Enhanced Care for Older People
Learning Session Number 21

Awareness and Identification of Swallowing Difficulties

Nichola Todd , Speech & Language Therapist , North Cumbria Integrated Care Trust

EnCOP

Enhanced Care for Older People

EnCOP Lead: Lynne Shaw Date: Wednesday 20th September 2023

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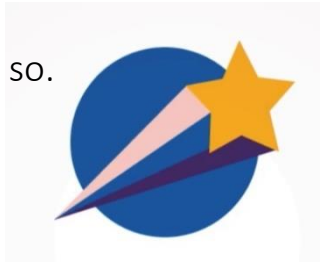


Session Aim & Linked Competencies

Aim:

To raise awareness of how to identify swallowing difficulties experienced by older people , recognise the impact that these difficulties can present for older people and how they can be managed effectively

Linked EnCOP Domains:

Domain A: Values, Attitudes and Ethical Practice
Domain B: Evidence Based Care : Supporting learning, leadership and improving care for older people
Domain C1: Partnership working and communication with older people, families and others
Domain C2: Interprofessional and interorganisational working , communication and collaboration
Domain D2 : Ageing Well: Assessing, planning , implementing and evaluating care and support with 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 D7: Ageing Well : End of life care – Recognition , assessment and care planning

AWARENESS & IDENTIFICATION OF SWALLOWING DIFFICULTIES

NICHOLA TODD

CLINICAL LEAD FOR CARE HOMES ACROSS NORTH CUMBRIA

INTRODUCTION

- CLINICAL LEAD FOR SPEECH AND LANGUAGE THERAPY INTO CARE HOMES ACROSS NORTH CUMBRIA WITHIN NORTH CUMBRIA INTEGRATED CARE TRUST
- MY ROLE IS FUNDED THROUGH THE AGEING WELL PROGRAMME AS PART OF THE NHS LONG TERM PLAN
- THE NHS LONG TERM PLAN COMMITS TO ROLLING OUT THE ENHANCED HEALTH IN CARE HOMES (EHCH) MODEL ACROSS ENGLAND BY 2024, STARTING IN 2020. THIS MODEL MOVES AWAY FROM TRADITIONAL REACTIVE MODELS OF CARE DELIVERY TOWARDS PROACTIVE CARE THAT IS CENTRED ON THE NEEDS OF INDIVIDUAL RESIDENTS, THEIR FAMILIES AND CARE HOME STAFF. SUCH CARE CAN ONLY BE ACHIEVED THROUGH A WHOLE-SYSTEM, COLLABORATIVE APPROACH.

HUGE GEOGRAPHICAL AREA

- 8 PRIMARY CARE NETWORKS-
  EACH PCN WORKING DIFFERENTLY
- 35 GP MEMBER PRACTICES
- OVER 63 CARE HOMES WITHIN NORTH CUMBRIA

AIMS OF THE SESSION

- ROLE OF THE SPEECH AND LANGUAGE THERAPIST
- CASELOAD/WHO WE WORK WITH
- WHAT IS DYSPHAGIA
- THE IMPACT OF DYSPHAGIA ON INDIVIDUALS
- THE NORMAL SWALLOW PROCESS
- WHAT CAN GO WRONG
- SIGNS OF DIFFICULTY/WHAT TO LOOK OUT FOR
- IDDSI DIET AND FLUID MODIFICATION
- ORAL HYGIENE
- FEEDING AT RISK - OVERVIEW

ROLE OF THE SPEECH AND LANGUAGE THERAPIST

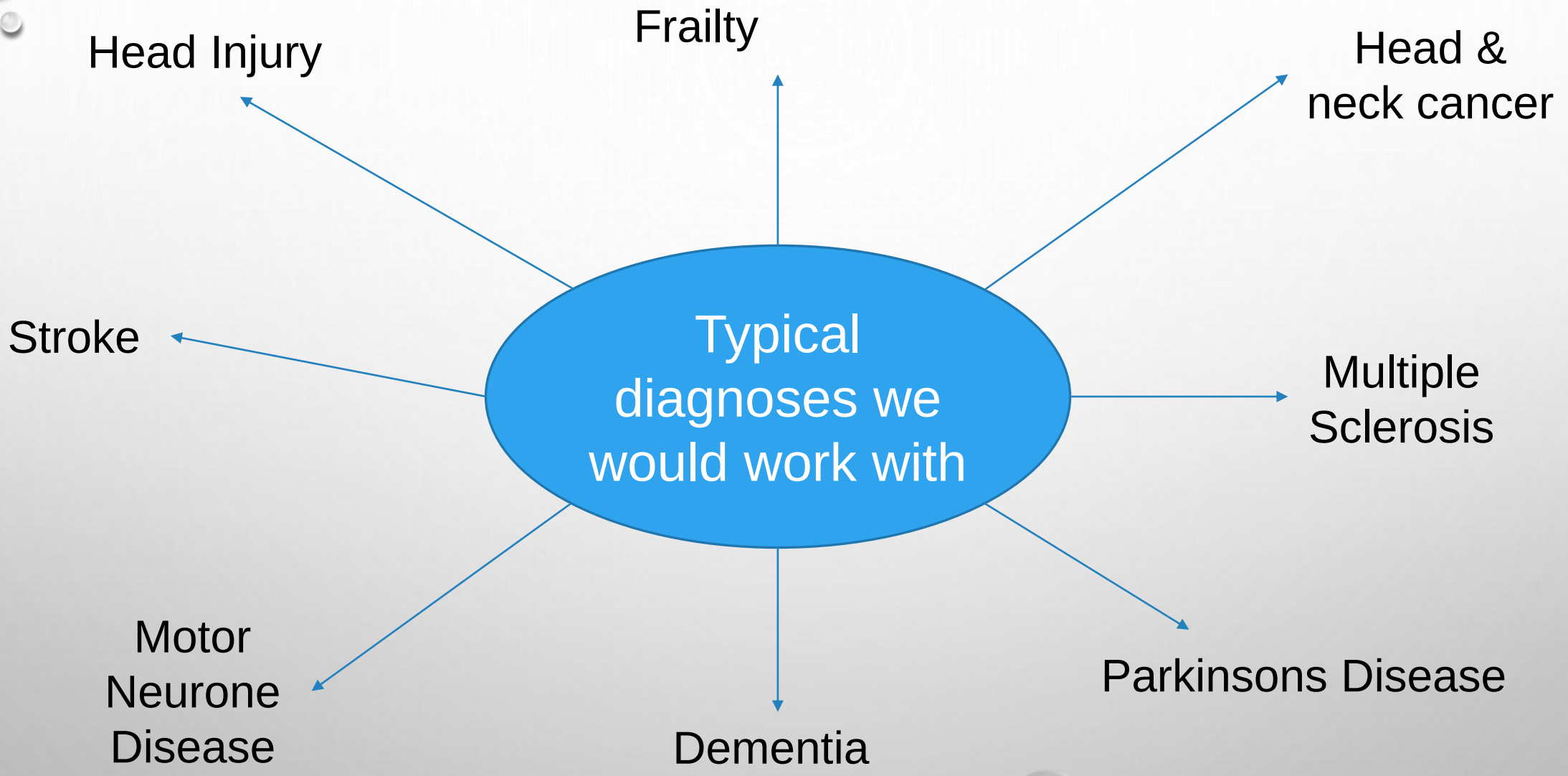
AS SLTS WE HAVE A ROLE IN HELPING PEOPLE WHO PRESENT WITH:

