EnCOP

Enhanced Care for Older People

Assessment Toolkit

Name:
Job Role:
Place of work / Team:

Section One

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"It is important that it isn't assumed that anyone can work with older people, older people deserve to have people with the right skills working with them. Some of the knowledge and skills is the same as for working with other people but there are some specialist elements too"

Older people's feedback, (**BASW, 2018).**

Introduction & Background

Within the UK, the number of people aged 65 and over is increasing rapidly (ONS, 2018). Older people are recognised as having specific needs, especially those living with frailty, (BGS, 2015), who are less able to recover or adapt to minor events, such as acute illness, falls or changes in their environment. As such, they are far more likely to experience adverse outcomes that can impact on their health, independence, and wellbeing (Kahlon et al, 2015; Poulton et al, 2020). It is therefore important that we have a workforce that has the knowledge and skills to be able to deliver timely, responsive, evidence-based care, to support older people to live well, and to lead meaningful lives. With this in mind, the Enhanced Care for Older People (EnCOP) competency framework focuses on the skills and competency of the workforce. It has been developed to support the ambitions of Regional and National Strategy regarding Ageing Well, (The NHS Long Term Plan, NHSE, 2019; We are the NHS: People Plan, NHSE 2020), and promotes consistent, high quality care right across the system.

The EnCOP framework was co-produced utilising evidence, policy and guidance, and other relevant practice development documents, details of which can be found in the full Enhanced Care for Older People competency framework, (Thompson et al, 2017).

Aims of the EnCOP Framework

The goal of the EnCOP Framework is to support the delivery of high-quality care for older people, across all settings and organisations. It is ambitious in its approach and has the following aims:

- To ensure consistency of approach to care and support planning and delivery across the system
- To enable the whole workforce to work together to deliver timely, responsive, and evidence-based care regardless of care setting
- To recognise that working with older people is rewarding and attractive and requires specific knowledge and skills as in any other specialism.
- To develop a valued and competent workforce that can work anywhere in the care system.

To achieve these aims, this assessment toolkit has been developed in alignment with the original EnCOP framework and focuses on workforce competency.
For the purposes of the EnCOP toolkit, **competence** is defined as **the ability to apply knowledge and skills in an appropriate manner, underpinned by appropriate attitudes / values, to achieve an occupational function.**

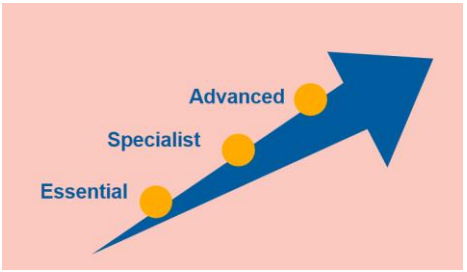
The EnCOP assessment toolkit is made up of 4 Key Areas of Practice (KAP):

Key Area of Practice A: Personhood, Relationship Centred Care & Ethical Practice
Key Area of Practice B: Workforce empowerment, leadership and improving care
Key Area of Practice C: Partnership Working: Collaborative Care & Communication
Key Area of Practice D: Supporting Older People with Ageing Well - Knowledge & Skills for Assessment and Care Delivery

These key areas of practice comprise 11 domains which describe competency across a number of measurable performance indicators. Competency is outlined within 2 core levels of practice: **Essential** and **Specialist**. In addition to these core levels of competence, there is an EnCOP **Advanced** level option, 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:

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

EnCOP competency levels are not job role specific, instead they are intended to be progressive and cumulative i.e., as levels advance, they integrate and expand upon competencies from the preceding level. **Advanced** level domains should only be adopted once the core **Essential** and **Specialist** levels of competence have been achieved. Individuals have the option to select one or more advanced domain depending on the focus(es) of their current practice.



Key Principles:

1) Everyone should aim to achieve all competencies within the 'essential' level.
2) Some individuals may have competencies from more than one level, relevant to their knowledge, skills and behaviours.
3) Through competency assessment and review, areas for development can be identified. On an individual basis, this knowledge can support personal development and career progression.
4) Advanced Level domains are optional extensions 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. These can only apply if Essential and Specialist EnCOP is achieved

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

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

This toolkit is designed to be a practical resource to support staff assessment, review and professional development against the defined competencies and comprises 4 sections.

Section 1 – Introduction and background to EnCOP, Glossary of terms and abbreviations, Essential & Specialist level domains
Section 2 – Optional EnCOP Advanced levels, Domains 1-3
Section 3 - Assessment toolkit templates & proforma's
Section 4 – Assessment Toolkit Glossary of Terms, References

Key Area of Practice: Personhood, Relationship Centred Care & Ethical Practice

Domain A. Values, Attitudes and Ethical Practice

Staff need to be aware of their own values and attitudes, but also acknowledge that older people and their families will have personal values and beliefs that influence their choices and decisions. Central to the delivery of safe, person-centred care, is a thorough understanding and application of the Mental Capacity Act, and Best Interest Decision Making with fundamental consideration of key ethical, legal, and safeguarding issues

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Recognises the importance of always demonstrating integrity, respect, warmth, empathy, patience, and compassion in all interactions			
	b. Knows the importance of getting to know the older person and is able to acknowledge, value and involve older people, families, and others in the care of the older person, wherever care is being delivered			
	c. Is able to ensure dignity and privacy is respected and preserved at all times, considering how someone might think or feel in the care environment			
	d. Is able to consider individualised spiritual, religious, and cultural needs during all interactions with older people, families, and others, referring on as required to make sure these needs are met			
	e. Demonstrates awareness of society's portrayal of old age, the potential impact of internal or external stigma of age on the older person and promotes equality			
	f. Demonstrates understanding of diversity within the older population, potentially marginalised or underserved communities, and promotes inclusivity			
	g. Demonstrates awareness of the types of abuse that are particularly linked to older people. Is aware of how and when to identify and report potential or actual sources of abuse or safeguarding issues			
	h. Demonstrates understanding of the relevant legislation, key principles and guidance for consent, deprivation of liberty safeguards, mental capacity assessment, and best interest decision making			
	i. Is able to assess capacity on an informal basis and apply best interest decisions to inform day-to-day care decisions. Knows how and when to refer on for further advice and/ or assessment			
	j. Is able to recognise ethical dilemma situations, for example, between older people, families, and others. Knows how and when to access further advice and / or assessment			
	k. Is able to recognise that caring for older people can be emotionally and physically demanding. Be aware of and demonstrate coping and resilience strategies and seek timely support as needed			

Specialist	a. Demonstrates self-awareness and acts as a positive role model to peers, always displaying behaviours that are open, honest and place the older person, their families at the centre of their care			
	b. Is able to support, guide and provide constructive feedback to staff on their values, attitudes and behaviours			
	c. Uses knowledge and leadership skills to develop and promote a culture that supports equality and diversity for all older people			
	d. Is able to act as an advocate for older people, families and others and is able to recognise and respond promptly and appropriately to situations where care or dignity may have been compromised			
	e. Knows how to apply legislation and support others in responding appropriately to safeguarding concerns to enable prevention, identification and reporting of potential and actual abuse and safeguarding situations			
	f. Know how to assess mental capacity in relation to complex or higher risk decisions and is able to use best interest decision making. Knows how and when to refer for independent advocacy in relation to this			
	g. Has knowledge of when and how to apply deprivation of liberty safeguards. Knows when and how to refer for further advice or assessment in relation to this			
	h. Is able to demonstrate knowledge and application of ethics, moral reasoning and complex decision making			
	i. Is able to recognise staff pressure and stress; use coping and resilience strategies to support self and colleagues practically and emotionally. Is able to signpost for additional advice and/or support			

Key Area of Practice: Workforce empowerment, leadership and improving care				
Domain B. Understanding and supporting evidence – based practice; leadership & improving care & support for older people All staff providing care and support to older people need to ensure that care delivered meets best practice standards. This means that staff must engage in lifelong learning to acquire, maintain, and continually develop evidence – based knowledge and skills to ensure delivery of quality care that matches the needs of the older population. This involves all staff recognising the need to use the principles of good leadership, organisation, and management of care provision, in order to facilitate safe, effective, and efficient practice that is relationship – centred and supports personhood. Within this, it is essential that staff are committed to continual service improvements for older people and their families and open to early adaption and adoption of change				
Level	**Performance Indicators (Knowledge, behaviours, skills)**	**Self - Assessment**	**Achieved Date/Sign**	**Evidence of achievement – see evidence key**
Essential	a. Is able to demonstrate awareness of relevant local policies and evidence-based guidelines in relation to older people's care			
	b. Understands and work towards the visions and values of their organisation in relation to supporting older people and their families. Is open to change and has the confidence to make suggestions for improving care			
	c. Demonstrates basic awareness of the underlying principles, similarities and differences between audit, research, and other quality improvement methods in order to judge the trustworthiness of information			
	d. Demonstrates understanding of the importance of and be willing to follow evidence-based practice guidelines to deliver care for older people			
	e. Demonstrates ability to prioritise workload using time and resources effectively to maintain high quality care for older people			
	f. Demonstrates the ability to reflect on their own skills, competence and learning and development needs. Is able to actively seek out and positively respond to any feedback to improve performance			
	g. Actively seeks out learning activities and keeps a record of learning and development opportunities relevant to the care of older people. Is able to report any pressures that inhibits learning and development			
	h. Is able to describe who to contact with any issues or questions about the effectiveness of services or an individual older persons' care and support provision			
	i. Recognises the importance of learning from incidents and complaints and how this can contribute to service developments which focus on safety and quality			
	j. Recognises the impact of financial constraints of service provision and its contribution to the delivery and sustainability of services for older people			

