EnCOP

Enhanced Care for Older People

Support Guide: EnCOP Facilitation

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Introduction

Being an effective Competency Development Facilitator (CDF), is about adequately supporting others through the EnCOP process and ensuring opportunity is given to progress and develop towards competency achievement wherever possible. Celebrating what others already do well and supporting them to identify their learning and development needs are also a core element of EnCOP.

EnCOP CDF's require a range of skills and values....

- ✓ **A passion for improving care for older people**
- ✓ **Experienced and knowledgeable in delivering care for older people**
- ✓ **An interest in workforce development**
- ✓ **Experience or interest in assessing others**

And need a willingness to...

- ➢ **Become familiar with the EnCOP Framework**
- ➢ **Champion Practice Development**
- ➢ **Expand own role within the team / organisation**
- ➢ **Create time to undertake role**

In turn, CDF's can expect....

- ➢ **Organisational support within their role**
- ➢ **Support from the regional team (Strategic Workforce Lead)**
- ➢ **Peer support**

This guide to EnCOP facilitation is intended to be a useful reference guide to support CDF's in their role and offer both theoretical and practical information and advice.

Purpose and Background of EnCOP:

The main aims of EnCOP are:

To ensure consistency of the approach to care delivery across the system

Organisations can use EnCOP as a benchmark for good practice, to promote high quality care for older people wherever they are being cared for. The ambition is to implement EnCOP across different providers, including the NHS. Social care, and in the private sector e.g., care homes and domiciliary care providers to improve care for

To enable the whole workforce to work together to deliver timely, responsive, evidence-based care regardless of care setting

EnCOP is based on the latest evidence and best practice guidance and therefore reflects the knowledge, skills and behaviours that are required in order to deliver high quality care

To recognise that working with older people is rewarding and attractive and requires specific knowledge and skills as in any other specialism

Many people underestimate the levels of knowledge, skill and experience that are required to meet the care needs of the older population, particularly those living with more advanced levels of frailty. This framework aims to outline all that is required, and provide a framework for professional development

To develop a valued and competent workforce that can work anywhere in the care system

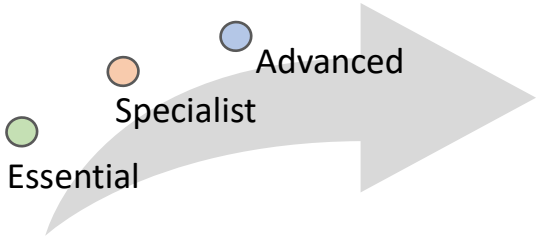
A key focus of EnCOP is to support and promote effective inter-professional and inter-organisational care. Defined competencies are outlined in relation to this which support staff to feel valued and to achieve their potential. For organisations, EnCOP competency provides assurance that staff are developed to the highest standards in delivering equitable, person centred and gold standard care for everyone

To achieve these aims, EnCOP has 4 Key Areas of Practice (KAP's)

These key areas of practice comprise 11 domains which describe competency across a number of measurable performance indicators.

Personhood, Relationship Centred Care & Ethical Practice	**Workforce empowerment, leadership and improving care**	**Partnership Working: Collaborative Care & Communication**	**Knowledge & Skills for Assessment and Care Delivery (Supporting Older People with Ageing Well)**
A. Values, Attitudes & Ethics	**B.** Evidence-based Practice : Supporting learning, leadership & improving care for older people	**C1.** Partnership Working and communication with older people, family and friends	**D1.** Ageing Well – Understanding Frailty: Prevention, Identification and Recognition
		C2. Inter-professional and Inter-organisational working, communication and collaboration	**D2.** Ageing Well – Assessing , Planning, Implementing and Evaluating Care & Support with Older People
			D3. Ageing Well - Promoting & Supporting Independence, Autonomy & Community Connectivity for Older People
			D4. Ageing Well – Promoting & Supporting Holistic Physical Health & Wellbeing with Older People
			D5. Ageing Well – Promoting & Supporting Holistic Psychological Health & Wellbeing with Older People
			D6. Ageing Well – Promoting & Supporting Older People with Medicines Optimisation
			D7. End of life care: older people and frailty – Recognition, assessment & care planning

Competency is outlined within 2 core levels of practice: **Essential** and **Specialist**. In addition to these core levels of competence, there is an optional EnCOP **Advanced** level, divided across 3 domains, which can be adopted to demonstrate competence in advanced clinical leadership influencing the design, delivery, and evaluation of enhanced care for older people:



OPTIONAL BOLT- ONS

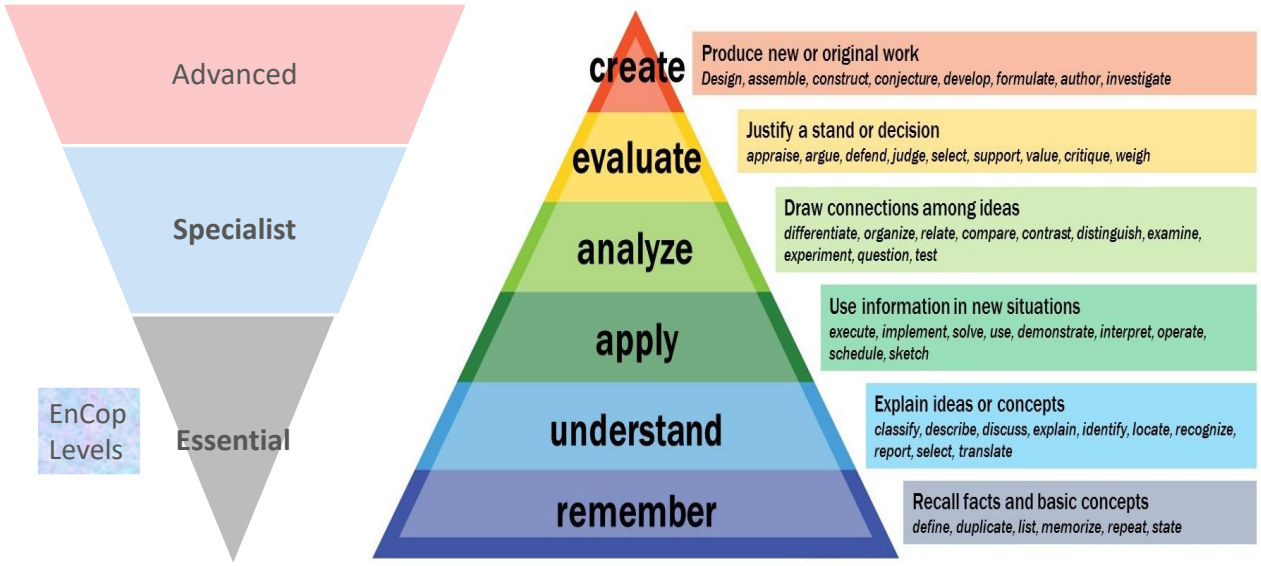
Advanced Domain 1: Advanced Clinician: Enhancing Care for Older People through clinical expertise

Advanced Domain 2: Advanced Leader: Transforming services and systems which Enhance Care for Older People

Advanced Domain 3: Advanced Influencer: Enhancing Care for Older People through Education and Research

Performance Indicators (PI's)

The performance indicators within the EnCOP domains are based on Blooms Taxonomy (1956), a recognised hierarchical educational model which supports the acquisition of knowledge. E.g. thinking, learning and understanding.



Objective assessment using PI's

- This knowledge acquisition reflects the expanding and cumulative level of knowledge and its application to practice at each EnCOP progressive level
- PI's offer a set of objective measures of achievement for each domain
- They are broad enough for them to be applied to a range of roles and across a wide range of health and social care settings
- There may be some overlap between the levels, however this is useful in identifying progression towards the next level

Who is the EnCOP assessment toolkit for?

The toolkit is designed to be applicable and relevant to all health and social care staff working in the care of older people, regardless of role or employing organisation.

The emphasis on levels of competency allows the assessment toolkit to be both standardised and flexible, enabling it to encompass and support the development of all staff.

Although not prescriptive, the following gives an indication of what might be expected at each level:

Level	Descriptor
Essential	Applies to all staff within adult health and social care who provide care to older people in all care settings
Specialist	Staff who work with a high degree of autonomy and have specialist knowledge relating to the care of older people
Advanced	Experts and leaders in the care of older people who influence change and improve service provision for older people

EnCOP Key Principles:

- Everyone should aim to achieve all competencies within the core 'essential' level
- Some individuals may have competencies from more than one level, relevant to their knowledge, skills and behaviours
- Through the cycle of competency assessment and review, areas for development can be identified. On an individual basis, this knowledge can support personal development and career progression
- Advanced Level domains are optional progressive add-ons to the core essential and specialist levels which can be adopted to support further advanced clinical practice and/or transformational leadership and/or research / education skills which represent enhanced care for older people. In addition to the key principle that everyone should aim to achieve all competencies within the core essential level, movement to the advanced level should be negotiated between the staff member and their EnCOP facilitator only when relevant underpinning Specialist level PI's are also achieved. This process will allow meaningful progression to the most appropriate advanced domain(s).

Adult Learning Theory

The delivery of EnCOP is based upon the principles of adult learning theory.

Adult learners….

- **Need to know why they need to learn something – how this might benefit them**
- **Are in control of what, when, and how they learn**

Therefore, outlining the aims and objectives of EnCOP are important to ensure staff understand how its use is of benefit to them, and their professional development. Staff should be encouraged to follow the iterative process of competency review (Pg10), and work with facilitators to identify potential learning opportunities, as required.

Learning Styles - According to Honey and Mumford, (1986) there are four distinct learning styles,

1) Activists: enthusiastic optimistic people who like to get stuck in and learn by doing- typically 'act now think later'
2) Reflectors: prefer to observe and think about things before doing anything. Look at the wider picture
3) Theorists: analytical people who like doing things methodically to try and reach a deeper understanding
4) Pragmatists: practical people who look for the quickest way to solve problems

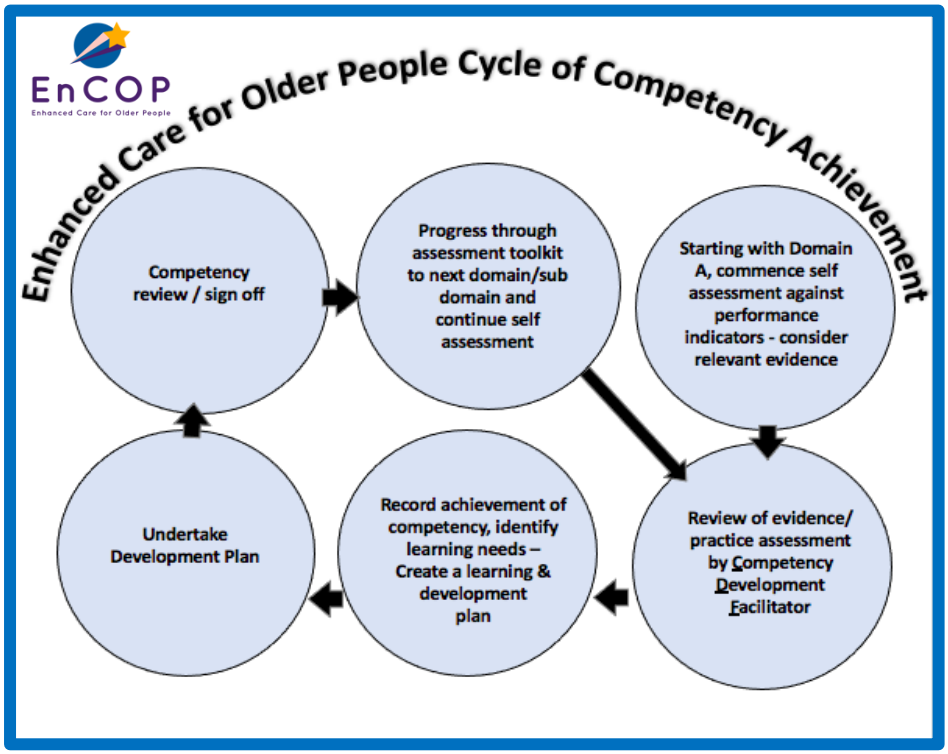
Key characteristics	Potential Drawbacks
Activists Philosophy: enjoy the 'here and now' Enjoy getting stuck in! Optimistic about anything new Less likely to resist change	Prone to take unnecessary risks Tendency to do too much themselves rather than delegate Can often get bored with 'implementation and follow through'
Reflectors Philosophy is to be cautions, careful and methodical Thoughtful people, often take a backstage in meetings Often hold a low profile / distant	Tend to refrain from direct participation Slow to make a decision Tendency to be over cautious – not willing to take risks Not necessarily assertive
Theorists Philosophy – 'if it's not logical it's not good' Often tend to be perfectionists, needing things to 'fit' to be rational Can be detached and dedicated to 'objectivity' rather than ambiguous subjectivity Good at asking probing questions	Restricted in lateral thinking Little tolerance for uncertainty and ambiguity Distrustful of anything subjective or intuitive Full of 'should, ought's and musts'
Pragmatists Philosophy 'there is always a better way' Like to just get on, acting quickly and confidently	Can often be impatient and prone to ruminating over open-ended discussions Not very interested in theory or basic principals Impatient with indecision More task than people orientated

Most people have strong preference for one of these but can draw on all elements to learn. It is important to consider your learning style as a facilitator, as well as the learning styles of the people you support, in order to have mutual respect and to guide them to the right learning opportunities and experiences.