DYSPHAGIA – DISORDER OF SWALLOWING

DYSPHASIA – DISORDER OF LANGUAGE

DYSARTHRIA – DISORDER OF SPEECH

DYSPHONIA – DISORDER OF VOICE


Typical diagnoses we would work with
Head Injury
Frailty
Head & neck cancer
Stroke
Multiple Sclerosis
Motor Neurone Disease
Dementia
Parkinsons Disease

WHAT IS DYSPHAGIA?

- DYSPHAGIA IS THE MEDICAL TERM USED TO DESCRIBE A DIFFICULTY WITH SWALLOWING FOODS AND LIQUIDS. DYSPHAGIA MAY OCCUR WHEN A DISEASE OR ITS TREATMENT AFFECTS THE MUSCLES, NERVES OR STRUCTURES NEEDED TO SWALLOW.
- DYSPHAGIA HAPPENS WHEN THE MUSCLES BECOME WEAK AND DIFFICULT TO MOVE

WHO MAY HAVE DYSPHAGIA?

- THE WORLD GASTROENTEROLOGY GLOBAL GUIDELINES ESTIMATES THAT DYSPHAGIA AFFECTS-
- 40-70% OF PATIENTS WHO HAVE HAD A STROKE.
- 60-80% OF PATIENTS WITH A NEURODEGENERATIVE DISEASE.
- >51% OF ELDERLY PATIENTS.
- 60-75% OF PATIENTS WHO HAVE UNDERGONE RADIOTHERAPY FOR HEAD AND NECK CANCER.
- 13-57% OF PEOPLE WITH DEMENTIA.
- IDENTIFIED AS A KEY RISK FACTOR FOR INDIVIDUALS WITH A LEARNING DISABILITY.
- PRESBYPHAGIA REFERS TO AGE RELATED CHANGES IN THE SWALLOWING MECHANISM IN THE ELDERLY AND SARCOPENIC DYSPHAGIA IS DIFFICULTY SWALLOWING DUE TO LOSS OF MUSCLE MASS AND STRENGTH (WAKABAYASHI., 2014)

HOW DOES DYSPHAGIA AFFECT INDIVIDUALS?

- CAN AFFECT QUALITY OF LIFE.
- SOCIAL ISOLATION
- DEPRESSION
- MALNUTRITION
- PNEUMONIA
- INCREASE RISK OF HOSPITAL ADMISSION AND LENGTH OF STAY IN HOSPITAL
- INCREASED MORBIDITY AND MORTALITY