Specialist	a. Demonstrates broad knowledge of local, regional, and national drivers which influence strategy and service development in relation to the organisation and management of care for older people			
	b. Is able to critically review, utilise, disseminate, and promote evidence-based care practices for older people			
	c. Is able to articulate how local workforce strategies can impact how effective services are in ensuring that staffing resource is flexible to meet the needs of older people			
	d. Is able to act as a positive role model and encourage others to contribute to a culture of enquiry, change and improvement			
	e. Is able to support others to utilise reflection as a tool to assess own strengths and areas for development when caring for older people and proactively offers formal and informal feedback to others			
	f. Demonstrates leadership styles that promote integrated relationship-centred care delivery. Is able to address aspects of culture and practice which may be barriers to this at an individual and team level			
	g. Is able to evaluate the processes and outcomes of their work daily, to expand own professional knowledge and expertise and takes opportunity to compare and share with others to improve care and support			
	h. Is able to include, integrate, and value, the knowledge, skills, and experience of a range of staff, agencies, and organisations to inform workforce, care delivery, practice development and quality improvement			
	i. Is able to contribute to the analysis and learning from complaints, incidents, safeguarding concerns and other feedback to challenge inadequate practice and inform improvements in care or service delivery			
	j. Is able to apply experience and knowledge of teaching, coaching, appraisal, and/or the assessment of others to facilitate or contribute to the identification of workforce learning needs			
	k. Demonstrates the ability to facilitate and/or provide learning and development initiatives that are matched with the increasing needs of older people. Understands how to evaluate impact of these on practice			
	l. Is able to report any challenges and pressures that inhibit staff development in the care of older people and contributes to plans to redress barriers to learning and development			
	m. Is able to utilise approaches to service development, evaluation and/ or improvement, to inform changes in practice. Is able to consider and promote the involvement of older people, families, and others in relation to this			

Key Area of Practice: Partnership Working: Collaborative Care & Communication				
Domain C1. Partnership Working and communication with older people, families, and others Staff should work in partnership with older people, their families and others who are significant to them, to support and empower them to make positive choices about their health and well-being and support them to navigate the care system, thus promoting resilience and ageing well. Effective communication with older people, families and others is integral to the development of trusting therapeutic relationships and partnerships. Staff must use a range of communication methods to support safe, quality care decisions. that account for older peoples' preferences and choices				
Level	**Performance Indicators (Knowledge, behaviours, skills)**	**Self - Assessment**	**Achieved Date/Sign**	**Evidence of achievement – see evidence key**
Essential	a. Is able to recognise that older people, themselves are a central part of the care and support team and demonstrate the ability to build and maintain a positive working relationship with them			
	b. Is able to engage with and talk to all older people, regarding preferences, goals, and choices about their care wherever this is delivered			
	c. Demonstrates the ability to listen to families and others, respect them as partners in the care of older people, and value their input in communication and care processes			
	d. Is able to communicate clearly, sensitively, and effectively using a range of communication skills to develop therapeutic relationships with older people, families, and others enabling shared decision-making			
	e. Recognises the key role informal carers play in the care of older people. Values and utilises the expertise of family and carers to promote optimal communication, care, and support with the older person			
	f. Can recognise if older people, and family have additional communication needs, health conditions that affect communication, language, or cultural barriers. Is able to adapt styles and environment accordingly			
	g. Demonstrates awareness of tools, formats, and/or strategies, which can enhance communication for older people. Knows when and how to access further advice and / or assessment			
	h. Is able to recognise a carers psychological and practical needs and the particular difficulties older carers may encounter. Is aware of services that support the needs of families/carers and when and how to refer or signpost			
	i. Is aware of the diversity of attitudes to accepting services and demonstrates partnership working with older people, families, others, and colleagues to promote positive risk-taking and resilience			
	j. Knows how and when to advocate and support older people, families, and others to exercise their rights. Is able to offer and/or facilitate access to information concerning their rights			
	k. Demonstrates awareness of the principles and relevance of lasting power of attorney for older people, families, and others			

	l. Is able to describe how care is funded. Knows when and how to signpost older people, families, and others when they need financial support and advice			
	m. Understands why and how older people are at increased risk of harm during transfers of care. Knows how and when to support older people, families, and others during care transitions			
Specialist	a. Displays broad understanding of the whole journey of care for older people and support appropriate navigation for older people, families, and others, through effective care processes			
	b. Is able to use appropriate outcome measures jointly agreed with the older person, family, or others to determine success against identified goals			
	c. Is able to utilise a range of creative and effective communication methods when undertaking clinical assessments and decision making to ensure that the older person voice is heard and acted upon			
	d. Is able to support older people, families, and others to collaboratively engage in care decisions. Knows when and how to share information, care decisions, plans and discussions sensitively, effectively, and proportionately			
	e. Is able to understand the complexity and diversity of interpersonal and family relationships. Is aware of the potential impact of being a 'carer' and being 'cared for' and the changes that this dynamic may generate			
	f. Is able to apply advanced communication techniques to minimise miscommunication with older people and families, reduce repetitious communication and support the resolution of conflict			
	g. Demonstrate knowledge of lasting power of attorney. Knows when and how to consider and discuss with older people, their families, and others. Able to support and advise colleagues regarding advocacy			
	h. Is able to act as an advocate and provide relevant advice or signposting aimed at matching individual care needs, choices, and preferences with available care options			
	i. Can support others when there is a difference of opinion about care, ensuring views of older people, families and others are represented. Is able to involve relevant advocacy services as needed			
	j. Is able to actively assist and support older people, families, and others in financial matters relevant to their care			
	k. Is able to support the appropriate pathways for the funding of care provision for older people with relevant information exchange and act as an advocate in challenging funding outcome decisions			

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

Inter-professional and inter-organisational working and communication underpin integrated care. Staff need to develop, engage in, and sustain collaborative, co-operative working relationships across the care system

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Is able to describe where their role and organisation sits within the wider integrated care system			
	b. Demonstrates awareness of local services and care provision and how to signpost or refer to these			
	c. Demonstrates respectful and effective communication and collaboration with other people who they work with across the health and social care system			
	d. Demonstrates effective use of communication, record keeping tools and handover techniques to facilitate data sharing and information exchange			
	e. Demonstrates the ability to be proactive in obtaining required and relevant information			
	f. Listens actively, and responds confidently, respectfully and with clarity to requests for information and support from all colleagues involved in older people's care			
	g. Make sure relevant information regarding older people and their treatment and care decisions are shared accurately in a timely way to ensure common understanding			
	h. Knows when to work independently and when to collaborate with or refer on to others to support decision making and ensure safe practice			
	i. Is able to provide timely and appropriate feedback regarding issues within both their own team and wider cross organisational working that impact on experience of care for older people, their families, and others			
Specialist	a. Demonstrates broad knowledge and understanding of local health and social care system provision for older people, their families, and others			
	b. Is able to establish a professional cross- organisational network which supports older people, and their families. Knows how to develop, deliver and/or support appropriate and integrated referral pathways			
	c. Is able to apply this knowledge and local system intelligence to facilitate, contribute to and support effective cross organisational working			

	d. Demonstrates awareness of formal shared governance arrangements and demonstrates shared accountability with other professionals and organisations for care outcomes			
	e. Demonstrates and supports others in the effective use of communication, record keeping tools and handover techniques to optimise data sharing and information exchange			
	f. Is able to apply leadership skills that support team effectiveness, inter- professional collaborative practices and inter-organisational communication			
	g. Demonstrates leadership in encouraging and empowering others to express their ideas, opinions, and concerns to ensure decisions about complex care situations are comprehensively informed			
	h. Demonstrates confidence and effective leadership skills within local multi-disciplinary and/or inter-professional meetings or forums			
	i. Demonstrates persistence and resilience when faced with barriers to accessing care and /or support. Knows when and how to report any gaps, difficulties or challenges which older people, families and others experience			
	j. Is able to engage and co-ordinate a range of inter- professional teams and colleagues in shared decision-making ensuring the inclusion of older people and families			
	k. Demonstrates ability to reflect on individual and team performance to inform improvement – Is able to provide, interpret, evaluate, and act on feedback about the effectiveness of teams			

Key Area of Practice: Supporting Older People with Ageing Well - Knowledge & Skills for Assessment and Care Delivery				
Domain D1. Ageing Well – Understanding Frailty - Prevention, Identification and Recognition Staff need to have an awareness of the concept of frailty and be competent in preventing, recognising and responding to frailty through the use of appropriate interventions and strategies to assist older people to live well across the whole spectrum of frailty.				
Level	**Performance Indicators (Knowledge, behaviours, skills)**	**Self - Assessment**	**Achieved Date/Sign**	**Evidence of achievement – see evidence key**
Essential	a. Is able to articulate what frailty is and can describe the physical characteristics of frailty			
	b. Demonstrates awareness of how frailty impacts some older people			
	c. Demonstrates awareness of a range of factors across a person's life course that can influence their health and wellbeing as they become older and may increase their vulnerability to frailty			
	d. Knows that if recognised early, there are interventions that can prevent and/or slow the onset and progression of frailty, improve quality of life, and increase resilience			
	e. Be able to support and empower individuals to make positive choices about their health and lifestyle. Provide advice and signpost, as appropriate			
	f. Is aware of recognised assessment tools to identify the presence of frailty and classify the severity			
	g. Demonstrates awareness of how the levels of frailty can fluctuate and can describe common factors or situations which can influence this			
	h. Is able to recognise the five frailty syndromes, and their significance within older persons care			
	i. Demonstrates understanding that older people might not like to recognise themselves as living with frailty and may be unwilling to acknowledge or disclose problems			
	j. Is able to respond to and report changes and deterioration that may indicate the presence or worsening of frailty. Knows when and how to access local MDT advice or specialist services			
Specialist	a. Demonstrates a broad knowledge of frailty, frailty indicators and frailty progression including the concept of phenotype and cumulative deficit models			
	b. Is able to involve and engage older people, family, and others with sensitivity to introduce the concept of frailty, building positive relationships that promote shared decision making			
	c. Adopts strengths-based approaches to effectively promote healthy living and preventative strategies with older people, their families, and others. Knows when and how to provide or facilitate access to preventative services			

	d. Demonstrates the ability to assess for the presence of and grade the severity of frailty using evidence-based tools. Utilise both opportunistic and systematic methods of identification			
	e. Is able to identify and respond appropriately when older people present with frailty syndromes			
	f. Is able to support and facilitate positive behaviour change using evidence-based approaches which support healthy living and self-management			
	g. Demonstrates broad knowledge of local care pathways and evidence-based frailty care. Recognises indicators for care and support planning or Comprehensive Geriatric Assessment (CGA)			

Domain D2: Ageing Well – Assessing, Planning, Implementing and Evaluating Care & Support with Older People

Staff should recognise that care and support needs of an older person living with frailty may be complex. It involves the ongoing comprehensive assessment of individual needs, and subsequent planning, implementation and evaluation of care that addresses the multiple and changing dimensions of the older person's life, health and care requirements and accounts for their preferences and expectations. The older person, their families and significant others should be fully involved within this process