Practice Assessment & Competency achievement.

The assessment, review and sign-off of EnCOP competencies should be completed using a collaborative, partnership approach between the staff member (assessee) and the **C**ompetency **D**evelopment **F**acilitator [CDF]. **Workforce competency** is defined within EnCOP as *"the ability to apply knowledge and skills in an appropriate manner, underpinned by appropriate attitudes / values, to achieve an occupational function"*.

The EnCOP Cycle of Competency Achievement is an iterative process and should be followed continuously throughout the assessment process



EnCOP Criteria for assessment

Effective implementation of EnCOP is underpinned by the principles of sound assessment which require the process to demonstrate:		
VALIDITY	**RELIABILITY**	**PRACTICALITY**
Opportunities for assessment and methods / evidence used relate to the performance indicators within the assessment framework	There is consistency of approach to assessment by CDF'S with the relevant knowledge and competence in the care of older people and practice assessment	Both the performance indicators, assessment tools and modes of EnCOP assessment are relevant to practice and easy to apply

Assessment is something you do 'with' someone rather than 'to' them.

For effective practice assessment think about:

- ✓ Who are you assessing?
- ✓ What are you assessing?
- ✓ What evidence of learning is required?
- ✓ How will learning be assessed

Top Tip - Be consistent in your methods of assessment whilst flexing and adapting to your learners (assessee) style. Think of your role as a supporter and encourage the assessee to take ownership of their own learning

Skills for Self-Assessment

Person-Centered Care:

Self-assessment is a natural and essential starting point when using the EnCOP toolkit. It makes us think about what we do at work, how we do it and how our health and social care colleagues, and most importantly, the older people we work with (and their families) see us. **As health and social care staff, studies tell us that we need to feel valued as individuals, to deliver high-quality person-centered care to older people**

Preparing yourself and others for self – assessment against EnCOP

- Becoming familiar and comfortable with the EnCOP assessment framework is crucial to be able to support others with competency achievement
- Begin with becoming acquainted with the EnCOP domains and sub-domains and the key components associated with EnCOP levels. **Self – assessment is the best starting point to help you feel at ease with EnCOP**
- Avoid overkill or feeling overwhelmed, start with Domain A and work forward from there.
- Remember as you begin to review yourself and your evidence, it may become clear that you have evidence that applies to more than one domain

Consider: 'How do I do that? 'Why do I do it that way?'

Always try to be open and honest with yourself!

Encourage others to do the same

Key points about self – assessment

- It can be difficult to do initially
- As humans we can tend to under or over rate ourselves
- How we see ourselves may not always be how other people see us
- The more you do it, the easier it gets!

ASK YOURSELF

- Are there any obvious areas of learning and development?
- Which EnCOP domain am I reviewing / mapping myself against?
- What are the essential performance indicators?
- What evidence do I have of achievement?

Checkpoint – Consider how you will use your own EnCOP experience to support others with their own self-assessment. Think about how you will effectively support individuals who over or under assess.

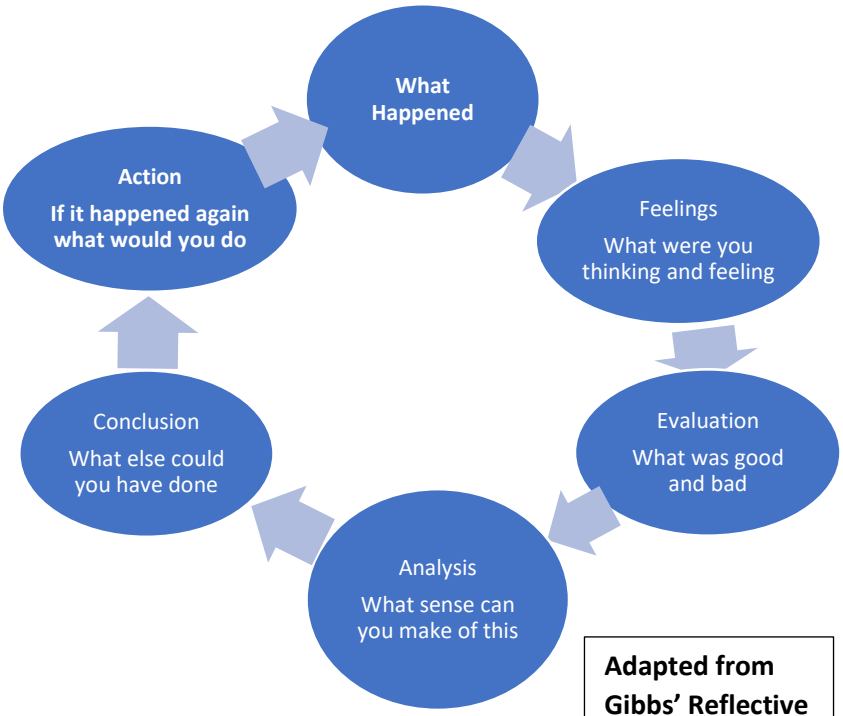
REFLECTIVE PRACTICE

Reflective practice is critical and deliberate inquiry into practice in order to gain a deeper understanding of oneself, others and the meaning that is shared among individuals (Peters 1991, Schon 1983)

When do we reflect?

- ✓ During Practice
- ✓ After the fact
- ✓ Alone or with others

Using a reflective model, either formally or informally, can support the process of learning through experience, for example after a positive experience or outcome, critical incident, complaint or complex interaction



Adapted from Gibbs' Reflective Cycle, (1988)

Using EnCOP to support reflective learning

Using the EnCOP Domains and Performance Indicators

Think about:

- What do I do within my job that makes a positive impact for older people?
- Do I apply the right evidence, knowledge and experience to my day-to-day practice?
- Do I recognise my own feelings and assumptions when I am working with a diversity of older people and their families OR interactions with my own team or other colleagues?
- How can I use incidents, complaints, mistakes and near misses to learn from and improve the care I deliver to older people?
- What are my development needs in relation to EnCOP and are there opportunities to progress across the EnCOP levels?

TOP TIPS for reflective learning

- Some people find it useful to keep a reflective diary or journal of experiences. This could support EnCOP assessment and review
- Consider writing up reflections and analysis of situations which have triggered reflection, do this as soon as you can
- Use actual dialogue wherever possible to capture the situation accurately and realistically
- **Always balance problematic experiences with good experiences -** celebrate the positive impact you make**,** reflection is not just about learning from mistakes

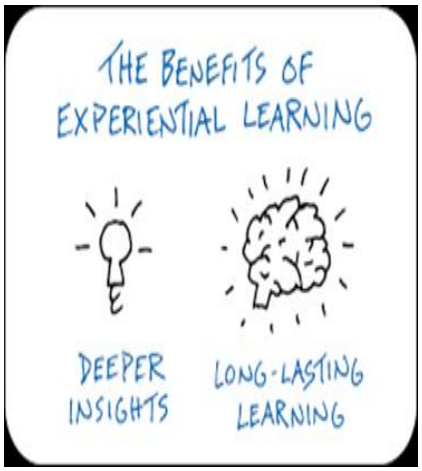
- Use EnCOP as a tool to challenge yourself about something that you normally do without thought or take for granted – this keeps you up to date with evidence- based care for older people and can stimulate great ideas for improving care

Checkpoint

Consider:

Do you recognise learning in practice?

Do you make time for reflection?



Evidence for EnCOP Competency Achievement

Collecting evidence:

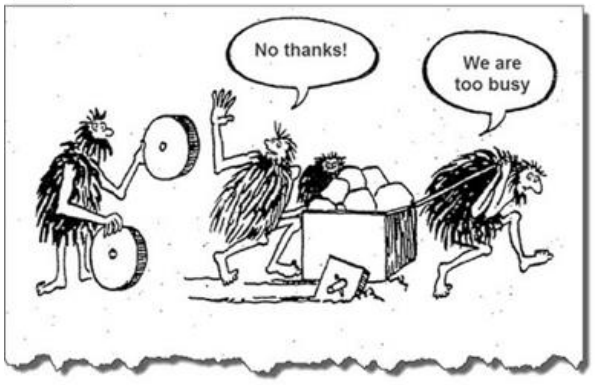
- *Working with older people across a variety of health and social care settings is valuable, rewarding, and attractive but also very often demanding, fast -paced and challenging therefore collecting evidence for EnCOP should not be onerous and burdensome*
- *There will be lots of work products and examples of feedback and scenarios found within your day-to-day work that you can either use to demonstrate competency or as the basis of reflection with your EnCOP assessor*

Examples of evidence

Type of Evidence	Key	Examples
Reflection	**R**	Around on the job experience, an episode of care, a training session or other learning and development, interaction with others within the health and social care workforce. Reflection around feedback received – good or not so good.
Direct Observation of Practice	**DOP**	Shadowing, working together, joint visits, formal observed practice.
Witness Testimony	**WT**	A statement from someone who has observed you doing something well, or a particular situation which shows your competence in a particular area or areas of care.
Feedback	**FB**	Teamwork – feedback from others (multi-source within the workforce), feedback from those receiving care or families. A thankyou card, an email, supervision sessions
Case Based Discussion	**CBD**	Discussion with your facilitator based around an episode of care with an older person, or situation in which you can discuss what happened, how you felt about it and what you learned from it.
Discussion	**D**	General discussion with your facilitator about anything related to EnCOP and older persons care which demonstrates or helps to demonstrate your competence.
Formal Qualification	**FQ**	Care Certificate, NVQ, City and Guilds, Diploma, Degree, Masters, PhD, preceptorship, leadership awards,
Work Product	**WP**	Anonymised record of care ,referral forms, reports you've written or contributed to, teaching materials,
Other	**Oth**	Practice development project, Professional or academic portfolio, written pieces,

CROSS REFERENCING EXISTING EVIDENCE

EnCOP is not about re-inventing your knowledge & experience …it's about **applying it to the needs of older people. You will** have **examples of prior learning or development** activities that you have undertaken or participated in that can be used or adapted to review against EnCOP



Checkpoint:

Is my evidence contemporary? Is it relevant to EnCOP?

Assessment and Feedback

Some assessment techniques can make us feel apprehensive and even a little uncomfortable. However, with supportive preparation and skilled facilitation, they have great potential to provide effective and comprehensive feedback, as exampled below:

SEEKING FEEDBACK FROM OTHERS: *It is human nature to welcome positive feedback about ourselves and our work, and most of us appreciate it, more so if it is well thought out and genuine rather than just flattery. The first step to seeking feedback is to decide what you want it for and who can provide the most useful feedback*

Ask yourself:

- **What exactly do you need feedback on & how will you use it?**
  The performance indicators within EnCOP and your own learning & development plan should help to guide this

- **What specific questions should you ask to get the most focused and useful answers?**
  E.g., how would you describe my contribution within the MDT meeting? What specifically am I doing well when I communicate with older people and what would be even better?

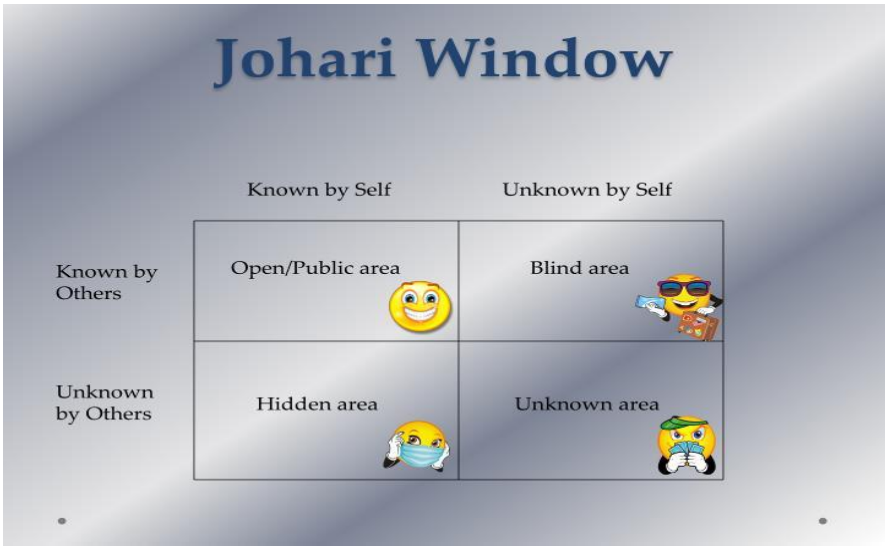
- **Are you seeking feedback from the right sources?**
  Who will be most honest? Who will have the most insight? Who is the most trustworthy? Do they understand why I need feedback?