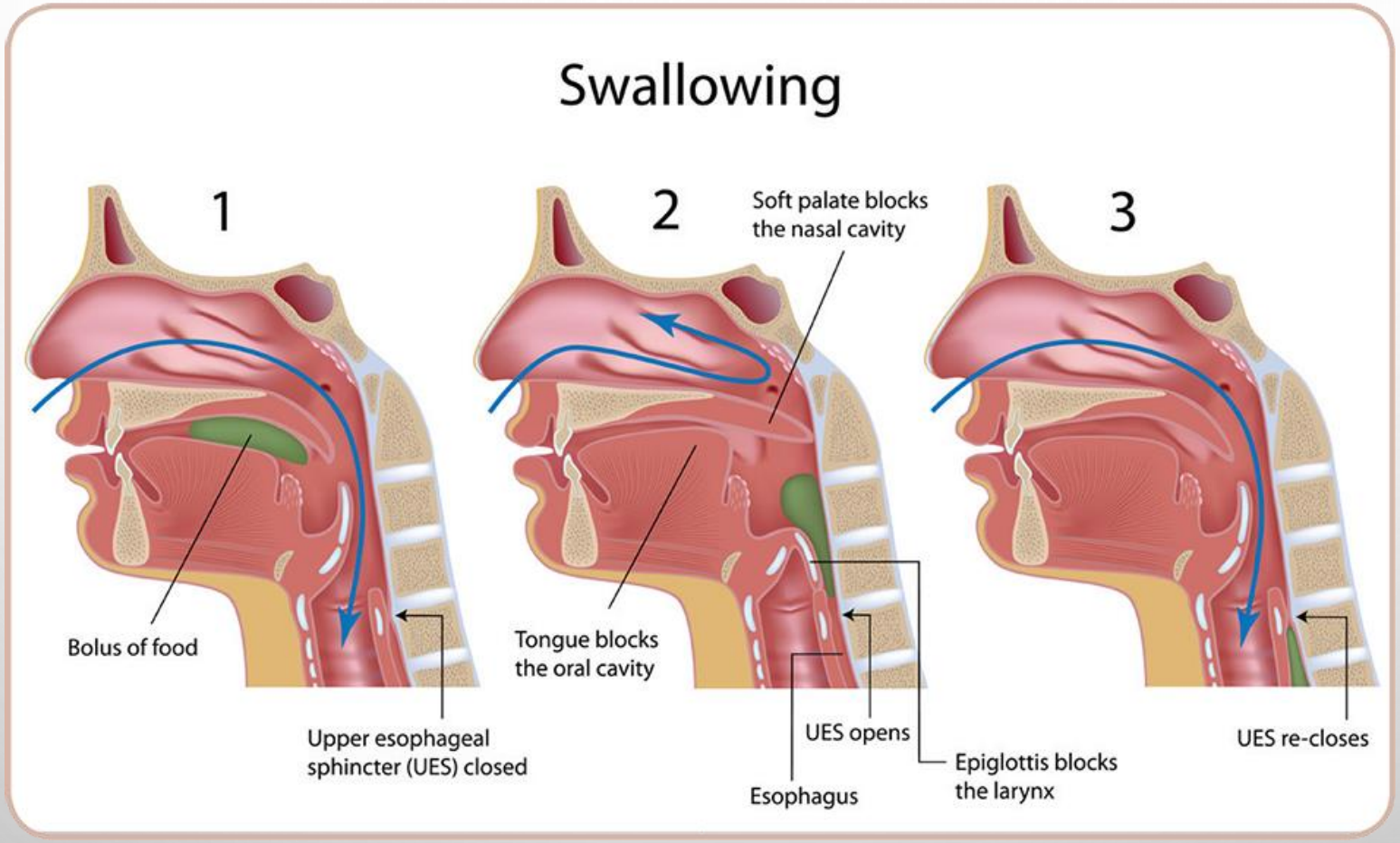
THE NORMAL SWALLOW PROCESS

ACTIVITY

- YOU WILL NEED A DRINK AND A BISCUIT/SOMETHING TO EAT
- TAKE A MINUTE OR TWO AND THEN POP SOME IDEAS IN THE CHAT ABOUT WHAT WE DO WHEN WE EAT OR DRINK

THE NORMAL SWALLOW PROCESS

- CAN BE DESCRIBED IN 4 STAGES-
- 1. ORAL PREPARATORY STAGE
- 2. ORAL STAGE
- 3. PHARYNGEAL STAGE.
- 4. OESPHAGEAL STAGE.

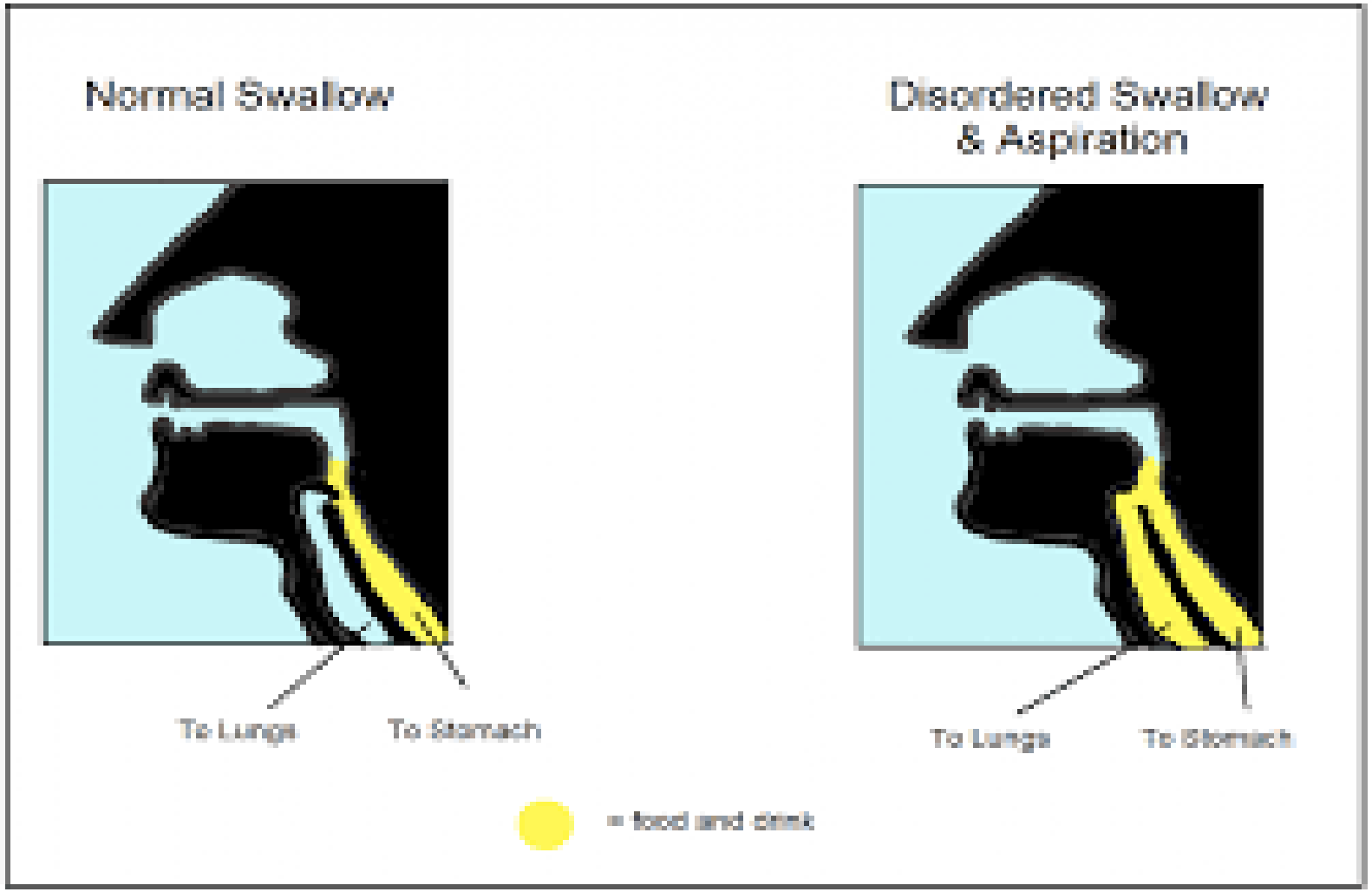

Swallowing
1
2
3
Soft palate blocks the nasal cavity
Bolus of food
Tongue blocks the oral cavity
Upper esophageal sphincter (UES) closed
UES opens
Esophagus
Epiglottis blocks the larynx
UES re-closes

WHAT CAN GO WRONG WITH SWALLOWING?