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Demonstrates awareness of Comprehensive Geriatric Assessment (CGA) and why it is important as an approach in older person's care			
	b. Is able to understand how individualised information regarding the older person, their family and others is crucial to ensure effective assessment and care and support planning			
	c. Is able to recognise the importance of individualised risk assessment for older people Demonstrates awareness of a selection of commonly used evidence-based tools which contribute to this			
	d. Understands that carers are entitled to an assessment of their own individualised needs and demonstrates awareness of local referral pathways to support this			
	e. Demonstrate understanding of the importance of providing all older people with the opportunity to discuss, explore and share their future care needs and wishes			
	f. Is able to contribute to the assessment process appropriately and follow individualised care and support plans for older people. Knows when and how to communicate effectively with the MDT in relation to progress			
Specialist	a. Demonstrates broad knowledge of a Comprehensive Geriatric Assessment (CGA) approach to care and can articulate it's key principles and components			
	b. Is able to initiate or undertake a multi-professional, multidimensional comprehensive geriatric assessment (CGA)			
	c. Is able to select, recommend and utilise valid and reliable screening, assessment, and risk assessment tools in conjunction with clinical judgement to assess individual needs			
	d. Is able to adopt a shared decision – making approach to fully involve the older person, their families, and others to identify a stratified problem list, meaningful goals and individualised care and support plan			
	e. Is able to use appropriate outcome measures jointly agreed with the older person, their families, and others to determine success against identified goals			

	f. Demonstrates broad knowledge of the needs of informal carers and is able to initiate or facilitate a formal assessment to address these			
	g. Demonstrates broad understanding of the principles of a proactive case management approach to the care of some older people. Knows when and how to provide or facilitate access to these services			
	h. Has a broad understanding of social prescribing and local arrangements for this. Knows when and how to refer or signpost to these to support effective care for older people and their families			
	i. Demonstrates broad understanding of proactive anticipatory care. Can utilise strategies and interventions aimed at reducing avoidable unplanned health or social care			
	j. Is able to recognise the requirement for, undertake, or facilitate access to timely NHS Continuing Healthcare Checklists			
	k. Is able to support and enable all older people to explore, articulate and / or document and share future care needs and wishes. Knows when and how to utilise local/ regional guidance and documentation			

Domain D3: Ageing Well - Promoting & Supporting Independence, Autonomy & Community Connectivity for Older People

To support independence and autonomy, staff should aim to provide an enriched environment which accommodates older people's choices, rights, needs and aspirations about their life, health, and activities. Staff should promote and facilitate optimal self-care, recovery ,rehabilitation and reablement opportunities

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Is able to describe the basic concepts of recovery, rehabilitation and reablement in relation to older persons care and demonstrates awareness of local pathways for this provision			
	b. Demonstrates the ability to support older people and their families to enable independence and empower self-care and self-management wherever care is being delivered			
	c. Is able to support the older person to express their feelings, fears, grief and expectations regarding life transitions and significant losses, which may impact their independence and autonomy			
	d. Demonstrates the ability to ask about mobility and functional ability in routine assessments. Knows when and how to access local MDT advice and/ or assessment			
	e. Demonstrates awareness of environmental impacts on function and well-being. Contribute to environments that promote independence, provide familiarity, and minimise risk			
	f. Is able to support older people to access social opportunities and engage with others in a way that is meaningful for them regardless of place of residence			
	g. Is able to support and enable older people to utilise aids, equipment, technology, exercises, and rehabilitation regimes to support, maintain and improve their abilities			
	h. Is able to describe the differences between telecare, telehealth, and telemedicine. Demonstrates awareness of how these can contribute to supporting older people's independence and autonomy			
	i. Is able to follow care and support plans to safely promote positive risk taking within any care environment			
	j. Knows when and how to communicate effectively with the MDT in relation to progress			
	a. Demonstrates broad understanding of recovery, rehabilitation and reablement in relation to older persons care and has a broad knowledge of local pathways for this provision			
	b. Has broad knowledge of local community provision that can support older people's independence and autonomy, regardless of residence. Knows how and when to access resources or services			

Specialist	c. Demonstrates the ability to assess for, implement and evaluate strategies that promote recovery, rehabilitation and reablement. Is able to actively promote a 'Home First' approach			
	d. Is able to negotiate with older people and their families to explore risk, benefit, consequences, and appropriate goals. Facilitate and support others to value positive risk taking, where appropriate			
	e. Is able to optimise independence and self-care for older people, their families, and others. Is able to utilise teaching strategies with older people, their families, and others to promote and/or facilitate independence			
	f. Demonstrate knowledge of how to adapt the care environment to promote independence and safety. Knows how and when to access further MDT and / or specialist assessment as required			
	g. Is able to facilitate the provision of a socially stimulating environment that reflects the interests and abilities of older people, considering changing needs in progressive frailty			
	h. Demonstrates broad knowledge of local housing options. Knows when and how to access specialist advice that may suit an individual's care needs, quality of life and independence			
	i. Is able to promote independence and autonomy by recognising when older people might benefit from telecare, telehealth and / or telemedicine. Knows how and when to refer for this provision			

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

Staff need to be able to recognise and respond appropriately to common physical health changes that older people may experience.
This means that staff should be able to support and enable older people with a range of physical health conditions to access appropriate assessment, timely interventions and therapies that assist older people living across the spectrum of frailty, to optimise physical health and live well

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Is able to demonstrate awareness of the physical changes that are usually associated with normal ageing. Demonstrates awareness of the potential impact of these ageing changes for all older people			
	b. Demonstrates awareness of a range of preventative services relevant to older people. Is able to advise and/ or support older people to access these and to seek early advice for new physical health problems			
	c. Demonstrates awareness of a range of physical health issues that older people commonly experience. Understands these are not inevitable consequences of ageing and may be both preventable and treatable			
	d. Demonstrates awareness of the impact that physical health changes can have on wider health and wellbeing of older people			
	e. Is able to follow a care and support plan related to physical health needs of the older person. Knows when and how to access further planned local MDT advice or specialist services			
	f. Is able to describe signs, symptoms, or changes in physical, functional or cognitive health that may indicate physical health deterioration in older people. Knows how and when to access local unplanned MDT advice			
Specialist	a. Demonstrates broad knowledge of preventative care and demonstrates the ability to provide or facilitate access to preventative services wherever care is being delivered			
	b. Demonstrates a broad knowledge of a range of physical health conditions, signs, and symptoms which older people commonly experience			
	c. Demonstrates broad knowledge of the complex interplay between normal ageing changes, frailty, and acute or chronic physical health problems			
	d. Can apply this all of this knowledge when undertaking or facilitating access to the planned or unplanned assessment of physical health needs of older people			
	e. Demonstrates the ability to formulate or facilitate access to an evidence-based management plan related to the physical health needs of older people. Knows when and how to make referrals and/ or initiate escalation plans			
	f. Demonstrates understanding of the importance of weighing the benefits and burdens of physical health interventions, especially where non-concordance is an issue or mental capacity is compromised			

Sub-Domain D4.1: Assessment & management of pain				
Essential	a. Can describe the differences between acute and chronic pain. Recognises that acute and chronic pain may coexist, and it can be difficult to differentiate between these			
	b. Demonstrates the ability to be able to use effective communication skills to ask about pain in routine assessments and offer basic management advice			
	c. Is able to recognise and respond to any verbal or non-verbal signs of pain from the older person			
	d. Demonstrates understanding that self-reporting is the most valid and reliable indicator of pain and is aware that there are a range of evidence-based assessment tools. Is able to utilise simple pain assessment tools in practice			
	e. Is able to support older people and their families to optimise simple strategies to prevent, alleviate or manage pain			
	f. Is able to follow an older person's care and support plan related to the management of pain. Knows when and how to access local MDT advice or specialist services			
Specialist	a. Demonstrates broad knowledge of how pain can present in older people. Demonstrates a broad understanding of contributing factors which can lead to pain			
	b. Is able to undertake a multifactorial assessment of pain in partnership with the older person, their family, and others. Knows when and how to refer on for specialist assessment			
	c. Is able to develop an evidence-based care and support plan to identify, facilitate or implement pain management strategies including a range of pharmacological and non-pharmacological interventions			
	d. Demonstrates broad understanding of the complexity of managing expectations and potential distress for older people, their family, and others with regards to complex pain management			
Sub-Domain D4.2: Falls prevention, risk assessment and management				
Essential	a. Demonstrates awareness of a range of risk factors, symptoms and underlying causes which contribute to falls in older people			
	b. Demonstrates the ability to ask about falls in routine assessments. Know when and how to access local MDT for advice and/ or assessment			
	c. Demonstrates an understanding of the potential psychological impact of falls and how 'fear of falling' can impact on everyday function and increase the risk of falling			
	d. Demonstrates the ability to offer basic risk management advice regarding falls. Is able to support older people, their families, and others to optimise mobility and physical activity			

Specialist	a. Demonstrates broad knowledge of potential risk factors, possible underlying causes, and evidence-based management of falls			
	b. Is able to initiate or facilitate access to multifactorial risk assessment in partnership with the older person, their family, and others			
	c. Is able initiate or facilitate access to evidence-based care planning for falls management. Knows when and how to access MDT advice or assessment or specialist services			
	d. Is able to work collaboratively with the older person, their family, and others to identify appropriate preventative interventions to minimise the risk of falls. Knows when and how to facilitate access to interventions			
	e. Demonstrates broad understanding of the complexity of managing expectations and potential distress for older people, families, and others when recurrent falls persist, despite appropriate assessment /care planning			
Sub-Domain D4.3: Risk assessment, prevention and management of malnutrition and dehydration				
Essential	a. Is able to describe the range of common factors associated with reduced oral intake in older people			
	b. Demonstrates the ability to ask about oral health, swallowing , nutrition, and hydration in routine assessments			
	c. Demonstrates awareness that oral health has a significant impact on health and wellbeing. Can promote and/ or support good oral health with older people. Knows when and how to access MDT advice and/ or assessment			
	d. Is able to recognise signs of malnutrition, and understands the importance of using appropriate validated screening tools			
	e. Is able to recognise signs of sub-optimal hydration and dehydration			
	f. Recognises the benefits of evidence- based interventions to improve nutrition and hydration and can use a range of strategies to optimise oral intake. Knows when and how to access local MDT advice or specialist services			
	g. Is able to offer basic advice to older people, their family, and others regarding oral health, suitable diet and recommended daily fluid intake			
	h. Can recognise common risk factors, signs and symptoms that may indicate an older person is experiencing swallowing difficulties. Knows when and how to refer to local MDT for advice or assessment or specialist services			
Specialist	a. Demonstrates broad knowledge of risk factors, symptoms, and underlying causes of a range of nutritional difficulties which older people may experience			
	b. Demonstrates broad knowledge of risk factors, symptoms, and underlying causes of a range of hydration difficulties which older people may experience			
	c. Is able to initiate or facilitate access to a multifactorial assessment(s) related to oral health, swallowing, nutrition, and/ or hydration			

