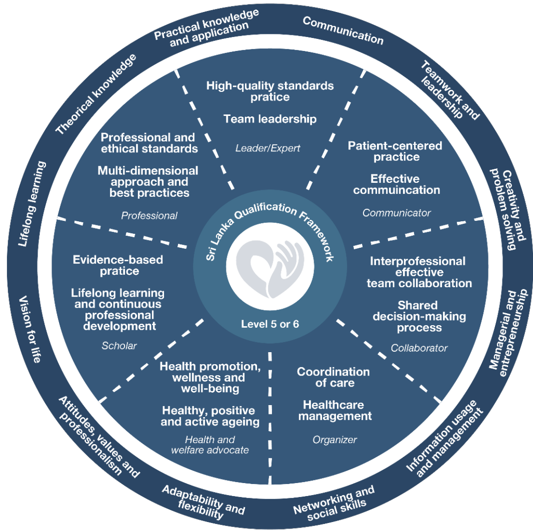

Figure 1. Core competences model for health care professionals working with older adults in SL.

DISCUSSION

Two WHO reports, although not specific for HC competences, provide important information on competences in healthy aging. The 2015 "World report on aging and health" (WHO, 2015) identifies that health professionals are often unprepared for older adults' healthcare needs, emphasizing shared decision-making, team-based care, and continual quality improvement. The 2020 "UN Decade of Healthy Aging: Plan of Action" (WHO, 2020) outlines a plan for 2021–2030, focusing on changing perceptions of aging, fostering abilities, delivering person-centered care, and providing long-term care.

The Asian Development Bank recommends that SL should improve primary care services for older people, integrating geriatric care, and providing training for healthcare providers. The primary care network needs adaptation to provide elderly care services, integrating primary care with secondary prevention (Asian Development Bank, 2019).

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The literature highlights the importance of developing knowledge and competence models for the HC of older adults (Abdi et al., 2019). Even though we tried to systematize our search, using new artificial intelligence tools, this paper is intended to be a literature review and not a systematic review per se. There are other important professional and clinical guidelines that did not comply with the inclusion criteria, or that we could have retrieved through grey literature. There was a high heterogeneity in how competences were described between studies, and so it was difficult to aggregate and present resumed data.

Interprofessional competences for professionals working with older adults were identified by the AGE and SIENHA projects; specific nursing competences by Tate et al. (2024) and Djikman et al. (2022); specific physiotherapists comopetences by the American Physiotherapy Association (2014). Those papers ere the stanting point of our framework development.

Some other papers, not included in the review, describe important aspects of older adult care, such as specific clinical condition-related competences (Yoshimatsu et al. (2024). Those papers did not fulfill the inclusion criteria and for that reason were not included in this literature review. Nevertheless, we have not included all the papers published, we believe we have collected some important documents regarding competences for health professionals working with older people to allow focus group preparation and discussion. We focused on reviews, guidelines and reference papers because the purpose was to identify the current competences for health professionals that work with older people.

This framework creation was based on a review of relevant literature and a focus group methodology with an expert panel. The session was meticulously planned, following a specific script, and included reflection and discussion (Silva, Veloso & Keating, 2014; Sim & Waterfield, 2019). This framework emphasises “competences” involving values, knowledge, skills, and abilities in a patient-centered practice, guided by older adults' needs, values, and preferences, essential for maximizing functionality and quality of life.

The framework should adapted to the SL HC context, considering socio, religious, cultural, and economic characteristics (National Elderly Health Policy, 2017). It maps competences according to the SL Qualifications Framework: theoretical knowledge, practical application, communication, teamwork, leadership, creativity, problem-solving, managerial skills, information management, networking, adaptability, professionalism, and lifelong learning (SLQF, 2015).

Several theoretical models could be used as references for framework development (Palermo et al., 2022). We based our framework on the CanMEDS model, but other methods and models could be used in this process; no clear guidance exists for the best method to explore and develop content in this field (Batt et al., 2021).

Despite the volume of frameworks developed in healthcare professions and the move toward competency-based education, many factors influence their implementation (Murad, 2017; McCarthy et al., 2023). We have considered the specificities of nursing and physiotherapy professions and the SL context, but further

development and involvement of health education institutions, professionals, stakeholders, and policymakers are needed.

CONCLUSION

Population aging has a significant impact on economic, social and health systems in SL, addressing new challenges for HC professionals in older adults' care. Main competences identified in this framework were: high-quality standards and team leadership (leader/expert); patient-centered practice, effective communication (communicator); interprofessional effective team collaboration and shared decision-making process (collaborator); coordination of care and healthcare management (organizer); health promotion, wellness and well-being (health and welfare advocate); evidence-based practice and lifelong learning and continuous professional development (scholar); professional and ethical standards and multi-dimensional approach and best practices (professional).

Physiotherapy and nursing professionals, academics and students need to progressively adapt their competences to this new reality. Health Education Institutions curriculum need to map these specific competences in the physiotherapy and nursing courses, to allow update and improve knowledge, know-how, skills and mainly the conceptual approach in care and management of older adults in SL.

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