- FORGETTING TO EAT OR DRINK/UNAWARE THAT ITS MEALTIME.
- DIFFICULTY GETTING FOOD OR FLUID TO THE MOUTH.
- ORAL LOSS- POOR LIP SEAL
- DIFFICULTY CHEWING,
- DIFFICULTY MOVING FOOD FROM SIDE TO SIDE TO CHEW.
- DIFFICULTY MOVING FOOD OR FLUIDS TO BACK OF THE MOUTH
- FOOD OR DRINK STICKS IN THROAT.
- DELAYED/ABSENT SWALLOW
- **ASPIRATION**
- SILENT ASPIRATION
- FOOD STICKS IN OESPHAGEOUS.

ASPIRATION

- ASPIRATION IS THE MEDICAL NAME FOR FOOD AND DRINK THAT GOES DOWN THE WRONG WAY.
- FOOD OR DRINKS ENTER THE AIRWAY AND TRAVEL DOWN INTO THE LUNGS INSTEAD OF THE STOMACH.
- CAUSING CHEST INFECTIONS AND PNEUMONIA


Normal Swallow
Disordered Swallow & Aspiration
To Lungs
To Stomach
To Lungs
To Stomach
= food and drink

SIGNS OF DYSPHAGIA

- COUGHING WHEN EATING OR DRINKING.
- THROAT CLEARING WHEN EATING OR DRINKING.
- HISTORY OF REPEATED CHEST INFECTIONS.
- HAVE A HOARSE, GURGLE LIKE OR WET VOICE.
- DO NOT CLEAR RESIDUE FROM MOUTH.
- LOSING WEIGHT FOR NO APPARENT REASON.
- HAVE A REDUCED URINE OUTPUT.
- DROOLING.
- HAVE A LOW LEVEL OF AWARENESS OR CONSCIOUSNESS

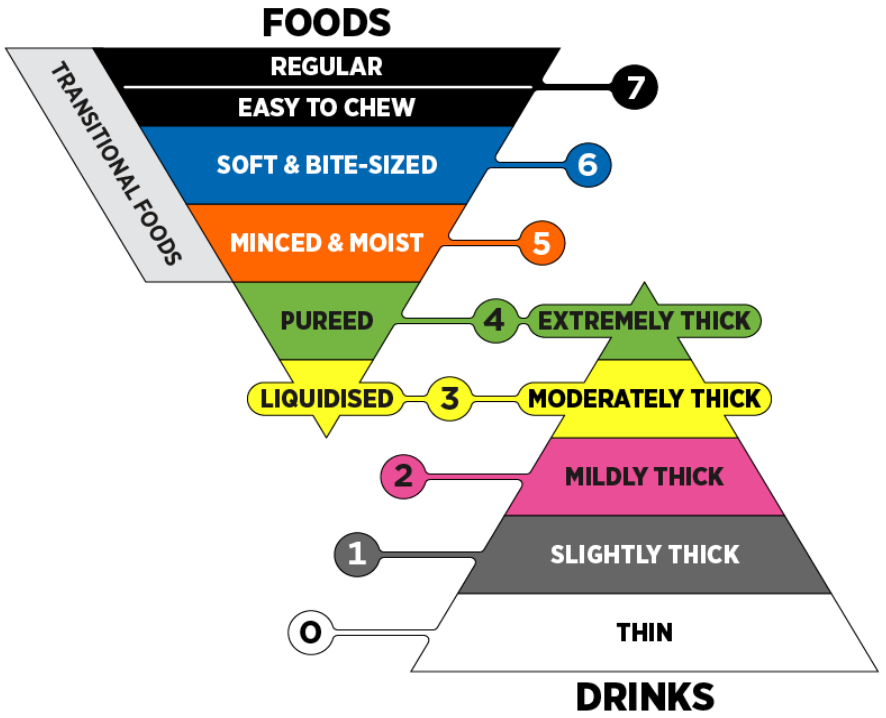
DYSPHAGIA MANAGEMENT
DIET & FLUID MODIFICATION

- IF APPROPRIATE AN INDIVIDUAL WITH DYSPHAGIA MAY BE RECOMMENDED TO HAVE THEIR DIET AND FLUIDS MODIFIED DEPENDING ON THE NATURE OF THEIR SWALLOWING DIFFICULTIES
- DYSPHAGIA MANAGEMENT NEEDS A MULTIDISCIPLINARY APPROACH AND MUST INCLUDE FIRST AND FOREMOST THE INDIVIDUAL, THE RELEVANT MEDICAL PRACTIONER, NURSES, THERAPISTS INVOLVED AND RESPONSIBLE FOR THE CARE OF THE PATIENT/CLIENT/RESIDENT
- FURTHER RESEARCH IN THE AREA OF DIET AND FLUID MODIFICATION IS NEEDED AND IS CURRENTLY ON GOING IN THE UK AND INTERNATIONALLY.
- THE RCSLT CURRENTLY HAVE A PAPER PUBLISHED ABOUT THE USE OF THICKENERS FOR INDIVIDUALS.