	d. Demonstrates broad understanding of the complexity of managing expectations and potential distress for older people, their families, and others with regards to oral intake, swallowing and weight loss			
	e. Is able to initiate or facilitate access to evidence-based care and support planning for older people regarding oral health, swallowing, nutrition and/or hydration. Knows when and how to refer to local MDT or specialist services			
Sub-Domain D4.4: Assessment & management of bowel & bladder health				
Essential	a. Is able to describe the range of common risk factors, symptoms, and underlying causes, related to altered bowel habits, associated with older people			
	b. Is able to describe the range of common risk factors, symptoms, and underlying causes, related to altered bladder function, associated with older people			
	c. Demonstrates awareness of the different types and causes of urinary & faecal incontinence. Understands the impact that loss of bowel and/ or bladder control can have on an older person			
	d. Demonstrates the ability to ask about bowel and bladder function, in routine assessments. Knows when and how to access MDT advice and/ or support			
	e. Demonstrates awareness of evidence-based guidelines related to urinary catheters and is able to advise and/ or support older people. Knows when and how to access local MDT advice or specialist services			
	f. Demonstrate awareness of evidence- based guidelines related to ostomy care and is able to advise and/ or support older people. Knows when and how to access local MDT advice or specialist services			
	g. Demonstrates the ability to offer basic advice and /or support older people and families to optimise bowel and bladder health			
Specialist	a. Demonstrates broad knowledge of risk factors, underlying causes and evidence-based management of conditions related to bowel health and/ or dysfunction			
	b. Demonstrates broad knowledge of risk factors, underlying causes and evidence-based management of conditions related to bladder health and/ or dysfunction			
	c. Is able to initiate or facilitate access to multifactorial assessment of bowel and bladder health. Knows when and how to refer on for further MDT advice or assessment or specialist services			
	d. Is able to initiate or facilitate access to evidence-based care and support planning, to optimise bowel and bladder health			
	e. Demonstrates knowledge of common aids and products which can optimise bowel and bladder management. Is able to advise and support older people. Knows when and how to signpost for further advice or support			

Sub-Domain D4.5: Assessment & management of skin health				
Essential	a. Demonstrates awareness of a range of common risk factors, symptoms, and underlying causes that relate to skin conditions that may affect older people			
	b. Demonstrates the ability to ask about skin conditions and skin health in routine assessments. Knows when and how to access further MDT advice or assessment			
	c. Is able to identify body areas where pressure damage is more likely to occur. Is aware of local evidence-based guidelines for the prevention and management of pressure damage			
	d. Demonstrates the ability to offer basic management advice with older people and their families to maintain healthy skin, prevent skin damage and seek early advice regarding skin changes			
Specialist	a. Demonstrates broad knowledge of risk factors , symptoms and presentations of a range of skin conditions which commonly affect older people			
	b. Demonstrates broad knowledge of the need for evidence-based MDT approaches regarding the maintenance of good skin integrity and the prevention and management of pressure damage and wounds			
	c. Demonstrates ability to initiate or facilitate access to multifactorial assessment of skin health. Knows when and how to access MDT advice or assessment or specialist services			
	d. Is able to initiate or facilitate access to evidence-based care and support planning, to optimise skin health			

Domain D5: Ageing Well – Promoting & Supporting Holistic Psychological Health & Wellbeing with Older People

Staff must be skilled in supporting all older people across the frailty spectrum, to communicate and express their needs, preferences, feelings, and fears to optimise psychological health and well-being. Staff need to be able to enable and support older people with a range of mental health conditions to access person-centered assessment, and timely evidence-based interventions that assist them to live we

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Is able to demonstrate awareness of the psychological and social changes that are usually associated with normal ageing. Demonstrates awareness of the potential impact of these changes for older people			
	b. Is able to describe common risk factors which can impact mental health and wellbeing of older people			
	c. Can support older people to access preventative services and seek early advice for new mental health problems			
	d. Demonstrates awareness of a range of mental health issues that older people commonly experience. Is aware that mental health conditions may present differently in older people			
	e. Understands that an older person with mental health needs may experience stigma and prejudice. Is able to challenge discrimination and promote equity of access wherever care may be delivered			
	f. Demonstrates understanding that the demands of being cared for or caring for others as an older person can exacerbate or trigger mental health needs. Is able to signpost towards relevant supportive services			
	g. Is able to follow a care and support plan related to mental health needs of the older person. Knows when and how to access planned local MDT advice or assessment or specialist mental health services			
	h. Is able to describe signs, symptoms, or changes in physical, functional or cognitive health that may indicate health deterioration in older people. Knows how and when to access local unplanned MDT advice			
Specialist	a. Demonstrates broad knowledge of factors that support older people with mental health conditions to recover, live well, prevent relapse, and the ability to provide or facilitate access to preventative services			
	b. Demonstrates broad knowledge of a range of common mental health conditions, signs and presentations affecting older people			
	c. Demonstrates awareness that older people with serious mental illness are at higher risk of physical health problems. Knows that treatments for mental health conditions can lead to physical health changes			
	d. Demonstrates broad knowledge of local mental health services and the indications for crisis assessment. Supports equal access to mental health assessment and support for all older people.			

	e. Demonstrates broad knowledge of the complex interplay between frailty, multi-morbidity and acute / chronic mental health problems			
	f. Can apply this all of this knowledge when undertaking or facilitating access to the planned or unplanned assessment of mental health needs of older people			
	g. Demonstrates ability to formulate or facilitate access to an evidence-based management plan based on the mental health needs of older people. Knows when and how to make referrals, and/or initiate escalation plans			
Sub-Domain D5.1: Cognitive Impairment: Recognition and Assessment				
Essential	a. Demonstrates understanding of what is meant by cognitive impairment. Is able to describe the difference between mild cognitive impairment (also known as neurocognitive impairment) and dementia			
	b. Is aware of early signs and symptoms which may indicate cognitive impairment. Knows these can indicate dementia but equally may be due to other mental or physical health conditions or circumstances			
	c. Demonstrates understanding of the importance of early and accurate diagnosis when cognitive impairment is suspected. Knows when and how to signpost or access local MDT for advice or assessment			
	d. Is able to sensitively ask about cognition during routine assessments			
Specialist	a. Demonstrates a broad knowledge of cognitive impairment in older people, including relevant diagnostic processes and criteria. Is able to support equal access to assessment and diagnosis for all older people			
	b. Demonstrates the ability to initiate or facilitate access to the multifactorial assessment of new or worsened cognitive impairment. Knows when and how to refer on for MDT advice or assessment or specialist services			
	c. Recognises the importance of a collateral history to aid accurate assessment, diagnosis and care and support planning with older people experiencing cognitive changes			
	d. Is able to initiate or facilitate access to evidence-based care and support planning, in response to cognitive assessment findings. Knows when and how to refer on for further MDT or specialist mental health assessment			
Sub-Domain D5.2: Dementia Care: Assessment and Person-Centred Management				
Essential	a. Can identify the most common types of dementia in the UK. Demonstrates awareness of the umbrella term 'Dementia' and the importance of understanding the type of dementia the older person is living with			
	b. Is able to discuss stigma, myths and stereotypes associated with dementia. Is able to describe how they might challenge these negative views and misconceptions			
	c. Demonstrates understanding of the progressive nature of dementia and some of the major impairments and difficulties older people, their family, and others may face as dementia progresses			
	d. Demonstrates awareness of principles of person-centred dementia care and actions and factors which support older people with dementia to live well. Is able to use this knowledge in their approach to care			
	e. Demonstrates awareness of the central role that home, housing and immediate community play in enabling an older person to live well with dementia. Is able to promote a positive enabling environment			

	f. Demonstrates understanding of how the attitudes and behaviours of others can impact on older people living with dementia. Can describe how they consider an older persons feelings and perceptions in all interactions			
	g. Demonstrates understanding that an older person's behaviour or changes in behaviour may indicate distress or an unmet need. Can describe a range of common underlying reasons for these behaviours			
	h. Is able to demonstrate effective, proactive and positive responses in their approach to care delivery for older people who are experiencing distressed behaviours			
Specialist	a. Demonstrates broad understanding of the main types of dementia, their underlying causes, primary symptoms, disease progression and variants			
	b. Demonstrates the ability to promote and support equal access to dementia assessment, diagnosis, and evidence-based care for all older people wherever care may be delivered			
	c. Demonstrates broad understanding of the significance and complexity of delirium and depression in dementia care			
	d. Demonstrates awareness of a range of evidence-based psycho- social approaches used to enhance well-being for people with dementia. Knows when or how to initiate or facilitate access to these			
	e. Demonstrates broad knowledge of the benefits, criteria, implications, and limitations of pharmacological interventions that may enhance memory or support symptom management			
	f. Is able to initiate or facilitate access to evidence-based assessment and care and support planning for older people living with dementia. Knows when and how to access MDT advice/ assessment or specialist services			
	g. Demonstrates a relationship- centred approach to dementia care, communicating with older people and families with sensitivity to facilitate interventions and relevant support services			
	h. Demonstrates awareness of the importance of post diagnosis support for older people with dementia. Knows when and how initiate or to facilitate access for older people and their families in post- diagnostic services			
	i. Demonstrates broad knowledge and understanding of a wide range of distressed behaviour presentations and a range of underlying causes			
	j. Demonstrates self-awareness, acting as a positive role model, always displaying effective , proactive and positive responses in their approach with older people who are experiencing distressed behaviours			
	k. Demonstrates ability to initiate or facilitate access to assessment and evidence-based care and support planning for distressed behaviours. Knows when and how to access MDT support or specialist services			