Reflect:

- ✓ On both the positive and suggested areas for development within the feedback
- ✓ What feedback was expected and what came as a surprise? This helps to link feedback to what you know already and in what areas you need to become more self-aware
- ✓ By increasing your self-awareness, feedback sessions become easier & more productive

Top Tip:
Don't forget to seek upward, peer and lower-level feedback
(360-degree feedback is a particularly useful tool to do this if used in a supportive environment

The **Johari Window** is a useful model to **increase self-awareness** and your **understanding of how you interact** with others and can also be a **useful tool to provide productive feedback to others.**



Luft, J. and Ingham, H. (1955)

Open

Represents what is known by you about you, which others also know about you e.g. I know I speak quickly, and others notice that too

Blind spot

Represents things you are not aware of about yourself, although these things are apparent to others e.g. you know I am good at putting people at ease, but I didn't realise that about myself

Hidden

Refers to things you know about yourself which you do not reveal to others e.g. I used to provide training to others in my old team and wish I could teach others more in this role

Unknown

This represents things about a person that are unknown both to themselves and to others. This area is normally left to professional mediators to deal with because neither party are aware of why the issue has happened and it may often need professional analysis

Reviewing your own Johari Window

Blind spot: Is there a mismatch between the views you have of yourself and how others see you?

Hidden: Would more disclosure improve trust and relationships? Are there any hidden or undeveloped talents or potential?

RECEIVING FEEDBACK IS PARTICULARLY USEFUL as it opens up your blind spots, and these are often the hardest areas to learn about.

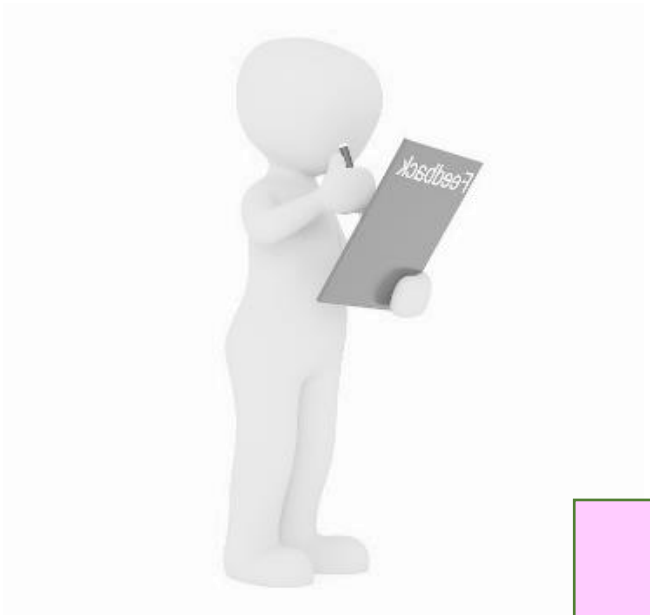
When giving feedback we assume people 'must know' the strengths and weaknesses that sit in their blind spot. When we receive feedback, if the feedback is not specific and real, we might fail to see areas that fall in our blind spot.

As a CDF you may want to consider:

- ✓ The need for self-awareness for you as a Competency Development Facilitator and your own skills in giving feedback
- ✓ When and where to give feedback
- ✓ How you will give constructive feedback
- ✓ Is the feedback you are giving motivational
- ✓ Is the feedback based on agreed assessment criteria within EnCOP?
- ✓ Does feedback highlight strengths of the work?
- ✓ Do you balance positive and negative comments?
- ✓ Do you provide specific ways to improve?
- ✓ Do you pose questions that encourage reflection?
- ✓ Do you explain all of your comments?

How do staff benefit from feedback within EnCOP assessment:

Adapted from: Wake and Watson **The Student Survival Guide to Assessment for Learning, Red Guide paper 32**



Helps the CDF improve in their role as a facilitator

Encourages the belief of "I can do"

Tells the person how well they are doing

Helps close the gap between where they are and where they want to be

Helps the staff member understand what is expected of them

Encourages interaction with the CDF around learning

Helps them to reflect on their own learning

Approaches to consider when supporting assessee's within the EnCOP Cycle of competency achievement

Coaching

What is coaching?

- It is essentially a non-directive form of development
- It focuses on improving performance and developing individuals' skills
- Personal issues *may* be discussed but the emphasis is on performance at work
- Coaching activities have both organisational and individual goals
- It provides people with feedback on both their strengths and their weaknesses
- Usually coaching would be for the short term

6 Principles of coaching

- ✓ Coachee has the ability to resolve their own situation
- ✓ Coach's role is not to give advice
- ✓ The Coachee sets the agenda
- ✓ Coaching is designed to bring out the best in already effective people
- ✓ Coaching is confidential where agreed
- ✓ People are capable of infinitely more than they believe

Active listening is a core skill to be an effective coach. How would someone know that you are *really* listening to them?

Active listening involves paying attention to what the other person is saying. To acknowledge that you are engaged in the conversation you can nod your head, make 'mmm' sounds and use encouraging words such as 'yes' and 'I see'. (Skills for Care, 2018).

Active listening skills - Non-verbal behaviour	Active listening skills - Verbal behaviour
Open alert posture	Encouraging words
Good eye contact	Clarifying
Encouraging gestures	Paraphrasing
Mirroring and pacing	Summarising
Suspend judgement	Reflections
Distinguish facts/feelings	Questions
Whole message not part	Silence

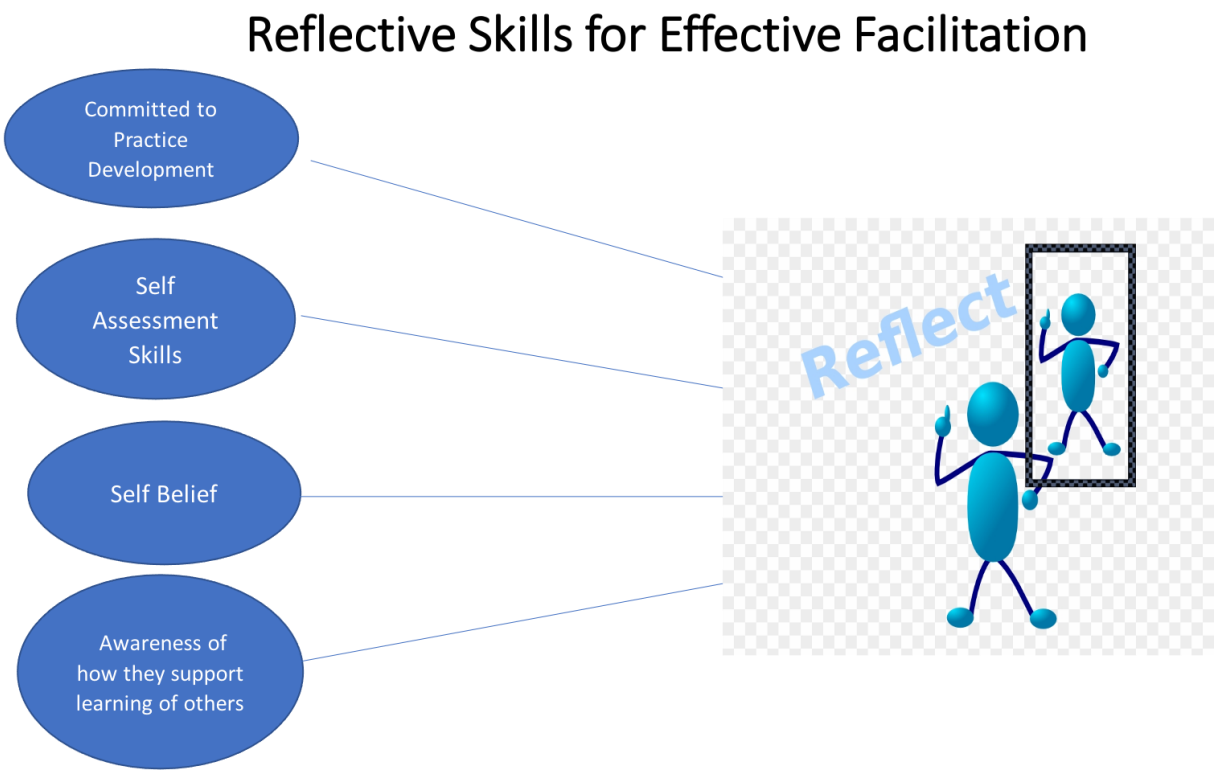
Caring Conversations

As outlined within this guide, being an effective Competency Development Facilitator is about adequately supporting the staff member through the EnCOP process and ensuring opportunity is given to progress and develop towards competency achievement wherever possible. Caring conversations can help to make this a positive development

The Caring Conversations Framework, Dewar & MacBride, (2017).

Key attribute	Dimensions	Key questions to ask others
Being Courageous	Courage to ask questions and hear responses. Feeling brave to take a risk. Persevering. Having courage to stand up for things.	What matters? Help me to understand what has happened? What would happen if we gave this a go?
Being Celebratory	Making a point of noticing what works well. Explicitly saying what works well and asking questions that get at 'the why'. Continually striving to reframe language to the affirmative.	What worked well here? Why did it work well? How can we help this to happen more of the time? If we had everything we needed, what would be the ideal way to do this? What are our strengths in being able to achieve this? What is currently happening that we can draw on? I like when you.....
Connecting emotionally	Using 'windows of opportunity' to create openings for people to discuss emotional and personal issues in the context of ordinary conversations. Inviting people to share how they are feeling. Noticing how you are feeling and sharing this.	How did this make you feel? How would you like to feel?
Being Curious	Asking curious questions about even the smallest of happenings. Wondering in the moment about what you see, hear and feel. Using micro-noticing practices by being attentive and open to what is happening. Questioning, weighing up this or that, hunting for meaning. Looking for the other side of something that's said, checking it out. Being receptive to be changed by what you hear.	What strikes you about this? Help me to understand what is happening here? What prompted you to act in this way? What helped this to happen? What stopped you acting in the way you would have wanted to?
Considering other perspectives	Creating space to hear about another perspective. Recognising that we are not necessarily the expert. Checking out assumptions. Being open to hearing perspectives, recognising that they may not be the same as your own and feeling comfortable to discuss this in an open way. To enlarge and expand my point of view.	Help me to understand where you are coming from? What do others think? What matters to you? What is real and possible? What would it look like if we did nothing?
Being Collaborative	Talking together, involving people in decisions, bringing people on board, and developing a shared responsibility for actions. Looking for the good in others to encourage participation and collaboration. Finding out about what we care about – our shared aspirations. Making connections and realising the relevance of these to help make choices.	How can we work together to make this happen? What do you need to help to make this happen? How would you like to be involved? How would you like me to be involved? What would the success look like for you? What can each of us do to make this better?
Compromise	Being open and real about expectations Working hard to suspend judgment and working with the idea of neutrality. Helping the person to articulate what they need and want and share what is possible. Talking together about ways in which we can get the best experience for all.	What matters most to you? What is real and possible? What could we let go of? How would we feel about letting go?

A final point to note - Facilitators with adept learning strategies that engage learners with problem-based learning are more likely to be reflective



Adapted from Chee Choy, S., Sau-Ching Yim, J. and Leong Tan, P. (2017)

- **Self-assessment is defined as the ability to discover and assess the strengths and weaknesses about oneself after experiencing an event**
- **Self-assessment therefore enables CDF's to be reflective of what they are teaching and their relationships with EnCOP assessee's**
- **Self-belief will have a significant relationship with how you perceive yourselves in relation to the colleagues you will be assessing and your ability to support their learning and development**
- **Using reflective practices within your daily work and your CDF role will result in increased self-awareness, which will in turn encourage self-assessment and self-evaluation.**

All of these processes can support you to feel motivated, proficient, and effective in your Competency Development Facilitator role.