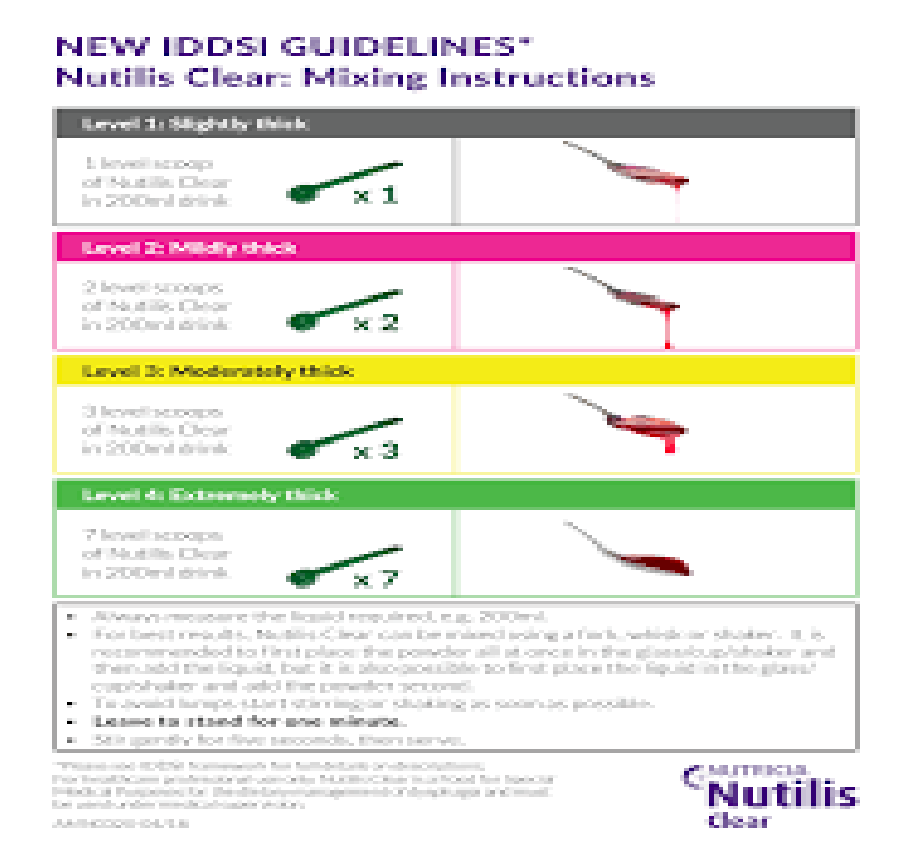
IDDSI

The IDDSI Framework

Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.



FLUID MODIFICATION



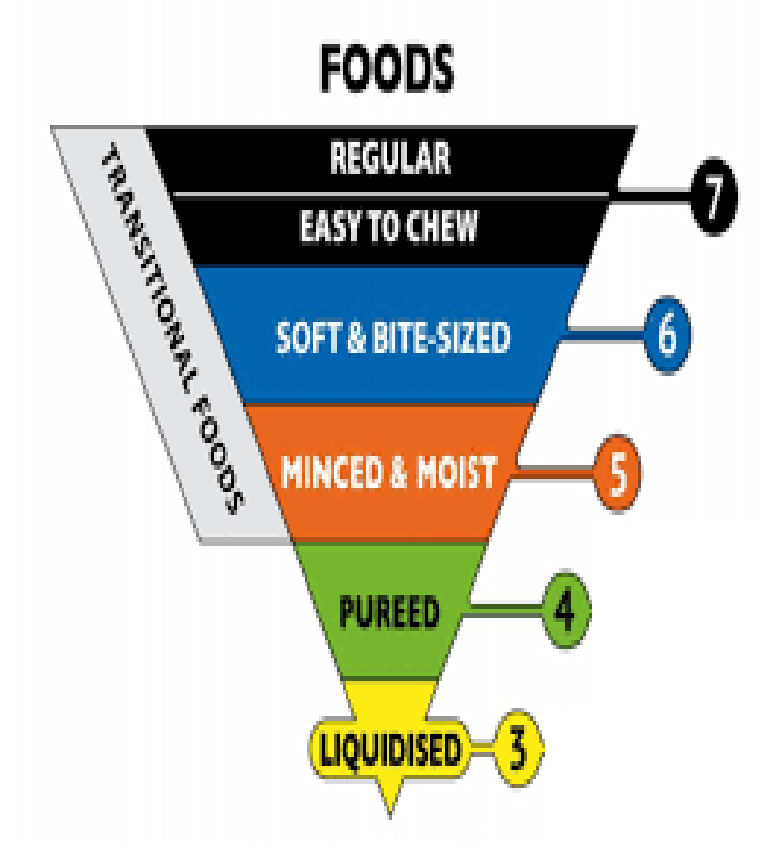
HOW TO USE NUTILIS CLEAR

FOR BEST RESULTS, NUTILIS CLEAR CAN BE MIXED USING A FORK OR WHISK.

1. PUT THE CORRECT AMOUNT OF NUTILIS CLEAR INTO A CLEAN, DRY CUP OR GLASS – AS DIRECTED BY THE SALT.
2. ADD 200MLS OF THE DRINK OR LIQUID TO THE POWDER (USING A MEASURING JUG OR SHAKER).
3. STIR VIGOROUSLY FOR 15-30 SECONDS.
4. LEAVE TO STAND UNTIL THE DRINK HAS REACHED THE DESIRED CONSISTENCY.
5. STIR GENTLY FOR 5 SECONDS AND SERVE.

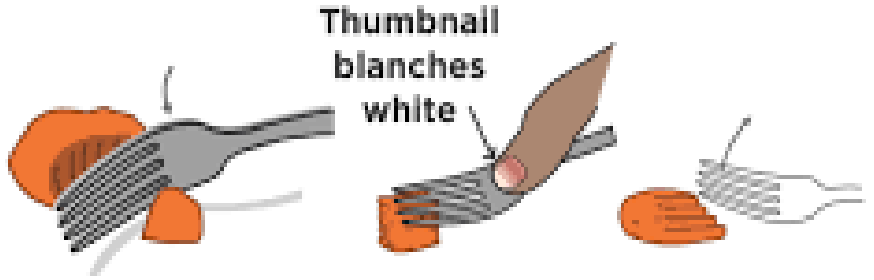
NB: THE QUANTITY OF NUTILIS CLEAR MAY VARY SLIGHTLY DEPENDING ON TEMPERATURE OR THICKNESS OF LIQUID AND VISCOSITY REQUIRED.