Sub-Domain 5.3: Mood disorders in later life: Recognition, assessment, and management				
Essential	a. Is able to describe both anxiety and depression and demonstrates awareness of the common factors which may increase the risk of these for older people			
	b. Is aware that early identification is important and that there are evidence-based guidance and risk assessment tools for anxiety and depression specific to older people. Knows how to access MDT for advice or assessment			
	c. Is able to sensitively ask about mood during routine assessments			
	d. Demonstrates awareness of the impact of mood disorders on physical and mental health and wellbeing, functional ability and self-care, social engagement, and wider outcomes for older people and their families			
	e. Recognises the potential impact of home circumstances or care setting on an older persons' mood. Is able to promote a positive enabling environment which optimises mood for older people			
	f. Demonstrates awareness of risk factors for suicide and self-harm within the older population			
	g. Can offer basic management advice and support to older people experiencing mood disorders and their families. Knows when and how to signpost to supportive services			
Specialist	a. Demonstrates broad knowledge of signs, symptoms and behaviours that may indicate mood disorder in older people, and understands the relationships and differences between anxiety and depression			
	b. Demonstrates broad knowledge of evidence-based screening tools for older people. Is able to select and apply these appropriately with the older person when anxiety or depression is suspected			
	c. Is able to initiate or facilitate a multifactorial assessment of mood with older people. Knows when and how to refer on for MDT advice or assessment or specialist services			
	d. Is able to initiate or facilitate access to evidence-based care and support planning, to optimise management, self-care and recovery for older people experiencing mood disorders			
	e. Demonstrates broad knowledge of the criteria, benefits, and limitations of a range of evidence- based interventions. Knows when and how to access MDT advice or assessment and specialist services			
	f. Demonstrates knowledge of signs of self-neglect, self-harm, and suicidal ideation. Knows when and how to access appropriate urgent MDT and/ or specialist mental health advice and/ or assessment			
Sub-Domain D5.4: Delirium: Recognition, assessment, and management				
Essential	a. Is able to describe what delirium is and the common symptoms of hypoactive delirium, hyperactive delirium, and mixed delirium			
	b. Demonstrates awareness that delirium is preventable, treatable and can worsen outcomes for older people. Demonstrates understanding of factors which may increase the risk of delirium and of how to minimise risk			
	c. Demonstrates awareness of the recovery pathway in delirium and the short and / or long- term impact that delirium can have on older people and their family			

	d. Is able to ask about symptoms when delirium is suspected. Knows when and how to refer on for further advice, assessment, and/ or management			
	e. Is able to demonstrate sensitivity and can offer basic management advice and support to older people experiencing delirium, their families, and others			
Specialist	a. Demonstrates a broad knowledge of a range of risk factors for delirium, differing delirium presentations and interventions aimed at prevention and / or management			
	b. Demonstrates broad knowledge of evidence-based screening tools and assessment aids. Knows when and how to apply these in practice with the older person when delirium is suspected			
	c. Is able to initiate or facilitate access to multifactorial assessment when delirium is suspected. Knows when and how to access MDT advice or assessment or specialist services			
	d. Demonstrates knowledge of evidence-based practice guidelines when there is difficulty in diagnosing delirium or delirium is unresolved. Is able to demonstrate application of these in practice			
	e. Is able to initiate or facilitate access to evidence-based care and support planning to treat the underlying cause(s) of delirium and manage associated symptoms, behaviours, and emotions			
	f. Demonstrates the ability to effectively communicate a delirium diagnosis to the older person and family and provide access to support, information, and education to minimise short- and long-term impacts			

Domain D6. Ageing Well – Promoting & Supporting Older People with Medicines Optimisation

An important aspect of the care process is the management of medicines. Staff must have knowledge of medications relating to older people, ensure medicines are managed safely and effectively, and involve the individual in decisions regarding the use of interventions, related to medication, in their care

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Recognises the importance of the older person being able to understand their medicines and access and take medication correctly .Knows when and how to access relevant advice, information and guidance about medication and older people			
	b. Demonstrates awareness of the importance of regular medication review. Knows when and how to support an older person to access a planned or unplanned medication review			
	c. Demonstrates awareness of groups of medications that are time critical and should never be omitted without first seeking clinical advice			
	d. Demonstrates awareness that over the counter , alternative medicines, illicit drugs and alcohol can have important and potentially harmful interactions each other and with prescribed medication			
	e. Is able to recognise the risks associated with the ordering, prescribing, dispensing, administration and storage of medicines for older people. Knows when and how to refer on for additional MDT advice and / or assessment			
	f. Demonstrates awareness that medication management may require MDT decision-making in accordance with the Mental Capacity Act. Knows when and how to access specialist support			
	g. Is aware of a range of common side effects of medications which can affect older people. Knows how to recognise, respond and report suspected Adverse Drug Event's (ADE's) appropriately			
Specialist	a. Demonstrates broad knowledge of relevant issues which are relevant to medicines optimisation for older people, in particular: - • Effects of ageing, multi-morbidity and frailty on medication absorption, distribution, metabolism, and elimination • Common medicines which present a 'Higher Risk' in older age • Articulating polypharmacy and its associated risks • Increased risk of Adverse Drug Events (ADE's) especially during care transitions			

	b. Demonstrates knowledge and application of the ethical and legal requirements which ensure safe and effective practice, in particular: - • Supporting older peoples' choice and preference even when mental capacity may be compromised. • Initiate or facilitate access to prescribing and de-prescribing using recognised guidance/ decision-support tools • Appropriateness, legality, safe initiation, and monitoring of covert medication regimens • Recognising opportunities for safe and effective use of anticipatory prescribing			
	c. Demonstrates broad knowledge, of a range of medication (including associated side effects and drug interactions) to address common physical and mental health problems within older person's care			
	d. Is able to promote involvement of the older person, their family, and others in shared decision-making regarding medication. Utilises a range of strategies to support self-medication and concordance			
	e. Is able to utilise knowledge and skills to support risk assessment and advocates for older people in all aspects of medication management. Knows when and how to undertake or facilitate access to planned or unplanned medication review			
	f. Demonstrates broad and accurate recording of all aspects of medicines management. Is able to ensure system wide recording of any allergies or adverse drug events (ADE's)			

Domain D7. End of life care: older people and frailty – Recognition, assessment & care planning

Staff must be able to consider the needs of and provide high quality care for older people living with frailty who are approaching the end of their lives. Central to the provision of this is the need to support access to a range of life care and support interventions and therapies for symptom management. Staff need to be skilled in supporting the older person, family and others with choices about end-of-life care. Staff also need to recognise and respond to the needs of families and others to ensure access and signposting to support during the stages of end of life and following the death of the older person

Level	Performance Indicators (Knowledge, behaviours, skills)	Self - Assessment	Achieved Date/Sign	Evidence of achievement – see evidence key
Essential	a. Demonstrates understanding that , for older people, disease pathways can be complex, and patterns of decline (or trajectories) may be different			
	b. Is able to recognise the importance of end-of-life care being accessible and equitable for all older people regardless of diagnosis or where care is being delivered			
	c. Demonstrates awareness of and considers the use of specialist advice, support, and therapeutic interventions available locally. Knows when and how to access these for older people and their families			
	d. Demonstrates awareness of the principles, legal and ethical aspects of advance care planning and is aware of all related local or regional documentation			
	e. Is able to follow an older person's care and support plan related to end of life care. Knows when and how to access local MDT advice or specialist services			
	f. Understand the impact of bereavement on family and friends and is aware of local services to enable advice and signposting			
Specialist	a. Demonstrates broad understanding of end-of-life care in relation to older people. Demonstrates use of evidence-based tools to enable the identification of older people who may be in the last 12 months of life			
	b. Demonstrates broad understanding of the principles, legal and ethical aspects of advance care planning and is aware of all related local legislation, guidance & documentation			
	c. Facilitates caring conversations with older people, their families, and others about wishes, preferences and concerns about end of life. Knows how and when to provide information, support, or further assessment			
	d. Assess and respond to individualised spiritual, religious, and cultural end of life needs. Know when and how to refer on as required to ensure these needs are met			
	e. Demonstrates broad knowledge of ethical frameworks and the principles of realistic medicine to inform decisions about preferred place of care, ceilings of care and de-escalation of treatment			

	f. Is able to undertake or facilitate a holistic assessment of end-of-life care needs in partnership with the older person, their family, and others			
	g. Is able to initiate or facilitate the development of an evidence-based end of life care & support plan. Knows when and how to refer on for local MDT or specialist management			
	h. Can provide frailty or dementia specific advice or guidance on end-of-life care. Is able to provide or facilitate access to a range of therapeutic interventions to manage symptoms at the end of life			
	i. Knows when and how to ensure that all end-of-life care planning is effectively shared and coordinated across all the local interfaces of care			
	j. Knows when and how to provide or facilitate holistic bereavement support for family, friends, staff, or other service users			

EnCOP

Enhanced Care for Older People

Assessment Toolkit

Section Two

- EnCOP Advanced Domains 1-3

EnCOP Optional Advanced Domains

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

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

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

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

Healthcare professionals in advanced clinical roles require specific expertise regarding older people, and in particular those living with frailty. These clinicians are able to play a significant role in the management of the older person through critical application of comprehensive knowledge which demonstrates fundamental differences between normal ageing and older people living across the frailty trajectory. Advanced clinicians demonstrate enhanced clinical leadership skills supporting the comprehensive geriatric assessment process, complimenting, and enhancing the effectiveness of multidisciplinary teams. This incorporates the delivery of advanced clinical assessment and care with a high level of autonomy, competence in complex decision making and the application of highly advanced communication skills. Advanced clinicians demonstrate the ability to navigate complex legal and ethical issues and support effective advanced and anticipatory care planning and safe care transitions. Shared decision-making with older people and their families is paramount as well as displaying highly effective interagency collaborative practices and innovative problem- solving to enhance experience and improve outcomes for older people and their families.