Domain & Cycle of Competency Achievement Guidance – Introduction to Crib Sheets

The following Crib sheets are provided for your reference and use throughout the cycle of competency achievement with your assessee's. They are intended as a guide only and are in no way prescriptive. There are blank sections for your own local considerations - you may want to add any notes, questions, evidence examples or general comments to these to support you in your ongoing role as a Competency Development Facilitator.

EnCOP CRIB Sheets

Domain A: Values, Attitudes & Ethics

Essential Level

Consider:

- How they consider the feelings of the person in interactions and always ensure dignity, e.g., explaining what they are doing/ why they are doing it/ ensuring privacy, etc.
- Ability to always give adequate time to interactions
- Their understanding of the main principles of mental capacity act and liberty protection safeguards and how to apply these
- Ability to recognise safeguarding issues and act on these accordingly
- Understanding of, and adherence to professional boundaries
- Awareness of the range of marginalised or underserved older population groups who may not be accessing mainstream care and support e.g., people living with Learning Disabilities, homeless, travelers, harder to reach groups

Ask:

- Can they explain how an older person may feel if their dignity is compromised?
- Can they give examples of how they involve family and friends in care and interactions? Have they received any positive feedback in relation to this?
- Can they describe what is meant by unconscious bias? Can they describe any situations where this be may have impacted on care delivery e.g., making assumptions?
- Can they give examples of when they have worked with someone from a different culture to their own or a marginalised group? Did this make them think about things differently or act in a different way?
- Can they give an example of when they may have challenged negative behavior, labelling or stereotypes in relation to older people? How did that feel? Are they confident doing this?
- Can they describe the difference between best interest day-to-day decisions and decisions that may require a formal Liberty Protection Standards application? Can they outline their role in relation to this?
- Can they describe the most common types of abuse older people may be vulnerable to? (E.g. physical, financial, psychological, neglect, domestic, institutional, sexual)? Can they describe the local safeguarding policy /referral routes?
- Can they describe what is meant by the term 'ethical dilemma' and give an example of when they have experienced this in practice?
- What strategies do they use to manage stress? Where do they access support at work to help with the emotional challenges of caring for others?

Local Considerations / Notes:

Domain A: Values, Attitudes & Ethics

Specialist Level

Consider:

- Specialist knowledge and understanding of the importance of values and attitudes on care delivery
- Their position as a role model and the strategies they use to support staff in relation to values and attitudes, e.g. supervision, mentorship, coaching, peer support and guidance
- Their ability to give constructive feedback
- Their role in supporting staff resilience and wellbeing

Ask:

Can they name key legislation/ principles relating to equality and diversity?

- Equality Act 2010
- Health & Social Care Act 2012
- Care Act 2014
- Mental Capacity Act 2005
- Human Rights Act 1998
- Can they give an example of where they have seen dignity or care as compromised? What did they do? What were the outcomes?
- Can they outline when or how they would apply the MCA to formally assess capacity? What processes would they follow? Who would they involve? (Case example may be useful)
- Can they explain the best interest decision making/ Liberty Protection Standards process, when and how it might be used? e.g. medication, not free to leave, need for continuous supervision
- Can they give an example when they have accessed independent Mental Capacity Advocacy to support the older person and the care process? (Or when they would do this?)
- Can they describe a situation where they or a staff member raised a safeguarding concern? How was this addressed/ dealt with? How would they support others to highlight potential safeguarding issues?
- Can they outline a situation(s) where they have needed to draw on their comprehensive knowledge of ethics, moral reasoning and complex decision making and apply these in practice?

Local Considerations / Notes

Domain B: Understanding and supporting evidence-based practice: Leadership & improving care and support for older people

Essential Level

Consider:

- Can they evidence good time management of care delivery, appropriate prioritisation, and safe sharing of the workload, (effective delegation)?
- Do they demonstrate person-centeredness as opposed to task orientated approaches to the care of older people?
- Is the use of care plan, care standards and evidence-based guidelines & tools evident?
- Is their approach to health and safety in relation to care delivery safe, effective, and compliant?
- Their ability to reflect on own strengths and learning needs
- Role and learning and development expectations and exposure
- Engagement in improving care. How open are they to change?

Ask:

- How do they access local, team and organisational clinical/ operational policies, practice / policy guidance or protocols, care standards? Understanding of relevance of these in their job role.
- Can they name the organisations vision and values and show how they support these vision and values?
- Can they explain why change is important in care delivery?
- Can they describe or give examples of how costs need to be considered when delivering high quality care for older people?
- Why is appraisal important? What is their understanding of feedback?
- Can they give examples of when they have received and when they have provided feedback?
- What are their experiences of learning and development opportunities specifically related to the care of older people?
- How do they learn best? example on the job (experiential) online, face to face in big groups, one to one
- Do they feel that they are able to access learning and development opportunities? – discuss further if they do not for example what are the barriers for opportunities, how could they overcome this?
- What are their aspirations for development?
- Are there any competencies within the EnCOP Framework where they feel they could be at or working towards within essential or specialist level if so, what would enable them to get there?
- What service improvements have they contributed to/ made suggestions about, or are aware of?
- What ideas do they have for change/ improving services? Do they know how to share their ideas?
- Do they understand what is meant by the term 'audit'? Are they aware of any audits, improvements or research that are completed within their team/ service?
- Can they outline examples of care that they deliver that are underpinned by evidence? e.g. moving and handling, nutrition & hydration, pressure care, falls management, etc.

Local Considerations / Notes:

Domain B: Understanding and supporting evidence-based practice: Leadership & improving care and support for older people

Specialist Level

Consider:

- Is leadership demonstrated in practice? How do they apply transformational leadership qualities and techniques, change management approaches, team management?
- Is evidence- based care of older people evident in their day-to-day care delivery or management within role? Do they influence others within role? E.g., Use of evidence- based tools and resources
- Do they play an active role in the monitoring and evaluation of care standards, policies, and practices? E.g., Clinical audits, service user surveys, staff surveys, PDSA cycles, Root Cause Analysis
- Do they demonstrate effective resource (human and non-human) management in their day-to-day practice? E.g., This may include rostering staff, ordering stock, managing clinics or home visits, managing own diary and others
- Formal Qualification or specialist experience in teaching and learning (at specialist level these may differ depending on role and working environment).
- Experience of facilitating or delivering teaching and learning initiatives
- Quality improvement programmes they have they lead/ been involved with
- How they utilise/ lead/ support audits or other forms of evaluation. How has this influenced service provision?
- How they involve older people and their families in improving care within their team/ service/ wider organisation
- Involvement/ engagement with research? Can they describe the research process and how this could influence practice? E.g., ethics, sample sizes, validity, reliability, study types or methods

Ask:

- Can they describe the current local, regional, and national agenda steering the safe effective care of older people and frailty care? E.g., NHS Plan, NENC Ageing Well Strategy, Getting It Right First Time (GIRFT)
- Can they articulate what good leadership looks like? E.g., Transformational, Emotionally Intelligent, Coaching styles, Positive Change Management
- How do they manage complaints and /or conflict?
- How do they ensure safe governance within their role, service, and team for older people, family & friends, and staff / colleagues? E.g., Local system / organisational tools / resources
- How do they contribute to promoting 'working with older people 'as a key specialist focus or element of their role or service? E.g., role recruitment campaigns, through staff appraisal or PDP, staff line management
- What strategies do they use to ensure effective resource management to ensure fair and proportionate distribution that meets the needs of all older people? E.g., Continence products, medication, staff skill mix
- Can they articulate their understanding of coaching?
- What is their experience of supervising and assessing other staff? e.g. – involvement in staff appraisals, personal development plans (PDP)
- What is their experience of receiving and giving feedback? Have they reflected upon this?
- Have they ever had 360- degree feedback? How did they find this process/experience? How did they use this?
- Have they carried out staff training needs analysis? Examples of these?
- Do they self-reflect on their own learning and development needs?
- Have they done their own SWOT analysis? What resulted from this?
- Have they facilitated any training / development? Examples? PROMPTS- who were the staff group, topic, content, what was the feedback, impact upon care for older people.
- What do they feel are any challenges and enablers for their own and other staff members learning and development opportunities?

- Are there any competencies within the EnCOP Framework where they feel they could be at or working towards in specialist or advanced level if so, what would enable them to get there?
- What are their future aspirations?
- Can they give an example of how they have applied evidence to change or influence practice?
- How do they stay up to date with evidence?
- Can they describe an example of how they have been a role model for change?
- Can they give an example of being creative or innovative to support service improvement?
- Have they been involved in gathering/ using information and data to evaluate and/or improve services? E.g. surveys, focus groups

Local Considerations / Notes:

Domain C1: Partnership working and communication with older people, families, and others

Essential Level

Consider:

- Do they always introduce themselves sensitively and initiate meaningful conversations with the older people, family, and friends
- Do they have good verbal and non-verbal communication techniques with older people, family, and others? E.g., Use active listening skills, display appropriate responses to verbal and nonverbal cues, their tone of voice and language demonstrates interest, compassion, empathy, and appropriateness
- Do they seek to rectify or compensate for simple barriers to effective communication during usual care e.g., Ensure spectacles worn and clean, ensure hearing aids worn and in working order, overcome barriers caused by the use of Personal Protective Equipment
- Do they inherently recognise and involve the patient, family, and others as part of the care team?
- Do they work within the limitations of their role and can they recognise when extra support or assessment is needed and make or facilitate access to appropriate onward referrals E.g., SALT, Audiology, Optician
- Do they have awareness of how funding for care works e.g. personal care budgets, financial assessments
- Their understanding of transfer points in care and the significance of these for older people. E.g. movement between care services or environments whether its physical or being admitted or discharged from a caseload or episode of care
- Do they understand that key legislation is important in older person's care e.g. The Care Act, Continuing Health Care Process

Ask:

- What are the common types and/or causes of communication difficulties experienced by older people? E.g., expressive, and receptive dysphasia (e.g., due to stroke /neurological conditions, mild cognitive impairment / dementia), sensory loss (e.g., hearing impairment, sight loss)
- What do caring conversations involve? E.g., Being courageous, being collaborative, considering other perspectives
- Can they give an example of when they have acted as an advocate for older people and their families?
- What strategies have they used or considered to enhance communication with older people experiencing communication difficulties? E.g., involving family and others, use of pen / paper, talking mats, other technological aid
- Do they understand what transfer points in care are? And why these can be detrimental to older people?? E.g., associated risks such as medication errors, miscommunication, risk of delirium , low mood / increased anxiety
- Are they aware that older people who need support may be eligible for benefits? (E.g. Attendance Allowance)? Do they know how to support older people to access further support or advice?
- How do they consider the needs of family and other informal carers? Can they describe how to access carer support locally?

- Can they describe the basic principles regarding power of attorney e.g. health and financial aspects and what that means with regards to best interest decision making?
- How do they consider and overcome the impact that wearing PPE can have on communication for themselves and for the older person? I.e., Increased anxiety, increased frustration, impact on distressed behaviours for older people with dementia

Local Considerations / Notes:

Domain C1: Partnership working and communication with older people, families, and others

Specialist Level

Consider:

- Their experience of using of life story in planning care to support ageing well.
- Is there evidence that they utilise a range of approaches to ensure that older people, family, and others can be actively involved with all aspects of assessment, goal setting and care and support planning? E.g., Accessing interpreters, involving specialist services
- Do they exhibit whole local system awareness regarding older persons care? E.g., health and social care services & pathways, VCSE provision, peer support, their own networks,
- Their engagement with and ability to lead difficult conversations with older people, family, or others where there are communications difficulties or barriers which hinder shared decision-making related to individualised care and support planning?
- Do they actively seek, acknowledge, and aim to address the needs of family and other informal carers?
- How they support the learning and development of others, both formally and or informally, related to effective communication with older people, family, and others. E.g., Role modelling, coaching, facilitating access to or providing staff training

Ask:

- Do they act as a role model in supporting system navigation and advocacy for older people? E.g., Inward, and outward referral processes, promoting staff awareness / understanding and promotion of whole system awareness and approach
- Can they give an example of involvement in a situation where family dynamics or relationships were complex or there were differing opinions about care and support? How did they deal with this?
- What is their understanding of difficult conversations related to older people, family, or others? Can they give examples of when they have been involved in initiating difficult conversations?
- Can they give examples of how they negotiate goals and interventions with older people and how they have measured effectiveness?
- Can they describe the local processes and considerations for accessing funding for older people? E.g., CHC and Care Placement, benefits, social care assessments, social prescribing and VCSE sectors
- Are they aware of or do they use any relevant communication frameworks? E.g., SPIKES (Setting, Perception, Invitation, Knowledge, Emotions, Summary), SAGE & THYME (Setting – Ask – Gather – Empathy – Talk – Help - You – Me – End)
- How their communication skills are adapted where face to face communication with older people family and friends is compounded? E.g., Remote consultations, long distance communication, pandemic social distancing restrictions
- How do they use advanced communication skills when dealing with complex clinical situations or conflict? E.g., differing viewpoints, ethical dilemma, language barriers / cultural differences, complex advanced and emergency care planning

- Can they describe what is involved in advocating for older people? When might they refer on and what are the local routes for independent advocacy e.g. IMCA commissioning arrangements
- What are the implications of an older person employing a legal power of attorney…. on assessment, care delivery and decision-making? Do they have an example of this in practice? What strategies do they use to manage risk and acceptance of services?