IDDSI DIET DESCRIPTORS



LEVEL 7 EASY TO CHEW DIET

- IDDSI EASY TO CHEW (LEVEL 7) IS **SUITABLE FOR INDIVIDUALS WHO MAY HAVE SOME DIFFICULTY WITH CHEWING HARD/FIRM TEXTURES.**
- THIS LEVEL DOES NOT RESTRICT THE SIZE OF FOOD PIECES, HOWEVER MODIFIES THE TEXTURE OF FOODS TO ALLOW SOFT/TENDER TEXTURES FOR EASIER CHEWING



Must be able to break food apart easily with the side of a fork or spoon

Easy to Chew foods must break apart easily and pass Fork Pressure Test!

IDDSI Fork Pressure Test

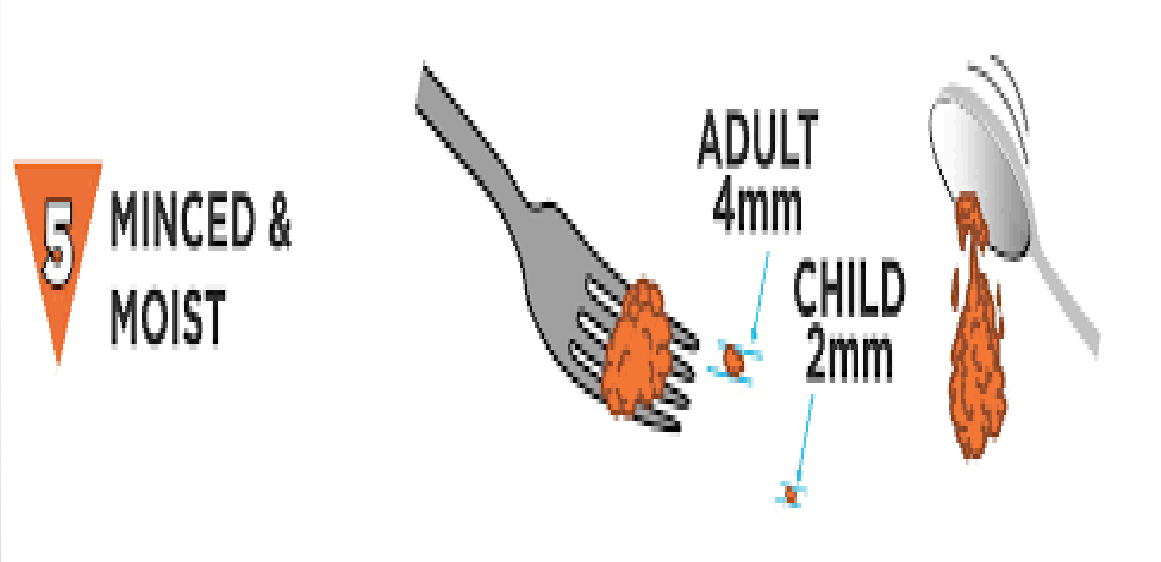
To make sure the food is soft enough, press down on the fork until the thumbnail blanches to white, then lift the fork to see that the food is completely squashed and does not regain its shape

LEVEL 6 SOFT AND BITESIZE DIET

- FOR ADULTS THE LUMP SIZE IS NO BIGGER THAN 1.5CM X 1.5CM, WHICH IS ABOUT THE WIDTH OF A STANDARD DINNER FORK.
- TO MAKE SURE THE FOOD IS SOFT ENOUGH, PRESS DOWN ON THE FORK UNTIL THE THUMBNAIL BLANCHES TO WHITE, THEN LIFT THE FORK TO SEE THAT THE FOOD IS COMPLETELY SQUASHED AND DOES NOT REGAIN ITS SHAPE

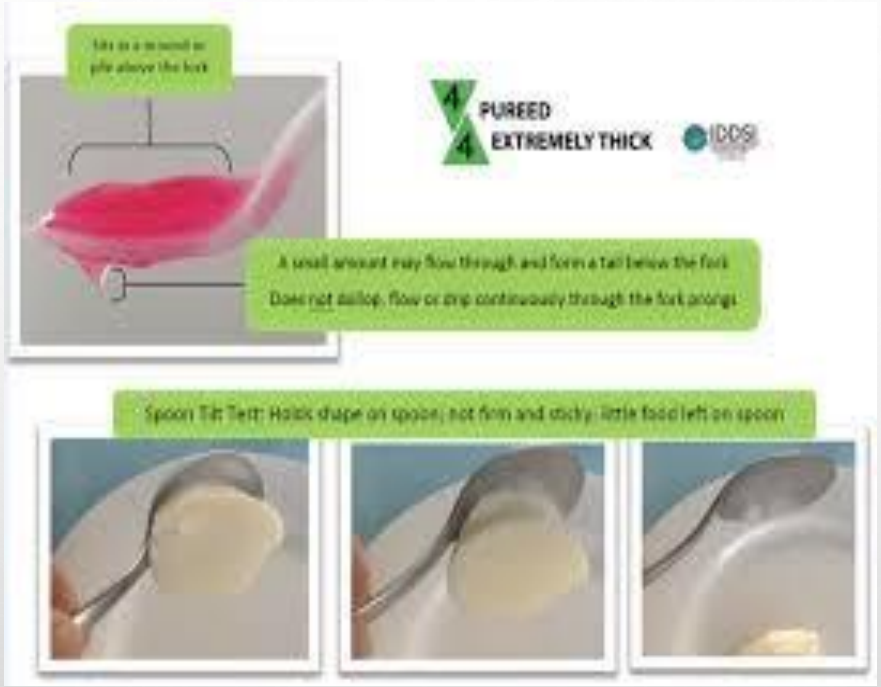
LEVEL 5 MINCED & MOIST

- LEVEL 5 – MINCED & MOIST FOOD MAY BE USED IF YOU ARE NOT ABLE TO BITE OFF PIECES OF FOOD SAFELY BUT HAVE SOME BASIC CHEWING ABILITY. SOME PEOPLE MAY BE ABLE TO BITE OFF A LARGE PIECE OF FOOD, BUT ARE NOT ABLE TO CHEW IT DOWN INTO LITTLE PIECES THAT ARE SAFE TO SWALLOW.
- MINCED & MOIST FOODS ONLY NEED A SMALL AMOUNT OF CHEWING AND FOR THE TONGUE TO ‘COLLECT’ THE FOOD INTO A BALL AND BRING IT TO THE BACK OF THE MOUTH FOR SWALLOWING.