	Self-Assessment	**Achieved? Date/Sign**	**Please document how the competence was determined (see evidence key)**
a. Demonstrates expert knowledge of biological, psychological , spiritual and social theories of ageing and dying			
b. Is able to apply expert knowledge of the complex interplay between the wider determinants of health and other factors which may affect older people's health and well- being			
c. Demonstrates expert knowledge of the wider care system. Is able to confidently and respectfully challenge practice, systems and policies			
d. Is able to apply advanced understanding of assessment, investigation, legislation and professional guidance in recognising and managing adult safeguarding concerns.			
e. Is able to utilise this expert knowledge and engage with research and evidence to lead or participate in the development, implementation, evaluation and monitoring of flexible clinical care models supporting the management of health and well-being with older people across the frailty continuum.			
f. Is able to lead comprehensive person-centred assessment and intervention (CGA), working clinically and offer expert clinical advice in complex interventions. Is able to provide innovative solutions where frailty is associated with complex comorbidities, diagnostic uncertainty, or problematic symptom control			

g. Can articulate and apply a critical understanding of the principles of risk assessment and management. Is able to use advanced assessment, diagnostic reasoning skills and support tools, and a range of potential intervention options in order to manage complexity and uncertainty in presentations in older people			
h. Is able to apply expertise in working with older people, families, and others to explain interventions aimed at addressing modifiable and reversible presentations.			
i. Is able to provide expert advice on informed consent, capacity, and best interests; support staff when there are competing views. Is able to carry out formal capacity assessments where risks might be high			
j. able to initiate or facilitate relationship centred collaboration and discussion to inform best interest decision making where outcomes are likely to have a lasting impact			
k. Is able to apply knowledge of evidence regarding choice and concordance to balance the benefits and burdens of disease-specific treatment with personalised care, specific support needs and the wishes of the older person and their family.			
l. Acts as a positive role model with advanced communication skills including active listening , negotiaion, communicating sensitive information and defending own viewpoint. Acts as an expert in complex decisions relating to the planning of care for individuals including conflict resolution where there may be competing needs and priorities.			
m. Demonstrates advanced communication skills to work with older people, families and others to discuss and develop management skills for both anticipated and unforseen points of crisis, exploring the potential risks and benefits .			
n. Is able to adapt to the needs and informed choices of older people in response to acute deterioration, across multiple settings. Can facilitate inter-professional and inter-organisational working which supports older peolple to remain in their preferred place of care			
o. Is able to coordinate and lead complex interprofessional, multi-agency meetings where needs and risks may be high. Demonstrates leadership in encouraging and empowering others to express their ideas, opinions and concerns to ensure decisions about complex care situations are comprehensively informed			
p. Is able to co-ordinate and contribute to NHS continuing healthcare assessment to inform or challenge Clinical Commissioning Group funding decisions			
q. Demonstrates advanced leadership in promoting and supporting asset-based , rehabilitative approaches. Is able to promote self determination, patient activation and postive risk taking.			
r. Displays critical awareness of new and emerging pharmacological evidence that can be utilised to enhance the health and wellbeing of older people in relation to medicines management and utilises and supports its application to practice			

s. Demonstrates autonomy in undertaking medication reviews, ensuring that older people across the care pathway have access to regular reviews of prescribed medication utilising a person-centred approach and taking opportunities to de-prescribe where appropriate			
t. Demonstrates expert understanding of the ethical issues regarding choice of drug treatments in the care of older people. Is able to assess the risk and benefit of medications for primary and secondary prevention and undertakes medication review and rationalisation within scope of practice			
u. Demonstrates the provision or facilitation of expert advice and support towards MDT decision-making regarding complex pharmacological issues for the individual			
v. Is able to use expertise to identify older people who may have limited reversibility of their condition and determine the need for palliative and end of life care Uses the evidence base to work with older people, their families and others, to discuss prognosis and develop person-centred advance care plans			
w. Is able to act as a clinical expert regarding complex end of life care issues for older people living with frailty and / or dementia, including complex ethical considerations, advance care planning and symptom management			

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

In everyone's life, every single day counts no matter what their age. With an ageing population where people are living longer but not always ageing well, it is important that older people continue to be valued for the contribution they make to society, recognising that older people wish to maintain their autonomy and be responsible for their own life situation for as long as possible. Advanced leaders are integral to this, embodying positive leadership behaviours, utilising advanced knowledge and skills which support the delivery of connected communities, upholding the rights and safeguarding of older persons' individuality ins. Advanced leaders need to function at a highly developed level within organisations and care systems in line with their scope of practice and sphere of influence; demonstrating expert ability to work across boundaries, use networks and optimise resources creatively so that that all older people can be provided with appropriate, equitable, and individually tailored care. This involves driving whole system change through transformational leadership and processes. Demonstrating innovation, the advanced leader is able to implement and evaluate service redesign with emphasis on consistent delivery and continuous improvement of high- quality, safe, efficient, and timely care and support that is co-ordinated around people's, choices, goals, and preferences

	Self-Assessment	**Achieved? Date/Sign**	**Please document how the competence was determined (see evidence key)**
Leadership and Transformation			
a. Is able to recognise the profile and trends of older people locally, regionally, and nationally and be able to lead on and develop systems and inform policy development			
b. Is able to demonstrate expert knowledge and understanding regarding the whole of the older population and is able to develop systems and practices that integrate opportunities and advocacy for older people to exercise their rights and choices			
c. Recognises the diversity and existing health inequalities within the older population. Is able to work across agencies including carer groups and VCSE to develop, manage and review health programmes for population health and wellbeing, health needs, and redressing inequitable service usage			
d. Is able to collaborate with and advocate on behalf of older people, families and others ensuring their views are represented at local, regional, and national level.			
e. Is able to demonstrate expert knowledge of leadership and change management theory and is able to apply this in practice to enhance evidence-based care and support planning for older people			

f. Demonstrates expert leadership by seeking and acting on opportunities to influence the commissioning and development of care systems for older people that are effective, efficient, and sustainable. Analyse and synthesise appropriate outcome measures to inform service provision			
g. Is able to develop teams from a range of professions, agencies, and organisations, including older people, families and friends. Motivate, co-ordinate and empower teams in collaborative decision-making and problem-solving that address service delivery challenges			
h. Is able to demonstrate expert application of leadership approaches which support the effective management, utilisation and analysis of staff and non-staff resources to influence how care is delivered to older people across the care system			
i. Demonstrates effective high-level negotiation skills and conflict resolution strategies to enable and create a culture of openness to change and improvement. Disseminate information about service improvements for older people, in a meaningful way			
j. Is able to include, integrate and value the knowledge, skills, and experience of a range of staff, agencies and organisations to inform workforce skill mix, practice development and quality improvement			
k. Demonstrates ability to seek and act on opportunities to represent the inter-professional and inter-organisational team at local, regional, and national platforms			
l. Is able to provide opportunities for colleagues to network and develop cross agency/organisational relationships to enhance effective care pathways for older people			
m. Is able to demonstrate knowledge of market forces and is able to scope and identify opportunities for new business to improve care for older people			
n. Is able to apply and monitor governance systems aimed at the prevention, identification, and reporting of safeguarding concerns. Ensures effective implementation of support systems for older people, families and staff involved in safeguarding processes			
o. Is able to contribute to the development, implementation and evaluation of guidelines and information governance policies which support effective information exchange across the care system. Considers innovative use of digital technologies			
p. Is able to inform or contribute to policy and designs of care environments and technology to promote independence of older people			
q. Is able to influence providers to enable all older people to be able to access appropriate rehabilitation services and reach their potential			

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

Creating, critically interpreting, and applying evidence-based practice is fundamental for continual assurance of quality, standards and improved outcomes in care and ageing well for older people, and their families. Equally, ensuring competence of individuals, multi-disciplinary teams and agencies through workforce strategy and provision of robust education policy which support a range of learning and development opportunities is paramount. This requires professionals and clinicians working at senior levels across all settings to be research active and role model an evidence-based approach to best practice, which embraces personhood and influences relationship centred integrated care models. An advanced influencer enhancing care for older people through education and research is a lead ambassador for the speciality of older persons care and is able to influence workforce and education policy and guidelines, can critically appraise and undertake research and manage and analyse data appropriately. The advanced influencer leads and encourages innovation and development in others to ensure a skilled, confident, and valued workforce whilst influencing inter-agency frailty care pathways so that quality of care is both maintained and equitable wherever older people are experiencing care and support.

	Self-Assessment	**Achieved? Date/Sign**	**Please document how the competence was determined (see evidence key)**
Education and Research			
a. Is able to use expert knowledge of research methods and methodologies to analyse and synthesise evidence in order to critically review care practices and inform local, regional and/ or national care policy and guidelines			
b. Displays critical awareness of new and emerging evidence that can be utilised to enhance the health and wellbeing of older people, families, and others. Is able to translate, disseminate and demonstrate application in practice effectively.			
c. Utilises extensive knowledge of evidence-based frailty care to raise awareness of the speciality of older person's care at a local, regional, and / or national level. Is able to lead, motivate and encourage staff development in care of older people through supporting education, learning and development of others.			
d. Demonstrates the ability to source and critically explore the evidence base to inform and evaluate the effectiveness of education and training strategies aimed at whole workforce development, relative to the needs of older people, families, and others			

e. Is able to recognise how to develop the workforce, maximising the capacity, opportunity, and motivation, to ensure all staff are provided with training and support to meet the needs of older people and how to actively engage a multi-disciplinary and multi-organisational approach to care			
f. Is able to undertake staff training needs analysis and recognise workforce skills gaps. Is able to develop, implement and evaluate creative, innovative, and flexible learning solutions for the whole workforce which match the needs of older people.			
g. Is able to contribute to cross organisational workforce development strategies which ensure a workforce skilled in the delivery of enhanced care for older people, this may be on a local, regional and / or national level			
h. Is able to source, engage with and forge partnerships with a range of partners to facilitate own, staff and whole workforce learning opportunities.			
i. Is able to influence local, regional and / or national education policy for the benefit of staff working with older people across all settings.			
j. Is able to plan, commission and quality assure education programmes for the current and future workforce to meet service needs related to older people, families, and others			
k. Is able to build capacity and capability to support learning in practice settings. Collaborate with education service providers / commissioners to implement strategies to improve engagement			
l. Is able to lead, undertake or contribute to research, to inform the development, implementation, evaluation and monitoring of evidence-based care practice, standards and models which promote enhanced care for older people. Ensure the involvement of older people, families, and others in the co-production of research studies where relevant			
m. Is able to promote a culture of research and enquiry by leading, motivating, and supporting others to become more research aware and active in the speciality of older persons care			

EnCOP

Enhanced Care for Older People

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Section Three

- Templates and Proformas

List of Competency Assessor's/ Reviewers

A sample signature must be obtained for all entries within this document

Name (please print)	**Job Title**	**Signature**	**Initials**
	STRATEGIC WORKFORCE DEVELOPMENT LEAD, NENC AGEING WELL NETWORK		

EnCOP Learning Contract

Staff Name:

Competency Development Facilitator:

Aims of Process:

- To provide an opportunity to reflect and critically examine knowledge base, skills, attitudes & competence in relation to enhancing care for older people. Utilise this process to sign off achieved competencies, and to identify relevant learning and development needs.
- To establish a professional and productive relationship based on mutual respect and trust which supports individual learning and development.