Local Considerations / Notes:

Domain C2: Inter-professional and inter-organisational working, communication and collaboration

Essential Level

Consider:

- Their awareness of their own role and the service they work within
- Communication skills and the importance of clarity in information sharing (range of methods e.g., record keeping, verbal, handover tools, digital solutions)
- Teamwork in general, relationships within teams, empathy, respect, seeking to understand each other's role and perspective, conflict.
- Responsibility, Accountability, Autonomous working, limitations of role – is there evidence they know when to refer on / seek help
- Their ability to undertake effective record keeping within the scope of their role

Ask:

- Who / what are the key services they interact with in the course of their work?
- How do they make sure they are proactive in both seeking and providing (clarity of) information when needed?
- What do you understand about your role & responsibilities in information governance & confidentiality?
- Do they understand the reasons for keeping comprehensive records/ notes?
- How do they ensure everyone involved in the persons care is clear about treatment and care decisions?
- What do you consider before sharing patient / client information and data?
- What is your understanding of responsibility and accountability?
- Can you give an example of when you needed to involve someone else in a person's care rather than you manage on your own?
- Do you feel comfortable giving feedback on how effective your team is, other teams, or about referral systems? How do you make sure you give this feedback in a timely way? Do you know who to give this feedback to? Why is it important to flag things up?
- If problems arise when accessing support from others, how would you deal with this?

Local Considerations / Notes:

Domain C2: Inter-professional and inter-organisational working, communication and collaboration

Specialist Level

Consider:

- Their position as a role model and both motivating and supporting others
- Specialist experience, skills, and knowledge in older persons care,
- Their comprehensive knowledge of the health and social care system and services / pathway of care for older people
- Do they have advanced communication skills? E.g. demonstrating a range of methods, and supporting others.
- Is there evidence of them having a key specialist role within the MDT
- Do they delegate safely? E.g. including consideration of accountability and responsibility, safety, and quality (might be cross organisational)
- Is there evidence they have a key role in shared decision making.
- Their lead role in problem solving and responding to concerns, flagged issues etc. (older person, family and friends, colleagues, team, other teams, cross organisational, interagency)
- Their ability to facilitate effective information exchange to ensure safe and timely care. Examples?
- Do they engage and motivate others to ensure teams deliver optimal care to meet older person's needs and appropriate to the care situation?

Ask:

- How do they advise and support other staff in caring for older people?
- Can they give examples of how they include all relevant parties in shared decision making?
- How do you collaborate with others to both deliver and improve care?
- How do you ensure the care you give to older people is holistic in nature?
- Can you explain the strategies you use to break down barriers when accessing support across teams?
- How do you ensure yourself and others adhere to information governance and confidentiality during information exchange both internal and external to their own organisation?
- What is your understanding of the challenges of multiple organisations working together delivering care to older people? (e.g., staff competence, delegation, different policies, and procedures) how would you overcome this?

Local Considerations / Notes:

Domain D1: Ageing Well Understanding Frailty- Prevention, identification, and recognition

Essential Level

Consider:

- Is there a clear understanding that frailty is not an inevitable part of ageing, is a long-term condition, can vary in severity and is not static – can be made better or worse
- Their awareness that frailty is most common in older people but may also have earlier onset. E.g., Those living with long term conditions, marginalised groups or learning disabilities,
- There is awareness and sensitive management of introducing the term frailty where older people may be uncomfortable with the reference to living with frailty. E.g., common association of frailty with loss / vulnerability / dependency

Ask:

- Why is it important to support healthy ageing? What are the things they can do in your role to support an older person with this?
- Can they describe what frailty is? What do they know about frailty? Are they aware of factors which can increase the risk of developing frailty?
- Can they identify what positive choices older people can make which may prevent or delay the onset of frailty?
- Why is it important to identify when a person is living with frailty?
- Can they identify the five frailty syndromes and how they might recognise these?
- Can they give an example of when an older person was displaying one or more frailty syndromes and how they responded to this?
- Can they give an example of an older person and describe their level of frailty using the CFS?
- How would they help an older person to understand frailty and what it may mean to them, particularly when the older person may not want to think of themselves as living with frailty? E.g., education, supportive conversations

Local Considerations / Notes:

Domain D1: Ageing Well: Understanding Frailty- Prevention, identification, and recognition

Specialist Level

Consider:

- Is their evidence of a specialist knowledge of frailty and complexity / long term conditions? Different models of frailty, assessment scales and tools
- Their knowledge and understanding of the needs of varying ageing population groups when considering frailty identification and management e.g., people living with Learning disabilities, premature frailty, harder to reach marginalised groups, travelers, homeless
- Is there evidence of knowing the difference between a care and support planning approach and CGA
- Do they demonstrate sensitivity when discussing frailty with older people, family, and significant others

Ask:

- Can they articulate what the phenotype and cumulative deficit models of frailty are?
- Can they articulate benefits of proactively assessing for frailty and why it is always important to look for first presentation?
- Can they give examples of how they have / would use evidence-based tools in practice to identify and diagnose frailty?
- Can they articulate the difference between frailty, other long-term conditions, and disability?
- Can they give an example(s) of recognising deterioration in an older person living with frailty? What is the significance of frailty syndromes?
- Can they describe local pathways for preventative care and evidence-based frailty care?
- Are they able to describe what is meant by the terms strengths-based approach and patient activation?
- Can they give a practice example(s) of how they have facilitated positive behaviour change with older people?

Local Considerations / Notes:

Domain D2: Ageing Well: Assessing, planning, implementing, and evaluating care and support with older people

Essential Level

Consider:

- Their awareness of CGA as the cornerstone of frailty care. Clarity about their role & contribution within a CGA approach
- Their understanding that the wishes of the older person are what matter most in assessing, planning, implementing, and evaluating care
- Do they use the life story of the older person to ensure the best care delivery?

Ask:

- Can they describe what CGA is and why it benefits older people living with frailty?
- How do they Involve the older person and their family and friends to identify preferences and expectations, how do they do this and really get to know the person? E.g., talk to the person about background, what's important.
- What is their understanding of risk and screening tools? What tools do they commonly use in their role? Do they feel confident in there use and how to manage the information gathered?
- How do they use their knowledge of the older person and their family and friends, to contribute to the formulation of plans of care? E.g., Use continuous observation, day to day interactions with the person and families, collateral history
- What is their understanding of continuing healthcare assessments for individuals they are caring for? What is their role in this process?
- Can they give an example when they recognised an older person had a deterioration in their condition? How did they manage this? Can they describe how they decide who / how to access urgent and emergency care when necessary for a person in their care?
- How do they consider the needs of informal carers and what are the local pathway for assessing carers' needs?
- Can they describe what is meant by advanced care planning and when it might be used? E.g. to anticipate and plan for the future of a progressive condition.

Local Considerations / Notes:

Domain D2: Ageing Well: Assessing, planning, implementing, and evaluating care and support with older people

Specialist Level

Consider:

- How they involve the individual, family and others in Identifying the older people's needs, goals and problems
- Their understanding of shared decision making as a process that occurs between the older person and health and care staff, utilises this approach in assessing and planning care in partnership with the older person
- Their recognition and value that all parts of CGA are equal
- Is there evidence of parity of esteem between physical and mental health problems
- Their understanding of the presentations of multiple pathology, and age-related epidemiology of disease and presentation of illness
- Their ability to formulate a management plan based on the possibilities of differential diagnoses
- How they use a range of clinical care interventions & appropriate referrals e.g., appropriate hospital admission, to manage these changes/diagnoses

Ask:

- Can they articulate how they encompass holistic comprehensive assessment – what might they include in this? (E.g. biographical information, physical and illness conditions, sensory, functional and cognitive abilities, mental capacity, environment, psychological and mental health, social needs, spiritual needs, family issues, safety and safeguarding, and ongoing support and treatment). How do they support others to do this?
- Can they give an example of how they formulate a stratified problem list?
- Can they undertake a range of clinical assessment and diagnostic tests, including those utilising digital technology? Examples? Can they critically interpret assessment data? Example?
- Have they been involved in, or facilitated advanced care planning? Can they give examples of when this should be considered e.g. progressive conditions
- Can they articulate how they apply the Mental Capacity Act in practice – Capacity assessment, best interest decisions, and advocacy to embed anticipatory care into practice?
- Can they describe what NHS continuing Healthcare Assessment and provision entails? Example of involvement in this process?

Local Considerations / Notes:

Domain D3: Ageing well: Promoting and supporting independence, autonomy, and social connectivity for older people

Essential Level

Consider:

- How they promote choice on relevant decisions? e.g., clothing, when to get up, personal care, etc.
- Their understanding of the challenges and losses that may be associated with ageing
- Strategies they use to help older people to feel secure in their care (familiar items/ family/ routine/ choice, etc.)
- Strategies they use to support older people's independence.
- How they promote positive risk taking. Can they describe what this is?
- Is there an awareness of the importance of meaningful activity and how to support and promote this
- Is there evidence that they have an awareness of using a range of equipment that can support older people to live well, e.g., assistive equipment, technology

Ask:

- Can they describe the difference between recovery, reablement and rehabilitation?
- Who would they refer to, to enhance independence? E.g. in feeding, function, mobility- can they give examples of doing this?
- Can they describe risks that might be present in an older person's environment? Can they recall a time when they have adapted or changed the environment to minimise risk and/or enable better outcomes or quality of life for an older person?
- Can they explain how social isolation/ loneliness can affect older people? Can they offer examples of what they do routinely promote and support social connectivity?

Local Considerations / Notes:

Domain D3: Ageing well: Promoting and supporting independence, autonomy, and social connectivity for older people

Specialist Level

Consider:

- How do they determine the goals of treatment/ intervention?
- How they act as a role model to ensure others feel able to offer choice and promote independence
- Their experience and knowledge of adapting care environments to facilitate independence.
- Their ability to use teaching skills when promoting self-care with older people and their families.
- Is there evidence of specialist knowledge and support for others in relation to determining opportunities and appropriateness of positive risk taking
- Their involvement in service improvements that support access to meaningful activity/ preventative opportunities/ social connectivity
- Their knowledge of the pros and cons of local housing options and provision and how to access relevant advice and assessment for older people
- Is there any evidence of engagement with community organisations to improve opportunities for older people

Ask:

- What outcome measures do they use to evaluate practice?
- Can they give an example of when they have supported an older person, and their families in relation to finances, relevant to their care? E.g., referral to voluntary sector
- Can they give an example of when they have supported positive behaviour change e.g., lifestyle? Can they describe the strategies they used or would use to promote healthy living?
- What do they understand by a strength -based approach? How do they use this to inform practice? E.g., using what the older person can do well to support them to live well
- How do they use a partnership approach and positive risk taking to support older people to live well?
- Can they give examples of initiating or facilitating the use of telecare, telehealth or telemedicine and describe how it benefitted the older person

Local Considerations / Notes:

Domain D4: Ageing Well: Promoting and supporting holistic physical health and wellbeing with older people

Essential Level

Consider:

- If they understand the process of normal ageing?
- Do they display confidence and understanding when supporting older people experiencing deterioration in their physical health either through ageing changes, morbidities, frailty, or acute illness?
- Is there awareness of common preventative interventions and do they promote these routinely (opticians/ vaccinations/ podiatry, strength and balance, etc.)? Are there any they could promote more widely?
- Do they have the understanding that physical health problems can impact on other aspects of the older persons well- being including decline in functional ability, increased reliance on others, impact on mood and anxiety levels and social interaction and show a compassionate and sensitive approach when delivering care and support?
- Do they display a positive approach to care for older people with physical health difficulties and encourage the same with peers, informal carers, and older people themselves?
- If they ask older people (family and friends) relevant questions which can indicate whether their physical health and well-being is optimised, during simple assessments and episodes of care
- If they seek advice from or involve other health and social care colleagues in the most timely and appropriate way, when new physical health problems are suspected or there are signs that an existing physical health problem has deteriorated e.g., new symptoms, medication not working as expected, unexplained functional decline, non-specific signs such as lethargy, delirium signs