5
MINCED &
MOIST
ADULT
4mm
CHILD
2mm

LEVEL 4 PUREED DIET

- PUREED MINCE AND GRAVY, SMOOTH MASHED POTATOES, PUREED VEGETABLES, CUSTARD OR SMOOTH YOGURT.
- **PUREED FOOD** MAY BE USED IF YOU ARE NOT ABLE TO BITE OR CHEW FOOD OR IF YOUR TONGUE CONTROL IS REDUCED. PUREED FOODS ONLY NEED THE TONGUE TO BE ABLE TO MOVE FORWARD AND BACK TO BRING THE FOOD TO THE BACK OF THE MOUTH FOR SWALLOWING.


4
4
PUREED
EXTREMELY THICK
IDDSI
A small amount may flow through and form a tail below the fork
Does not dollop, flow or drip continuously through the fork prongs
Spoon Tilt Test: Holds shape on spoon; not firm and sticky; little food left on spoon

DEMENTIA & EATING AND DRINKING

- SUPPORTING THE PERSON WITH DEMENTIA.
- ENVIRONMENTAL MODIFICATIONS
- POSITIONING
- STRATEGIES FOR THOSE ASSISTING – PACE, BOLUS SIZE, INTERACTION, VERBAL PROMPTS, ARM OVER ARM FEEDING.
- MODIFICATIONS FOR ORAL SENSATION – FLAVOURS AND TEMPERATURES
- IF NECESSARY DIET AND FLUIDS MODIFICATIONS.

ORAL HYGIENE

- **ROUTINE MOUTHCARE-**IS THE PRACTISE OF MAINTAINING A CLEAN COMFORTABLE MOUTH AND PREVENTING ORAL INFECTIONS. I.E CLEANING TEETH, DENTURES, TONGUE, GUMS AND PALATE AND MAINTAINING ORAL MUCOSA.
- INCREASING WEALTH OF EVIDENCE ON THE LINK BETWEEN ORAL HEALTH AND GENERAL HEALTH.
- ORAL HEALTH CAN BE AFFECTED BY A NUMBER OF FACTORS – SARCOPENA, COGNITIVE DECLINE, SURGERY, NEUROLOGICAL DISORDERS, DEPENDENCE AND LEVELS OF CONSCIOUSNESS, MEDICATION, RADIOTHERAPY AND NBM STATUS.

ORAL HYGIENE

- POOR ORAL HEALTH E.G THE PRESENCE OF DENTAL BACTERIA PLAQUE IS RELATED TO HIGHER RATES OF ASPIRATION PNEUMONIA AND ADULTS WITH DYSPHAGIA ARE ALSO MORE LIKELY TO PRESENT WITH POOR ORAL HEALTH.
- MOUTHCARE - REGULAR MOUTHCARE WITH TOOTHBRUSH, GUM/TONGUE BRUSHES, MOUTHWASHES OR GELS, REMOVAL OR SECRETIONS/FOOD RESIDUE CAN DECREASE PNEUMONIA RATES (YONEYAMA ET AL 2002).
- NBM RESIDENTS – STILL REQUIRE REGULAR MOUTH CARE TO ENSURE MOUTH IS MOIST AND CLEAN. RECOMMEND A LOW FOAMING TOOTHBRUSH WITH A SOFT BRUSH/GAUZE.

WHAT IS FEEDING AT RISK

- PATIENT IS DEEMED 'UNSAFE' WHEN EATING AND DRINKING DUE TO:
    - ORAL DYSPHAGIA
    - PHARYNGEAL DYSPHAGIA
    - OROPHARYNGEAL DYSPHAGIA

- PLACES THE PATIENT AT AN INCREASED RISK OF:
    - CHOKING AND/OR
    - DEVELOPING FREQUENT CHEST INFECTIONS DUE TO ASPIRATING ON DIET AND/OR FLUIDS
    - THESE RISKS CAN IN SOME CASES RESULT IN DEATH

WHY MAY SOMEONE BENEFIT FROM FEEDING AT RISK

- ALTERNATIVE FEEDING MAY BE DEEMED INAPPROPRIATE WITH RISKS OUTWEIGHING THE BENEFITS
- THE PATIENT MAY DECLINE NON ORAL FEEDING (E.G. NG/PEG)
- THE PATIENT MAY DECIDE THEY WANT TO CONTINUE WITH TASTES FOR PLEASURE EVEN THOUGH THEY ARE MEETING NUTRITIONAL REQUIREMENTS NON ORALLY
- THE PATIENT MAY REFUSE RECOMMENDATIONS FROM SLT
- END OF LIFE CARE

FEED AT RISK POLICY

- FEED AT RISK POLICY CAN BE FOUND ON THE TRUST WEBSITE: HTTPS://WWW.NCIC.NHS.UK/APPLICATION/FILES/3915/7192/1087/FEED_AT_RISK_ADULTS_V2.0.PDF

- IF THE MEDICAL TEAM INITIATE THE POLICY PRIOR TO SLT ASSESSMENT, THE PROTOCOL CAN BE ACCESSED AND THE DOCUMENT PRINTED
  - IT IS INAPPROPRIATE TO KEEP A PATIENT NIL BY MOUTH OVER A WEEKEND WITHOUT ALTERNATIVE DIET/FLUIDS OR HOSPITAL ADMISSION WHEN THE FEED AT RISK POLICY AND EMERGENCY/WEEKEND PATHWAY IS RECOMMENDED
  - A SLT REFERRAL MUST ALWAYS INFORM THE RISK FEEDING DECISION SO RISK REDUCING CONSISTENCIES AND STRATEGIES ARE ESTABLISHED.

Patient label:	**ADULT FEED AT RISK FORM**	Date: Time:

Stage 1: Identification – Is the patient for Feed at Risk?