Expectations of staff:

Staff working to meet the competencies within the EnCOP framework are expected to:

- Be familiar with the EnCOP framework and its domains and relevant levels
- Show willingness to be self-reflective and to work collaboratively with the competency development facilitators to determine level of competence within each domain
- Identify their learning needs in collaboration with their competency development facilitator
- Demonstrate commitment to undertake any actions/development plans identified as part of the EnCOP process
- Undertake e-learning, training/ development opportunities within the agreed timeframe
- Inform the competency development facilitator of any factors affecting their ability to achieve the agreed learning outcomes
- Ensure they are satisfied they have achieved the competencies identified, and are able to confidently apply these within their role
- The staff member should avoid cancelling review meetings, if this is necessary then it is their responsibility to contact the competency development facilitator directly to inform and re-arrange

NB Usual lines of accountability and responsibility don't change

EnCOP Learning contract continued

Expectations of Competency Development Facilitator

Competency development facilitators, who are supporting the assessment and learning and development of others, are expected to:

- Observe and assess the staff member's competence against the performance indicators identified in the assessment framework
- Consider all sources of evidence that encompass knowledge, skills, attitudes, and the views of those receiving care
- Provide support and constructive feedback to assist staff to learn from reflective practice.
- Support the formation and ongoing review of a learning and development plan in collaboration with the assessee
- Assist the assessee to identify opportunities for learning and practice experience
- Facilitate observation and role modelling of high-quality care for older people
- Highlight any organisational barriers for achieving competency to the organisational EnCOP leads

Evaluation/ review meetings:

- Both parties agree to undertake the necessary preparation for each review meeting
- Both parties agree to protect the time and space for EnCOP meetings whether virtual or face-to-face, by keeping to agreed appointments and the time allotted. Privacy should be always respected, and interruptions avoided.
- All discussions held in review meetings should be considered as confidential, unless agreed by both parties. If there is an issue/concern regarding risk, safeguarding or safety: relevant procedures and protocols would then be followed.
- There will be a summary of each meeting, recorded on the review form outlining discussions, issues and actions.
- The staff member should take responsibility for the safe keeping of the learning contract and EnCOP assessment toolkit. This will be brought to all meetings, as appropriate

This contract will be reviewed on …….. or at any time at the request of the assessee / Competency development facilitator

Signed Date: Signed: Date:

Items for discussion:	Delete as appropriate
1. Background/purpose of EnCOP	Yes
2. Local support/ organisational structure	Yes
3. Domains & levels of competence	Yes
4. Levels, achievement, and progression of competence	Yes
5. Process of assessment/ review	Yes

Action Plan/ next steps	
Signed: Assessee: Date:	Competency Development Facilitator: Date:

EnCOP Competency Review: Progress Summary

Date / Time / Location	Performance Indicators Reviewed	Competency achievement, Progress and Notes	Learning and Development needs identified	Next meeting date / time	Signed

Evidence List

No.	Description/ title of Evidence	Type of Evidence	Evidence Key			
1			Reflective Discussion	RD	Feedback	FB
2			Reflection	R	Case Based Discussion	CBD
3			Observed Practice	OP	Formal Qualification	FQ
4			Witness Testimony	WT	Work Product	WP
5			Other	Oth		
6			Domain Title and Numbers for reference against evidence grid			
7			**A** Values, attitudes & ethical practice			
8			**B** Understanding and supporting evidence-based practice; leadership & improving care & support for older people			
9			**C1** Partnership working and communication with older people, families and others			
10			**C2** Inter-professional and inter-organisational working, communication and collaboration			
11			**D1** Ageing well: Understanding frailty – Prevention, identification and recognition			
12			**D2** Ageing well: Assessing, planning, implementing and evaluating care & support with older people			
13			**D3** Ageing Well: Promoting & supporting independence, autonomy, & community connectivity for older people			
14			**D4** Ageing well: Promoting and supporting holistic physical health and wellbeing with older people			
15			**D5** Ageing well: Promoting and supporting holistic psychological health and wellbeing with older people			
16			**D6** Ageing well: Promoting and supporting older people with medicines optimisation			
17			**D7** End of life care: older people and frailty – Recognition, assessment & care planning			
18						
19						
20						

Evidence Summary Grid with EnCOP Domain Cross Reference

No.	Description/ title of Evidence	Type of Evidence	A	B	C1	C2	D1	D2	D3	D4	D5	D6	D7
1													
2													
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Evidence Key			
Reflective Discussion	**RD**	**Feedback**	**FB**
Reflection	**R**	**Case Based Discussion**	**CBD**
Observed Practice	**OP**	**Formal Qualification**	**FQ**
Witness Testimony	**WT**	**Work Product**	**WP**
Other	**Oth**		

Domain Title and Numbers for reference against evidence grid

A Values, attitudes & ethical practice

B Understanding and supporting evidence-based practice; leadership & improving care & support for older people

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

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

D1 Ageing well: Understanding frailty – Prevention, identification and recognition

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 and supporting holistic physical health and wellbeing with older people

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

D6 Ageing well: Promoting and supporting older people with medicines optimisation

D7 End of life care: older people and frailty – Recognition, assessment & care planning

EnCOP Competency Record **Name:** **Place of Work:**	**Essential Level**		**Specialist**		**Advanced Competence can be recorded by domain achieved directly below**
	Staff Member Initial	**Assessor Initial**	**Staff Member Initial**	**Assessor Initial**	
Domain A: Values, Attitudes and Ethical Practice					
Domain B: Understanding and supporting evidence based practice; leadership and improving care and support for older people					
Domain C1: Partnership working and communication with older people, families and others					
Domain C2: Inter-professional and inter-organisational working, communication and collaboration					
Domain D1: Ageing well – Understanding frailty – Prevention, identification and recognition					
Domain D2: Ageing well – Assessing, planning, implementing and evaluating care & support with older people					
Domain D3: Ageing Well – Promoting and supporting independence, autonomy, & community connectivity for older people					
Domain D4: Ageing well: Promoting and supporting holistic physical health and wellbeing with older people					
Domain D5: Ageing well: Promoting and supporting holistic psychological health and wellbeing with older people					
Domain D6: Ageing well – Promoting and supporting older people with medicines optimisation					
Domain D7: End of life care: older people and frailty – Recognition, assessment & care planning					

Final Competency Level Achieved	**Essential (tick)**	**Specialist (tick)**	**Advanced (tick)**		
			Domain 1	Domain 2	Domain 3
All					
Partial					
None / Not Appropriate					

Date all required EnCOP competencies achieved :	**Signed Staff Member** **Date:**	**Signed Assessor** **Date:**

EnCOP Case-based Discussion Template

This tool has been designed to enable you, as a staff member to use case-based discussion to reflect on how you provide care and support to older people. You may want to choose a single episode where you were involved with a particular older person or a case you were involved with over a longer period of time. Either way your involvement should have been significant and remember to consider things from your own personal perspective and where your own strengths and development needs lie. Think about:	
Describe the episode of care **Consider**: Anonymised description of older person, presenting problems and issues, issues relating to ageing, functional ability, cognition and frailty, cultural barriers and enablers, communication enablers and barriers, relationships (family and friends), assessment strategies , care and support planning and interventions, care outcomes	
Reflections relating to good care **Consider:** What are the systems that support good care and what is your place within them? Was all the information to hand? Was there enough time for effective care? Was the environment conducive to privacy and dignity? Were all required resources and facilities available? Were local guidelines available? What can I do to improve these factors?	
Reflections relating to maintaining good practice **Consider:** This refers to your level of knowledge: - How do I judge my level of knowledge or skill relating to this issue (s)? What unmet learning needs can I identify? How can I address these?	
EnCOP Case-based Discussion Template Continued	

Reflections relating to good relationships with older people, family, and friends **Consider**: How well did I communicate? Did the older person (family or friend) feel respected? Did they have sufficient time to tell their story? Did they feel like a partner in the outcomes? How did I gauge these? What skills can I identify which will enhance these?	
Reflections relating to good relationships with colleagues and other **Consider**: Did I consider notes from others within the care record? Did I gather information from others appropriately? Did I record my interactions and interventions in a comprehensive, legible way? Did I make appropriate referrals? Did I appropriately respect the professional approach of others even if it differs from my own? How can I improve in this area?	
OUTCOMES: **Consider**: Which outcomes can I use to positively impact my care delivery for older people? Are there any learning needs identified? What 3 Key Learning Points can I take from this case?	
EnCOP Competency Achievement: **Which domains / PI's do you think that this evidence supports?**	
Staff Member Name:	**Date:**

EnCOP Reflective Grid – Planned Experiential Activity for Learning

This tool is designed to enable you, as a staff member to undertake planned and structured reflective experiential learning within your workplace. This will allow you to use reflection before, during and after practice and after practice. Think about:

Before

What are you planning to do?

How does this meet your EnCOP learning outcomes?

What are you hoping to learn?

During

What actually happened?

How did you feel about this at the time?

What do you think others felt? e.g., service user or colleague

After

Reflect on whether the event went as planned to include both negative and positive comments

Did you receive any feedback at the time? From whom? (anonymised) What was the feedback and how did you feel about it?

What did you learn from this experience?

EnCOP Reflective Grid Continued

Next time What will you do differently next time? / How will you apply your learning in your practice? What changes will you need to make? What are the implications for others you may work with?
Literature, standards, frameworks of good practice What do the frameworks and guidance say? How did the reality compare with them? What can you do to improve the process or procedure? What changes if any could you recommend?
EnCOP Competency Achievement What EnCOP Domains or Performance Indicators does this link to? Have any additional learning or development needs been identified? Details:

Name:	Date:

EnCOP Direct Observation of Practice (DOP) Template

This tool is designed to enable EnCOP Competency Development Facilitator's to objectively use structured direct observation of practice with staff members to support evidence in practice for EnCOP competency. This will involve using skilled observations to provide effective and constructive feedback which supports learning and development	
Staff members name:	Observer's name:
Staff members role:	Observers Role:
Date of observation:	Time of Observation:
Location of observation:	Verbal consent for observation obtained from staff member: YES/NO
Brief description of session/work/situation/objectives and the context where observation takes place	
Length of Time Observed (pre- agree)	
What did you observe? e.g., hear, smell, and feel?	
How did the staff member respond to unanticipated issues or opportunities?	
What went well?	
What could have been better?	
EnCOP Direct Observation of Practice (DOP) Template Continued	

Any observed feedback from service users or colleagues?	
Overall comments on staff members performance, including strengths and suggestions for development of future practice	
Staff member's reflection on direct observation and response to feedback	
EnCOP Competency Achievement: Which domains/ PI do you think this feedback supports?	
Post feedback action plan :e.g., training , shadowing, further DOP	
Staff Member Signature: **Date / Time:**	**Observer signature:** **Date/ Time:**

EnCOP Reflection on a Learning Activity Template

This tool has been designed to enable you, as a staff member to reflect on a learning activity and how you have or will use this in your job to enhance care or support for older people, their family and friends. Think about:

Mode of Learning (circle):	Name or Title of Learning:
• Online learning • Course attendance • Independent learning • Qualification / certification or awards • Formal education / study • Research activity • Shadowing • Professional portfolio • Academic reading / journal club • Other	When did the learning take place? Where did the learning take place? Duration of Learning:

What was the topic?