Ask:

- Can they describe a range of common physical health problems that older people frequently present with and how to recognise these? E.g., Pain, falls, incontinence, malnutrition, dehydration
- Can they discuss how deteriorating physical health (both acute and chronic) can affect other aspects of the older person's quality of life? e.g., social isolation, embarrassment, loss of confidence, reduced motivation
- Can they describe how to access advice and / or support , in the most appropriate way, regarding the physical health need of older people e.g. appropriate use of unplanned care services, GP, community nurse referrals, referral for specialist nurse assessment

Local Considerations / Notes:

Domain D4: Ageing Well: Promoting and supporting holistic physical health and wellbeing with older people

Specialist Level

Consider:

- Do they frequently encounter, assess, and address difficulties associated with the general physical health needs of older people E.g., within specialist role or within a CGA type approach?
- Do others refer to them for specialist assessment or advice regarding the physical health of older people E.g., Family & friends, multi-disciplinary colleagues, receives referrals from social care or VCSE colleagues
- Initiates/ facilitates evidence-based clinical management and referral pathways regarding optimal physical health E.g., Access to diagnostics, specialist advice (e.g., Specialist Nurses, Secondary Care Referrals), appropriate prescribing and de-prescribing
- How they provide or support access to preventative interventions e.g. podiatry, optician, strength & balance training. Do they support others to be able to do this? How?
- Is there evidence of specialist knowledge of interventions that support ageing well?
- Do they support the learning and development of others in relation to optimising physical health for older people? E.g., peers, colleagues, other health and social care workers, older people, family, and friends

Ask:

- Do they have any case examples where they have formulated or contributed to anticipatory or emergency health care planning for older people using a shared decision-making approach, in collaboration with other health care professionals and shown excellent information sharing regarding this?
-

Local Considerations / Notes:

Domain D4.1: Assessment and management of Pain

Essential Level

Consider:

- Their awareness that pain is under-recognised and undertreated in older people, and may be subjective
- Do they recognise they have a role in the management of pain
- Their recognition of the link between low mood and depression as both a cause and result of pain.

Ask:

- Can they give an example of acute pain and chronic pain?
- Can they articulate or give an example of when it may be difficult to differentiate between acute and chronic pain?
- Can they describe common verbal and non -verbal signs of pain? (Changes in mood, facial expression, agitation, becoming withdrawn, reduced appetite, decreased function, complaints of pain, moaning, gasping or crying out, guarding an area on movement, being unusually short tempered)
- Are they aware that there are a number of assessment tools and scales to determine the presence / intensity of pain including those which are useful when a person is living with cognitive impairment? Do they use any? Can they name any?
- How can / do they support and educate an older person and their families and friends in managing pain? Can you give an example?
- Can they describe the effects that living with pain can have on an older person, their families and friends?

Examples of assessment tools/scales:

Numeric rating scale

Verbal descriptive rating scale

Verbal numerical rating scale

Pain Thermometer (For older people with moderate to severe cognitive / communication impairment)

Abbey Pain Scale (For older people with severe cognitive / communication impairment)

Local Considerations / Notes:

Domain D4.1: Assessment and management of pain

Specialist Level

Consider:

- Their experience in assessment and management of pain within their role.
- Their awareness of the limitations of their role / when it is appropriate to refer on for specialist management

Ask:

- Can they describe a multidimensional approach to a detailed pain assessment? May include:
  - Sensory dimension: the nature, location, and intensity of pain
  - Affective dimension: the emotional component and response to pain
  - Cognitive dimension: anticipation, cultural values,
  - Also impact on functioning, level, and participation in activities of daily living (compared to usual)
- How would they investigate pain from a physical health perspective?
- Can they give a case example(s) where they have worked collaboratively with an older person, their families and friends to facilitate appropriate pain management strategies (would expect discussion of pharmacological and non-pharmacological approaches) Rationale? Evaluation strategies

Local Considerations / Notes:

Domain D4.2: Falls prevention, risk assessment and management

Essential Level

Consider:

- Their awareness of falls screening and assessment tools
- Are they aware of local falls services and referral routes
- Their experience in giving basic falls prevention advice e.g., footwear, eye test, med review, removing rugs, etc. Can they give examples of this?
- Do they understanding that falls are *not* an inevitable part of ageing and that often there is something that can reduce the risk of falls

Ask:

- Can they describe some common causes of falls in older adults living with frailty? E.g., acute illness, deconditioning, medication, environment, sensory loss, medical conditions, etc.
- Can they explain what is meant by 'multifactorial risk assessment'?
- Can they describe why fear of falling is significant? E.g. reduced activity-deconditioning-risk f falls

Local Considerations / Notes:

Domain D4.2 : Falls prevention, risk assessment and management

Specialist Level

Consider:

- Use of multifactorial risk assessment in practice
- Their experience of undertaking lying standing BP and interpreting a positive result. Do they know what to do with this? E.g., repeat/ onward referral/ seek advice

Ask:

- Can they detail all elements that should be included as part of a multifactorial risk assessment? I.e. falls history, relevant medical history, medication, vision, hearing, feet, footwear, environment, cognitive ability, mobility, nutrition, hydration, fear of falling.
- Can they detail which of these elements should be addressed by them and when they should refer on?
- Can they describe some of the common medical issues that can contribute to falls e.g. hypotension, syncope, BPPV
- Can they describe the common medications that can increase the risk of falls: anti-hypertensives, sedatives, beta-blockers, antipsychotics, anticholinergics?
- Do they consider fracture risk in the falls assessment? E.g. Risk factors, FRAX
- Are they aware of interventions to address fear of falling and how to access them? E.g. OT/CBT

Local Considerations / Notes:

Domain D4.3: Risk assessment, prevention and management of malnutrition and dehydration

Essential Level

Consider:

- Good hydration and nutrition are a high priority within care and support planning with older people and a key element for good physical and mental health and daily functioning. E.g., Cooking / shopping ability, Dentition, Weight Loss/ Gain
- Asks about food and fluid intake and mouth care in routine assessment and/or routine care delivery. E.g., Oral intake amount, preferences, difficulty swallowing, oral pain
- Pays attention to oral health during routine care. E.g., Offering toothbrush/paste, assisting with brushing teeth, denture care
- Offers older people, family and friends accurate and evidence-based advice regarding daily dietary and fluid requirements. E.g., BAPEN Eatwell Plate, Minimum 1600mls RDA Fluids
- Uses locally agreed evidence-based screening tools for nutrition, hydration, swallowing difficulty, mouth care as recommended. E.g., MUST, Eat-10, Weight monitoring
- Follows the older persons care plan effectively to support nutrition and hydration changes and know who, when and how to report changes or concerns locally. E.g., Weight loss / Gain, Appetite Loss
- Recognises and responds appropriately to signs of malnutrition/ dehydration/ swallowing difficulties? E.g., Increase or alter offer of food/ drink, increase assistance with feeding, support with positioning, set daily fluid target, adapted cutlery / crockery, document appropriately, monitor intake and chart appropriately, refer on appropriately i.e., raise concerns to team / senior staff and/ or appropriate MDT referral E.g., GP, Dietician, SALT?

Ask:

- Are they aware of the common oral health problems which older people may experience? E.g., Poor dentition, caries, oral abscess, oral thrush
- Can they recognise the common signs and underlying causes of swallowing difficulties for older people? E.g., Choking or coughing when eating or drinking, reports difficulty with food, wet sounding voice, drooling, repeated chest infections
- Can they describe why older people are at increased risk of swallowing difficulties? E.g., frailty, ageing changes, neurological conditions i.e., stroke, Parkinson's Disease, dementia, muscular problems, obstructions, acute illness
- Are they aware of common risk factors, signs & symptoms, and underlying causes for malnutrition? E.g., frailty, loss of appetite, dementia, low mood, altered taste / smell, poor dentition, swallowing difficulties, physical/mental health issues, polypharmacy, long term physical health conditions, reduced functional ability, increased dependency on others
- Are they aware of common risk factors, signs & symptoms, and underlying causes for acute and chronic dehydration? E.g., Frailty, Long term physical health conditions, loss of thirst sensation, dementia, reduced functional ability, increased dependency on others, swallowing difficulties, medication, hot weather, environment

- Can they describe the standard modified texture diet and fluid consistency scale (IDDSI) and how it can be applied safely and effectively in practice? E.g., Education of staff, family, and friends. good signage, making food and drinks look appealing

Local Considerations / Notes:

Domain D4.3: Risk assessment, prevention and management of malnutrition and dehydration

Specialist Level

Consider:

- Whether they frequently encounter and effectively assess and address a range of multi-factorial hydration and nutritional difficulties, experienced by older people E.g., Within specialist role or within CGA type assessment
- Do other health and social care colleagues or older people, family and friends refer to them for advanced assessment or advice regarding oral health, hydration, nutrition, or swallowing difficulties
- How they support the learning and development of others (peers, colleagues, other HSC workers, older people, family, and friends) in relation to hydration management, nutritional management, management of swallowing difficulties and/or oral care
- How they approach shared decision- making regarding the maintenance and management of optimal hydration and nutrition with older people, family, and friends

Ask:

- Can they describe the local clinical management and referral pathways for the assessment and management of a range of oral health or swallowing difficulties? E.g., SALT, Dentistry, Gastro-enterology, Ear Nose and Throat specialists
- Can they offer comprehensive knowledge of the signs, symptoms, and common underlying causes of malnutrition? E.g., frailty, reduced oral intake, dysphagia, sarcopenia, acute illness, new pathology
- Are they able to demonstrate broad knowledge of local clinical management and referral pathways for malnutrition? E.g., initiating appropriate diagnostics, accessing specialist advice, appropriate prescribing of oral nutritional supplements
- Do they possess comprehensive knowledge and understanding of the signs, symptoms and common underlying causes of sub-optimal hydration and dehydration? E.g., frailty, dysphagia, reduced oral intake, medication side effects, long term condition management
- Are they able to demonstrate robust understanding of appropriate local clinical management and referral pathways for hydration management? E.g., initiating appropriate diagnostics, accessing specialist advice, appropriate prescribing of oral nutritional supplements, appropriate prescribing e.g., fluid thickeners, artificial hydration, appropriate de-prescribing

Local Considerations / Notes:

Domain D4.4: Assessment and management of bowel and bladder health

Essential Level

Consider:

- Do they ask about bladder and bowel health during routine care delivery?
- Are they able to follow a care plan for bowel and bladder management?

Ask:

- Can they identify common risk factors, signs & symptoms, and underlying causes related to altered bowel habits for older people?
- Can they identify common risk factors, signs & symptoms, and underlying causes related to altered bladder function for older people?
- Can they describe different types and causes of urinary and faecal incontinence?
- Can they give an example of the impact that loss of bladder and / or bowel control can have on an older person?