Identification

	Yes	No
The patient has an unsafe swallow which is not likely to improve *This assessment is usually made by a Speech and Language Therapist (SLT) but may be made by a consultant physician/GP*	☐	☐
The multidisciplinary team (MDT) have made the decision the patient is not / no longer appropriate for tube feeding **OR** The patient is choosing not to have a feeding tube **OR** The patient is already tube fed long term but requests or requires small amounts of oral intake for comfort (Please indicate which option you are selecting)	☐	☐

If **YES** to both, proceed to decision making

Stage 2: Decision Making

Decision Making

Establish possible feeding recommendations that balance risks, burdens and benefits to the patient
These are usually determined by an SLT but may be determined by a consultant physician/GP using weekend guidelines (SLT referral to support patient and family)

↓

Patient's capacity to consent to these recommendations is assessed and documented

↓

	Yes	No
The patient has capacity and after discussion, has made an informed decision to eat and drink with acknowledged risk of deterioration	☐	☐
OR		
The patient lacks capacity, but a best interests MDT discussion has taken place that has concluded that he or she should eat and drink with acknowledged risk of deterioration	☐	☐

If **YES** to either statement proceed to implementation

↓

Stage 3: Implementation and Communication

Implementation

Discuss recommendations with next of kin if appropriate and not previously done
Note: whilst important, this step should not delay timely implementation of feeding at risk

↓

Document agreed recommendations and strategies to support oral intake with acknowledged risk here:

↓

SLT / medical team to communicate feeding plan to relevant others including nursing staff/care home staff/carers, family and GP if agreed as inpatient

Stage 4: Escalation Planning

Escalation Planning

Medical team to document suggested management strategies in the event of deterioration, e.g. chest physiotherapy; parenteral fluids; antibiotics; symptom control measures

Has there been documentation of any ceiling of care? (e.g. ward based care only/non-admission to hospital)	Yes ☐	No ☐
Has a DNAR decision been documented?	Yes ☐	No ☐
If the patient is likely to be become End of life, has a Care of the Dying Patient document been considered?	Yes ☐	No ☐

Reconsider Feed at Risk Plan if:

Risks, benefits or burdens change

Adult Feed at Risk Form is completed and filed in medical notes by the managing team. Save in EMIS record by SLT.

Name of responsible consultant/GP.....

Signed by Doctor ..... Date .....

Signed by SLT ..... Date .....

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REFERENCES

- GUIDANCE ON THE MANAGEMENT OF DYSPHAGIA IN CARE HOMES – ROYAL COLLEGE OF SPEECH AND LANGUAGE THERAPY. GUIDANCE-ON-THE-MANAGEMENT-OF-DYSPHAGIA-IN-CARE-HOMES.PDF (RCSLT.ORG)
- IDDSI DESCRIPTORS : HTTPS://IDDSI.ORG/FRAMEWORK
- NUTRICIA WEBSITE: HTTPS://WWW.NUTRICIA.CO.UK/PATIENTS-CARERS/PIM-PRODUCTS/NUTILIS-CLEAR
- NICE GUIDELINES – ORAL HEALTH FOR ADULTS IN CARE HOMES.
- DELIVERING BETTER ORAL HEALTH : AN EVIDENCE BASED TOOLKIT FOR PREVENTION:
- HTTPS://WWW.GOV.UK/GOVERNMENT/PUBLICATIONS/DELIVERING-BETTER-ORAL-HEALTH-AN-EVIDENCE-BASED-TOOLKIT-FOR-PREVENTION
- WAKABAYASHI, H. (2014). PRESBYPHAGIA AND SARCOPENIC DYSPHAGIA: ASSOCIATION BETWEEN AGING, SARCOPENIA, AND DEGLUTITION DISORDERS. THE JOURNAL OF FRAILTY & AGING, 3(2), 97- 103.
- WORLD GASTROENTEROLOGY ORGANISATION (2014). WORLD GASTROENTEROLOGY ORGANISATION GLOBAL GUIDELINES: DYSPHAGIA. [ONLINE]. AVAILABLE AT: HTTP://WWW.WORLDGASTROENTEROLOGY.ORG/GUIDELINES/GLOBALGUIDELINES/DYSPHAGIA/DYSPHAGIA-ENG

Thanks


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Ideas for Learning Consolidation & Competency Conclusion

Consolidating Learning:

Reflection on the session & considering application to practice & what this means 'your people'

- Think about this session in relation to your own role
- How much of this was revision?
- What have you learned today ?
- How will this help you in your role ?
- Think about your EnCOP self–assessment; consider which performance indicators this session may relate to and how this can be used as part of your own development / competency achievement.

A: Values, Attitudes and Ethical Practice
B: Evidence Based Care : Supporting learning, leadership and improving care for older people
C1: Partnership working and communication with older people, families and others
C2: Interprofessional & interorganisational working, communication and collaboration
D2: Ageing Well: Assessing, planning , implementing and evaluating care and support with older people
D4: Promoting and supporting holistic physical health and wellbeing with older people
D5: Ageing Well: Promoting and supporting psychological health and wellbeing with older people
D7: Ageing Well : End of life care – Recognition , assessment and care planning

Enhanced Care for Older People
Learning Session Number 22
Better Mealtimes for People Living with Dementia in Care Homes

James Faraday , Clinical Educator NMAHP Research / ARC Dementia Fellow / Speech and Language Therapist
The Newcastle – Upon – Tyne Hospitals NHS FT

EnCOP
Enhanced Care for Older People

Tuesday 17th October 2023
1.30pm – 3pm

involve consider assess respond evaluate

Feedback about today's session and any future sessions you may like to see included in our webinar series….

All feedback welcomed; You may want to consider the following –

Was it easy to book onto the session?
Did you find the session went well in this online format ?
Was the content of the session relevant to your area of practice / job role?
Did you enjoy the session?

Thinking about future webinar's, which topics linked to older person's care would you be most interested in?
Please put any suggestions in the chat.

Please comment in the chat today or feel free to email us: ghnt.encop@nhs.net

More information can be found within the Frailty icare website

www.frailtyicare.org

Our EnCOP pages are located in the workforce section

EnCOP Library of Learning & Development Resources can be found at:
http://frailtyicare.org.uk/making-it-happen/workforce/enhanced-care-of-older-people-with-complex-needs-encop-competency-framework/encop-learning-resources/learning-resources/