Give a brief outline of the key points of the learning activity

Application to practice?

How have you or how do you intend to apply this to your work to support enhancing care for older people?

EnCOP Reflection on a Learning Activity Template Continued	
Application to EnCOP Which EnCOP domains or performance indicators do you think this links to?	
Have you identified or actioned any further related additional learning or development activity?	
Name of staff member:	**Date:**

EnCOP Reflection on a Work Product Template

This tool has been designed to enable you, as a staff member to reflect on a work product that you have used, developed, or contributed to. Consider how you have or will use this experience to inform care or support for older people, their family, or friends. Think about:

Type of work product (circle)	Audience / Recipients:
• Anonymised care records e.g., notes, letters, referrals • Care standards, protocols, guidelines etc. • Learning & development materials • Conference presentations • Service user resources • Audit and research products • Meeting minutes, reports, business cases • Other:	

Background to the work product?

Give a brief outline of the key points of the work product – e.g., Why was it used or developed? Purpose? Did you refer to any guidelines or research to support its use or development?

Application to practice?

e.g., How have you or do you intend to apply it to your work or the work of others? Have you encountered barriers? Has it been evaluated? Do you have good or bad feedback? What were the outcomes?

EnCOP Reflection on a Work Product Template Continued	
Application to EnCOP? Which EnCOP domains or performance indicators do you think this links to?	
Have you identified or actioned any changes or additional learning or development activity?	
Name of staff member:	**Date:**

Reflection of Experience in Practice Template	
This tool has been designed to enable you, as a staff member to describe what an older persons' health or social care journey was like from your perspective. To start, think about a particular older person that you have been involved with within your job. Consider a specific aspect of their care and think about what it was like to deliver care and/or support. Think about:	
What aspect of care are you thinking about? **Describe the situation / pathway**	
How did you feel as you were delivering care or providing support? **What made you feel like this?**	
What worked well and what did not work so well?	
Without giving away any confidential information, can you describe it from the older person's perspective e.g., feelings, experience, involvement	

Reflection on experience in practice template continued	
What 3 key points can be learned from this experience?	**1.** **2.** **3.**
How will you apply this learning in practice? **If appropriate, how will you share this learning with others?**	
EnCOP Competency Achievement: **Which domains / PI's do you think that this evidence supports?**	
Name:	**Date:**

EnCOP Reflection on Feedback or Witness Testimony Template	
This tool is designed to enable you, as a staff member to acknowledge and reflect on feedback you may receive from older people, family or friends or colleagues related to your job. This feedback may be written, verbal or in the form of a witness testimony	
Staff Name: **Work Location:** **Date of Feedback:** **Location of Experience:**	**Witness' Name (if appropriate e.g., colleague):** **Witness' Position (e.g., patient/client, colleague, manager):** **Type of Feedback:** Examples of feedback: Letter, e-mail, written and verbal compliments, complaint, appraisal feedback
Description of feedback received:	

EnCOP Reflection on Feedback or Witness Testimony Template Continued	
Self-reflection What did you do? How did you feel? Can you use this to improve your practice?	
EnCOP Competency Achievement: Which Domains/ PI's do you feel this supports?	
Name:	**Date:**

EnCOP

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Section Four

- **Glossary of terms**
- **References**

Glossary of Terms

Term	Meaning
Advance care planning	Offers people the opportunity to plan their future care and support, including medical treatment, while they have the capacity to do so
Adverse Drug Event (ADE)	An injury resulting from medical intervention related to a drug. This includes medication errors, adverse drug reactions, allergic reactions, and overdoses. Most ADE's are preventable and can happen anywhere, in hospitals, long-term care settings and outpatient settings
Advocacy / Advocate	Advocacy supports and enables people who have difficulty representing their interests, to exercise their rights, express their views, explore, and make informed choices
Anticholinergic Burden Score (ACB)	Drugs with anticholinergic properties can be problematic, especially for older people who are very susceptible to their cumulative adverse effects. ACB is a useful measure to know the effects of the different anticholinergic medicines, the higher the ACB number, the stronger the anticholinergic effect
Anticipatory Care	Most commonly applied to support those living with a long-term condition (s) to plan for unexpected change in health or social status. Describes action (s) which could be taken, to manage the anticipated problem in the best way. It is very much about clinicians sharing knowledge about their most complex patients with other health and social care colleagues
Assessor	An assessor is a person who has the knowledge and understanding of the workplace area where an assessee is working. The assessor should be experienced and have knowledge of working with older people. They may or may not hold a professional assessor qualification
Assessee	An assessee is a person who is being assessed
Autonomous	Being able to make independent decisions and be able to justify decisions made
Best Interest Decision	A decision made on an individual's behalf because they no longer have the capacity to make the decision themselves. A best interest decision is based on the individual's previously expressed wishes and preferences and should be the least restrictive option available
Care and support planning (CSP)	Care and Support Planning (CSP) is an approach which can be applied across the whole spectrum of ageing and frailty with the aim of improving health and wellbeing and optimising independence at any stage
Care Transitions	Key points in time when an older person may need to move from one environment to another, for example a hospital admission/ discharge, care home entry. It is essential that plans are in place to ensure continuity of care
Co-production	Co-production means professionals and older people working as equals to plan, deliver and evaluate services together. It recognises that everyone has an important contribution to make to improve quality of life for older people and communities
Covert Medication Administration	The practice of giving medication in disguised form i.e., food, drink /feeding tube without the knowledge or consent of the person receiving it. Covert administration is only likely to be necessary or appropriate following assessment and in certain circumstances
Deprivation of Liberty Safeguards	Provide protection for people aged 16 and over who are or need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements
Distressed Behaviours	Can be behaviours displayed by people with dementia when they become distressed, disorientated, frightened or anxious. Behaviours may include agitation or aggression (e.g., slapping, punching, spitting, pacing, or becoming uncommunicative and withdrawn
Emergency Health Care Plan (EHCP)	Is a document which records the care needed during and after an anticipated emergency. These decisions will have been made with the older person if they have capacity or using best interest's decision- making process

Ethics	Ethics is a system of moral principles that how people view good and bad and right or wrong
Evidence- based practice	This is the process of collecting, analysing, and applying research to improve care for older people"
Feedback	Feedback is a form of communication and the providing of information to a person as part of learning to aid them in developing competence and confidence in their workplace and career
Integrity	The quality of being honest and having strong moral principles that you refuse to change. It is about 'doing the right thing even when no one is looking'
Integrated Care System	Partnerships between organisations that meet the health and care needs across an area, to coordinate services and to plan care in a way that improves population health and reduced inequalities between different groups
Inter-professional working	When "multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings'
Lasting Power of attorney	Is when a named person is legally appointed according to the instructions of the older person to receive the authority to make decisions about either financial affairs and/ or health and welfare if they lose mental capacity
Life Story	The is used to describe a wide range of formal and informal activities which are undertaken with the aim of 'getting to know a person' their past, present, and future goals, hopes and aspirations
Medicines Management	Seeks to address medicines-related problems and optimise the use of medicines by providing advice on prescribing, medication monitoring, management of repeat prescribing systems and education and training on prescribing and the use of medicines
Medicines Optimisation	Looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team
Mental Capacity Act (2005)	This legislation is designed to protect and empower people over the age of 16 who may lack the mental capacity to make their own decisions about their care and treatment
Mental Capacity	Mental capacity is a persons' ability to understand information, retain information and weigh up the information to make an informed decision about a specific issue Nb. A person is assumed to have capacity unless proved otherwise
Mental Health Crisis Interventions	A range of immediate and short-term support services that provide person centred crisis care, tailored around the strengths and assets available individually or within the family unit.
NHS Continuing Health Care	NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need' as set out in a National Framework
Person Centred Care	Person-Centred Care requires any health and social care personnel involved in their care to work in partnership with the older person to ensure their needs and wishes are met
Personhood	Personhood is valuing the person as the unique individual that they are. Really 'getting to know' the person is central to personhood and a caring relationship should be based on mutual trust and respect
Polypharmacy	There is no single definition, and it is not defined as being over a specific number of medicines. Problematic polypharmacy is where multiple medications are prescribed inappropriately, the intended benefit of the medication is not realised, or risks of harms outweigh the benefits
Positive risk taking	Managing risk to allow choice and control

Quality Improvement	Systematic approaches to improving the safety, experience, and effectiveness of care for older people
Relationship centred care	Outlines ways in which people working with older people can help make families partners in the caring process and highlights the value of involving supportive in care
Resilience	An individual's capacity to manage and come back from demanding and/or stressful situations or trauma
Responsibility	The things which a person is required to do as part of their job or role
Safeguarding	Ensuring that older people live free from harm, abuse, and neglect and, in doing so, protecting their health, wellbeing and human rights. Children and adults in vulnerable situations, need to be safeguarded
Shared decision making	When people are supported to understand the care, treatment, and support options available and the risks, benefits, and consequences of those options, and decide about a preferred course of action, based on evidence-based, good quality information and their preferences
Shared Governance	Supports the principles of decentralised decision-making, shared accountability, and partnerships among all staff to deliver exceptional care to older people, improve quality of care and enhance work life for staff
STOPP/START Tool:	A decision aid designed to support medication review, particularly in older people. It consists of a series of rules/suggestions related to problems in prescribing for older people, both in terms of reducing medication burden and adding in potentially beneficial therapy
Structured Medication Review	Has the clear purpose of optimising the use of medicines for some people with complex health needs and can identify medicines that could be stopped or need a dosage change, or new medicines that are needed.
Transformational Leadership	A form of leadership that is inspirational and empowering, challenging thinking and offering informal rewards at every opportunity. The transforming leader seeks to engage the full person as the follower
Unconscious Bias	Unconscious bias is when a person favour or discriminate against an individual or group of individuals without even realising it. This is usually because of previous influences from our own life

References