Local considerations & Notes:

Domain D4.4: Assessment and management of bowel and bladder health

Specialist Level

Consider:

- Whether they frequently come across, address and assess bladder and bowel health problems encountered by older people
- Their experience and knowledge in assessment and management of bowel and bladder health within their role
- Their awareness of the current evidence base and guidelines for management of suspected urinary tract infection in people over the age of 65 years?
- Their knowledge of their local formulary and how to access the range of aids and products available to optimise bowel and bladder health
- Awareness of the limitations of their role / when it is appropriate to refer on for specialist management

Ask:

- Can they describe their approach to assessment of bowel function? (May include past medical history, usual function, ostomies, bowel drainage, manual evacuation, changes in usual habits, frequency, continence, consistency of stool, constipation, diarrhea, presence of blood, pain, participation in bowel screening, physical and cognitive function and ability in managing own toileting and bowel health needs, any impact on activities of daily living etc.)
- Can they describe their approach to assessment of bladder function? (May include past medical history, usual function, presence of catheter or urostomy, changes in usual habits, frequency, continence, (incontinence & type), colour and volume of urine, smell, bladder emptying ,urine retention, Haematuria - presence of blood, Oliguria – low volumes of urine passing, Dysuria – pain, pressure, discomfort or difficulty passing urine, Polyuria – abnormal increased urinary frequency, Nocturia – night time urination, physical and cognitive function and ability in managing own toileting and bladder health needs, any impact on activities of daily living etc.)
- Any male / female specific questions they may ask to gather information about bladder health?
- How would they begin to investigate changes in bowel function / habits from a physical health perspective?
- How would they begin to investigate changes in bladder function / habits from a physical health perspective?
- Can they give a case example(s) where they have worked collaboratively with an older person and their families to carry out an assessment of bladder and or bowel health as part of a comprehensive assessment and initiated appropriate management strategies through the development of an individualised care and support plan

Notes

Domain D4.5: Assessment and management of skin health

Essential Level

Consider:

- Do they prioritise skin health within routine care delivery with older people, family and friends E.g., prevention and management of skin conditions, maintenance of tissue viability, optimal wound care
- Do they ask about skin health and skin conditions in routine assessment and/or routine care delivery? E.g., Dry skin, broken skin, rashes, discolouration, bruising, moles & blemishes
- Is there evidence that they provide older people, family, and friends with accurate and evidence-based advice regarding the maintenance of healthy skin, prevention of skin damage and how to access early advice / assessment of skin changes E.g., skin tears, discolouration, wounds, rashes and new or altered moles, use of emollients, advice re: posture and positioning, accessing Primary Care advice
- Do they follow the care and support plan effectively to promote prevention and report changes in an appropriate and timely way E.g., good hygiene, posture, and positioning, use of emollients and prescribed medication
- DO they have an awareness of evidence-based guidelines and screening and assessment tools for the prevention and management of pressure damage E.g., Waterlow Score, wound measurement tools

  Is there evidence that they know the limitations of their role, when to report changes and refer on for specialist advice in an appropriate and timely way E.g., GP, Community Nurse, Tissue Viability Service

Ask:

- Are they aware of the common risk factors for the development of skin conditions, wounds, and pressure damage E.g., ageing changes (including chronic itch), increased skin dryness, sun damage, long term physical health conditions, poor nutrition / hydration, reduced mobility, poor posture and positioning, side effects of medication, urinary and faecal incontinence?
- What is their role in the prevention and management of skin damage, pressure damage and wound care within local care pathways and protocols? E.g., Management of simple wounds, provision / ordering of pressure relieving equipment, referral pathways for specialist advice?

Local Considerations / Notes:

Domain D4.5: Assessment and management of skin health

Specialist Level

Consider:

- Do they frequently encounter, assess, and address difficulties associated with optimal skin health for older people E.g., Within specialist role or within a CGA type approach
- Do others refer to them for specialist assessment or advice regarding skin health, skin integrity / pressure damage or wound care issues E.g., Family & friends, multi-disciplinary, colleagues
- Are they able to initiate/ facilitate evidence-based clinical management and referral pathways regarding optimal skin health E.g., Access to diagnostics, specialist advice (e.g., vascular team, dermatology, Tissue Viability Nurse Specialist), appropriate prescribing and deprescribing
- Is there evidence of appropriate use of incident reporting and safeguarding pathways regarding pressure damage occurrences within locally agreed evidence – based guidance and best practice to evaluate practice and inform service improvement E.g., Root Cause Analysis, incident reporting, clinical audits
- Do they support the learning and development of others in relation to skin health, tissue viability or other wound management? E.g., peers, colleagues, other health and social care workers, older people, family, and friends

Ask:

- Can they offer comprehensive knowledge regarding the pathophysiology of skin, ageing effects on skin and the common skin conditions and complications that affect older people? E.g., dry skin, pressure damage, skin tears, leg ulcers, eczema, psoriasis, pemphigoid, skin infections, skin cancer, medication side effects
- Do they display comprehensive knowledge about the aetiology and evidence-based locally agreed assessment, grading, management and evaluation of pressure damage and wounds?

Local Considerations / Notes:

Domain D5: Ageing Well: Promoting and supporting holistic psychological health and wellbeing with older people

Essential Level

Consider:

- Do they values the older persons psychological & mental health with equal importance as physical health
- Is there evidence that they ask about previous or known mental health conditions in routine care delivery to contribute to assessments? E.g., depression, dysthymia, anxiety disorder, bi-polar disorder, schizophrenia, psychosis
- Do they seeks to understand risk factors, triggers, symptoms, and behaviours which may indicate a 'flare-up 'of a known pre-existing mental health condition? E.g., hallucinations, delusions, low mood, apathy, anxiety
- Are they able to offers opportunities for older people to express how they are feeling, including supporting those with known communication difficulties? E.g., sensory loss, cognitive impairment, apathy
- Do they use local sources of advice and support effectively, to support older people with new or existing mental health issues? E.g., General Practitioner, Community Mental Health Team, Talking Therapies

Ask:

- Can they describe factors which promotes mental health and well-being for older people? E.g., social inclusion, promotion of support networks, activity, exercise, healthy diet
- Can they describe losses which may be experienced by older people and can result in grief reactions? E.g., loss …of spouse, sibling, home, independence, occupation, social groups
- Can they describe the signs, symptoms and management of common mental health conditions affecting older people? E.g., anxiety, dysthymia, later life depression, mild cognitive impairment
- Can they discuss how new mental health conditions and exacerbations of pre-existing mental health conditions can present as crisis and how this can impact on an older person's behaviour? E.g., functional decline, impact on physical health, physical health manifestations, increased use of /attendance at urgent care services
- Can they identify local carer support networks and services for older people with mental health conditions? E.g., MIND, Age UK

Local Considerations / Notes:

Domain D5: Ageing Well: Promoting and supporting holistic psychological health and wellbeing with older people

Specialist Level

Consider:

- Do they regularly undertake comprehensive assessment of the psychological / mental health needs of older people? E.g., within specialist role, as part of CGA approach
- Is there evidence that they use appropriate evidence-based screening and assessment tools relevant and validated with the older population? E.g., Geriatric Depression Score, 4AT Delirium Score
- How do they promote or support older people's equity of access to mental health assessment, diagnosis and / or support? E.g., Community Mental Health Team, Talking Therapies
- Do they promote shared decision-making with older people, family, and friends regarding mental health and well-being, E.g., Cognitive Behavioural Therapy (CBT) approaches, self-management plans
- Is there evidence that they assess the needs of family and friends within caring roles? E.g., accessing support services, referral for carers assessment
- Are they able to support the learning and development of others regarding older people and mental health needs? E.g., awareness raising, shadowing opportunities
- Is there evidence that they have specialist knowledge of interventions that support psychologically ageing well

Ask:

- Do they display comprehensive knowledge of common mental health conditions affecting older people? I.e.., typical presentation, signs, symptoms, and evidence-based management and interventions
- Are they aware of risks associated with older people with mental health conditions and indicators for crisis referral? E.g., signs of self-harm / suicide intention, risk to self and others
- What is their knowledge about how and when to use local evidence-based pathways and services for older people with mental health needs? E.g., crisis Interventions, Talking Therapies, clinical psychology
- What is their knowledge about how and when to access formal and informal support networks for older people with mental health needs and their carers?

Local Considerations / Notes:

Domain D5.1: Cognitive Impairment: Recognition and Assessment

Essential Level

Consider:

- Their awareness about what cognitive impairment is
- Their awareness of the term dementia and that this is often used as an umbrella term for a range of cognitive impairments including mild cognitive impairment.

Ask:

- Can they identify a range of common underlying causes of cognitive impairment aside from dementia E.g., Delirium, acute illness, undiagnosed physical health problem, depression, and side effects of medication?
- Can they describe when dementia should be suspected and how would they refer on for further advice, support, or assessment?

Local Considerations / Notes:

Domain D5.1: Cognitive Impairment: Recognition and Assessment

Specialist Level

Consider:

- Do they recognise and respond to potential signs of dementia effectively, establishing and eliminating other common potential causes for symptoms such as cognitive impairment, confusion, disorientation? E.g. Utilises evidence-based assessment tools, collects extended collateral history, initiates, or facilitates basic diagnostic investigations.
- Their awareness of the potential impact of diagnostic errors
- Are they confident in accurately differentiating between dementia, delirium, depression and other conditions presenting with similar cognitive symptoms

Ask:

- Do they have a comprehensive knowledge of cognitive impairment? Can they demonstrate their knowledge by talking about typology, presentations and trajectories of the common dementia - type conditions
- Can they give examples of the range of investigations they might carry out and screening tools they might use to support assessment of cognitive impairment?
- Can they give a case example of working collaboratively with the older person and their family to carry out a comprehensive assessment when the person experienced new or worsened cognitive impairment? What did this entail?
- How would they involve MDT colleagues when acting on assessment findings with older people and their families affected by cognitive impairment?

Local Considerations / Notes:

Domain D5.2: Dementia Care: Assessment and person-centred management

Essential Level

Consider:

- Do they display a positive attitude and calm manner and is their evidence that they recognise that delivery of care and/or support for older people with dementia needs to be compassionate and individualised.
- Is there evidence that they are aware of the stigma, myths and stereotypes linked to dementia – and are confident in challenging these?
- Is their evidence that they are attentive to the environment e.g. considering if the environment has a positive or negative impact, aware that home, housing and communities have a central role to play in enabling older people with dementia to live well.
- Is there evidence that they value the older person's life story to help to develop positive care strategies? E.g., Reminiscence, Sensory support, using familiar objects and belongings (e.g., photographs)
- Do they show a proactive approach and positive attitude to distressed behaviours and methods to identify unmet needs? E.g., acute illness, pain, huger, thirst, anxiety, loneliness
- Are they aware of local dementia resources, services, and pathways to seek appropriate advice and support, E.g. Community Mental Health Services, Mental Health Liaison Teams, Challenging Behaviour Teams, Alzheimer's Society,

Ask:

- What types of dementia are they aware of and what are the underlying causes? E.g., Alzheimer's Disease, Vascular Dementia, Frontal Lobe Dementia, Korsakoff's Dementia
- Can they talk about the common difficulties and impairments that older people with dementia experience, including those seen as dementia progresses? E.g., Memory problems, speech difficulties, word finding difficulties, disorientation, impaired mobility, continence issues, difficulty managing activities of daily living (ADL's) and Instrumental Activities of Daily Living (IADL's)
- How would they recognise and respond to signs of carer stress and difficulties?
- What is their understanding of meaningful activity? May include ensuring activities are relevant or attuned to the older persons likes and dislikes.

Local Considerations / Notes:

Domain D5.2: Dementia Care: Assessment and person-centered management

Specialist Level

Consider:

- Is there evidence that they have a comprehensive knowledge and understanding of different types of dementia, their symptoms and trajectories
- If they understand the importance of equity of access for older people related to elements of dementia care no matter where they live or are being cared for
- Are they an advocate and role model in delivering relationship- centered care for older people living with dementia? E.g., evidence of complex communication with family and friends, facilitating access to support and case management where appropriate, advanced, and anticipatory care planning
- Are they able to provide advice, support, and assessment regarding more complex aspects of dementia management? E.g. Delirium superimposed on dementia, distressed behaviours
- Can they evidence that they have a comprehensive knowledge in practice of appropriate use of pharmacological interventions used to enhance memory or support symptom management for older people living with dementia e.g. criteria, benefits, limitations, implications, managing expectations,
- Do they support the learning and development of others with regards to dementia care either formally or informally? E.g., Delivering dementia awareness training, Dementia Champion, providing clinical supervision, shadowing,

Ask:

- How do they engage with the current and emerging evidence-base regarding dementia care? E.g., Forums, networks, conferences. Can they describe how they use this within their practice to impact the care they deliver? (e.g. pyscho-social approaches, models of assessment and care, assessment tools, national guidelines, training standards, treatment options, managing complexity, post diagnosis support, end of life care planning)
- Can they give a case example of using a relationship centered approach to dementia care, working collaboratively with the older person and their family? e.g. in assessment, sensitive communication, facilitating relevant interventions and involving appropriate support services
- Can they evidence extensive knowledge of their role and understanding of the presentation, causes, assessment and management of 'distressed behaviours (BPSD)? E.g., Anxiety, Fear, Pain, Loneliness/ social isolation, Physical Health Issues (may include a case example), comprehensive assessment, formulation of an individualised care and support plan,
- How would they both recognise and address the older person's broader physical needs as dementia becomes more advanced?
- Do they have an extensive knowledge base of local access referral routes and management pathways for the assessment, diagnosis, post diagnosis care and support planning and end of life care for older people with dementia? E.g., Memory Protection Services, Community Mental Health services, Admiral Nurses, VSCE support services

Local Considerations / Notes:

Domain D5.3: Mood Disorders in Later Life: Recognition, Assessment and Management

Essential Level

Consider:

- Is there evidence that they are aware of common risk factors which may increase the risk of depression for older people? E.g. physical health problems, other mental health problems, pain, loss or grief, trauma, loneliness, functional limitations, substance misuse, finance issues, change in environment – moving home, admission to care home, admission to hospital,
- Do they sensitively ask about symptoms of anxiety or depression in routine care delivery?
- Are they aware that there are assessment tools for anxiety and depression specific to older people? E.g. HADS HADS-D, GDS, PHQ-9
- Is there evidence that they able to follow a care and support plan for an older person living with anxiety and / or depression?

Ask:

- Can they talk about what anxiety and depression are and why it is important to be vigilant to recognise any signs of these mood disorders with older people e.g. to identify early, access care for assessment, care and support planning, involving appropriate services, to put support in place, improve quality of life and reduce impact on the older person
- Are they aware of the common signs and symptoms of anxiety and depression with older people? E.g. for both – behaviours, thoughts, feelings, physical symptoms
- How would they access more advice or specialist services for an older person living with anxiety and / or depression?
- What impact do they feel home circumstances and environment can have on a person's mood? What could they do to ensure a positive enabling environment which optimises mood for older people?
- Can they talk about the overall impact that anxiety and / or depression can have on older people and their families? Could they offer any basic advice on ways to manage this impact?

Local Considerations / Notes:

Domain D5.3: Mood Disorders in Later Life: Recognition, Assessment and Management

Specialist Level

Consider:

- Is there evidence that they have a comprehensive knowledge of mood disorder in older people and the signs, symptoms and behaviours that may indicate these?
- Is there knowledge around screening tools for low mood, anxiety, depression and using appropriate tools confidently in practice with older people?
- Are they aware of the limitations of their role and when to refer on for specialist advice / assessment
- Is there evidence of knowledge of the range of interventions for depression, e.g. pharmacological, non-pharmacological, indications for use
- Their knowledge and recognition of potential self-neglect, self-harm or suicide, e.g. how to determine and act on risk and when to refer on for urgent specialist advice.

Ask:

- What are the relationships and differences between anxiety and depression in older people? E.g. crossover and similar feelings of worry or feeling overwhelmed but differences in sadness, hopelessness or emptiness in depression and fear, tenseness and panic in anxiety. Could prompt if necessary the similarities and differences across the spectrum of behaviours, feelings, thoughts and physical symptoms.
- Can they give a case example of working collaboratively with older people and their families to carry out a comprehensive assessment of mood? How did this feel? What did it entail?
- Can they give a case example or describe how to distinguish between depression and normal bereavement reactions? e.g. past history, reactive low mood, general low mood, grief response, timeline, focus on bereavement, general feeling of sadness, transient or changeable symptoms, thoughts of 'joining' the deceased, suicidal ideation in general, considerations such as co-existing grief and depression, or grief triggering a depressive episode.
- Can they describe the risk factors for suicide and self-harm for older people

Local Considerations / Notes:

Domain D5.4: Delirium: Recognition, assessment and management

Essential Level

Consider:

- Is there evidence that they recognise signs and symptoms of delirium and is aware of assessment tools that can be used in delirium care E.g., Soft Signs tools, 4AT, SQUID question, Antecedent Behavioural Charts (ABC)?
- Do they have effective communication skills and are confident in asking about delirium symptoms.
- Is their evidence that they can offer basic management advice (PINCHME for example or even if this is not mentioned – evidence of basic advice such as minimising noise and irritation, promote good nutrition, sleep, safety, not forgetting support and information for family members etc.) Do they provide evidence which demonstrates their understanding that delirium can be prevented and treated?
- Is their evidence that they can follow an older person's care and support plan related to delirium.

Ask:

- What do they look for when suspecting delirium – tease this out by asking are they able to describe what delirium is including symptoms of hyperactive, hypoactive and mixed presentation in delirium?
- Do they know who to refer on to for further delirium assessment? When would they do this?
- What impact might delirium have on an individual and their family – short term and long term? How would they support an individual and their family when delirium is present?

Local Considerations / Notes:

Domain D5.4: Delirium: Recognition, assessment and management

Specialist Level

Consider:

- Is there evidence of a comprehensive knowledge of delirium and the complexity of recognising and managing delirium alongside other mental health and or physical health conditions e.g. able to carry our comprehensive assessment and develop an individualised care and support plan including preventative elements,

Ask:

- Can they articulate risk factors for delirium? E.g. previous delirium, dementia or cognitive impairment, not exclusive but older age as a factor, frailty, multiple long term conditions, other physical or mental health conditions – current or past, acute illness / significant injury or trauma, alcohol or drug excess, sensory impairment, poor nutrition, reduced stimulation, end of life phase.

- What is their knowledge of evidence based support tools in the diagnosis of delirium? E.g. CAM, 4AT

- What would they do if there was difficulty in diagnosing delirium or delirium is unresolved? E.g. consider differential diagnosis, refer for specialist advice or assessment, use recommendations in clinical guidelines to guide practice (NICE CG103, Delirium: prevention, diagnosis and management, (2010) updated March 2019)

- Can they give a case example when they have communicated a delirium diagnosis to an older person and their family? How did they involve the older person's family in effectively managing the delirium e.g. recognizing and valuing the family contribution, facilitating involvement where appropriate, supporting through education and emotional support,

Local Considerations / Notes:

Domain D6: Ageing Well: Promoting and supporting older people with medicines optimisation

Essential Level

Consider:

- Do they have a role in supporting older people, family in the collection, administration, taking or handling of medication on a regular basis
- Is there evidence that they encourage/ enable the older person to be as independent as possible? E.g., linking with GP or pharmacist re: prescription access schemes or medicine taking aids (e.g., monitored dosing system), refer to tele- care for prompts
- Are they able to keep accurate records related to medicines and older people
- Can they undertake safe and effective ordering, checking and storage of medication within the care setting or able to advise older people, family, or friends regarding this? E.g., timely ordering, avoiding 'stockpiling', expiry dates of 'as required' medication?
- Do they arrange access to or promotes attendance at planned regular structured medication review
- Do they recognise the increased risks of medicine related harms and the importance of unplanned medication review at key events E.g., admission to or discharge from hospital /care home / caseload, change of care provider, acute illness, or presentation of frailty syndrome?
- Are they able to contribute to medication review or ongoing monitoring by supplying relevant information regarding reaction, response, and concordance to relevant healthcare professional /prescriber
- Do they recognise act, and refer on (or can describe who, where and when to access guidance / advice) for wider multi-disciplinary or specialist advice/ support regarding medicines. E.g. poor concordance, safeguarding issues, confirmed or suspected diminished Mental Capacity, need for MDT best- interest assessment and decision making

Ask:

- Which groups of medication are commonly considered as critical / time specific medication and where incidents of omission are considered 'never-events'? E.g., Diabetic medication & insulins, Parkinson's Disease medication
- What is common age -related changes and increased risks of medication related harms associated with older people? E.g. changes to absorption , changes in excretion due to altered liver and kidney function, increased risk of interaction with prescribed and over the counter medication
- What are common groups of medication that may have increased risks of side effects for older people? E.g., blood pressure medication, water tablets, laxatives, painkillers, and sedatives
- What are the common side effects that you should be vigilant for in older people? E.g., falls/ dizziness, drowsiness/ lethargy, constipation/ loose stools, altered cognition / delirium, nausea/ loss of appetite

Local Considerations / Notes:

Domain D6: Ageing Well: Promoting and supporting older people with medicines optimisation

Specialist Level

Consider:

- Is assessment and/ or review of medication management for older people part of their role?
- Do they use evidence-based approaches to all aspects of medicines management for older people? E.g., medication assessment and review, consultation, and prescribing (within role), use of Patient Group Directives
- Is there evidence that they can implement proactive risk management and advocacy for older people relating to safe and effective prescribing, ordering, storing and administration of medication? E.g., Optimising opportunities for self-care
- If they follow the principles of shared decision making through proactively offering choice and involving older people (and family and friend as appropriate) in what, how, and when to take medication. E.g., Telecare, rescue medication, education of older person, family & friends (e.g., PEG medication administration, insulin administration)
- Do they supports safe, effective prescribing practice within the ethical and legal frameworks underpinning medicines management? e.g., Safe covert medication practice, the use of safe anticipatory prescribing, safe use of PGD's
- Are they able to recognise opportunities for appropriate de-prescribing, including the use of deprescribing tools and guidance? E.g., Anticholinergic Burden Score (ACB), STOPP/START, Sick Day Rules
- Do they spots opportunities for learning and development of competence among health and social care colleagues? E.g., 121 shadowing opportunities, formal training programmes?
- How do they contributes to development or evaluation of local policies, systems, and governance in relation to medicines management for older people? E.g., Incident reporting / review, monitoring / review of prescribing data, clinical audit

Ask:

- What are the effects of ageing, frailty and multi-morbidity on the absorption, distribution, metabolism, and elimination of medication? E.g., increased levels / drug toxicity, reduced effectiveness, increased susceptibility to side effects
- Describe in detail the range of medications available and prescribed to the older population which represent a 'higher risk' in old age? E.g., Falls risk medication, anti-cholinergic burden, sedating medication
- What are the underlying cause and increased risks associated with polypharmacy, for older people? e.g., Adverse Drug Events, hospitalisation, falls
- Can you describe the range of other risk factors associated with higher risk of medication harms? E.g., Acute illness, compromised hydration / nutrition, care transitions, altered care package, dependency on others

Local Considerations / Notes:

Domain D7: End of life care: older people and frailty- Recognition, assessment, and care planning

Essential Level

Consider:

- Do they have recognition that the end of life for an older person living with frailty and / or dementia can be different than in other end of life trajectories
- How do they ensure the wishes, choices and preferences of an older person, their families, and significant others for optimum end of life care
- Their role and experience of using Emergency Health Care Plans, Advanced Care Plans, and legal declarations of wishes in end-of-life care
- Do they recognise that delivering end of life care can be daunting, stressful, challenging, and emotional for staff both pre and post death of the older person

Ask:

- Can you give an example of a time when you were involved with an older person who was coming to the end of their life? Did you have discussions about wishes and choices? What skills and knowledge did you use to help you with this?
- What do you understand about 'deciding right' documentation and what this means for older person's care?
- Thinking about end-of-life care, what is your role in this for older people and what skills do you have which you think are important to be prepared for this? (e.g., contributing to and delivering a plan of care, dignity, respect, privacy, confidentiality, and comfort, recognising symptoms and knowing how to manage or get help to manage these).
- Can you give an example of a time when you recognised a person may be close to or in the dying phase? What knowledge and skills do you have which helped you manage this situation? What was your role and responsibilities?
- Do you have any experience of supporting bereaved friends and family after the death of the older person you are caring for? Are you aware of any support services for bereaved families? How would you involve these services?
- If you have been involved with an older person at the end of their life, how did this make you feel? How do you make sure that you are thinking of your own needs and support in your role within end-of-life care for older people? How would you seek support if you felt that you needed it?

Local Considerations /Notes:

Domain D7: End of life care: older people and frailty- Recognition, assessment, and care planning

Specialist Level

Consider:

- The ability to act as a role model and support others in end-of-life care
- Do they have comprehensive knowledge and skills in proactive preparation for end of life in line with the wishes and preferences of the older person, family, and significant others
- Is there evidence of a broad knowledge of key legislation, (Mental Capacity Act, Palliative care guidelines, local, regional and national tools)

Ask:

- How do you ensure you facilitate or provide holistic care in supporting an older person with end-of-life care decisions? What needs to be considered?
- How do you ensure you facilitate or provide holistic care for an older person at the end of their life / dying phase? What needs to be considered?
- Deciding Right are key documents regionally for both planning for and managing care at the end of life, what is your role in advanced care planning, comprehensive assessment, and care / goal planning for the end-of-life phase?
- Can you give an example of a time when you recognised an older person may be in the last 12 months of their life? What knowledge and skills do you have which helped you to manage this situation? What was your role and responsibilities?
- When might the Mental Capacity Act and Mental Capacity Assessment need to be applied in end-of-life planning / care delivery?
- What is your understanding of realistic medicine and how do you apply this knowledge in your role linked to end-of-life care?
- Can you think of an ethical dilemma linked to end-of-life care for an older person? How would you manage this?
- End of life care can be challenging for everyone involved, including after the death of the older person, how do you effectively manage your own needs, those of the deceased family and friends and those of other staff or service users?

Local Considerations / Notes:

Your Notes & Clinical Quandaries – you may want to record some ideas of your own case-based discussion / clinical quandaries here for use in review meetings with assessee. Consider any useful case examples or clinical quandaries which result from your own self-assessment and reflections that you would be willing to use. Remember to anonymise anything recorded to protect confidentiality of both patients, service users, staff and organisations.

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