EnCOP

Enhanced Care for Older People

Assessment Toolkit

Name:
Job Role:
Place of work / Team:

Contents

Section 1 - Introduction to EnCOP & Essential and Specialist Level Domains

EnCOP is a gold standard competency framework collaboratively developed by older people, their families, professionals and educationalists from across the care system, who came together to share their experiences to create a framework that promotes the highest standard of care for everyone. It is designed to support workforce development to ensure all those working with older people hold the right values and are able to demonstrate the right behaviours, knowledge and skills to provide high quality care. EnCOP has been developed so that we're ready for what the future holds and we have a properly trained workforce to meet the needs of our ageing population. The framework supports the workforce to enable older people to live well and have meaningful lives.

EnCOP has four aims:

- to ensure consistency of competence
- to enable the delivery of timely, responsive, evidence based care
- to recognise working with older people as a specialism
- to develop a workforce that are valued, competent and able to work anywhere in the care system

To achieve these four aims, EnCOP covers four key areas of practice

- personhood, relationship centred care and ethical practice
- workforce empowerment, leadership and improving care
- partnership working, collaborative care and communication
- knowledge and skills for assessment and care delivery

For the workforce, EnCOP means:

- recognition of expertise in the care of older people
- professional development
- achieving potential

For older people receiving care, EnCOP ensures:

- high quality person centred care
- equity of care
- a gold standard of care for everyone

This EnCOP assessment 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. Focusing on workforce competency, the toolkit is a practical resource to support staff assessment, review, professional development and competency achievement. 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 emphasis on competency allows the assessment toolkit to be both standardised and flexible, enabling it to encompass and support the development of all staff.

Underpinned by the themes of the four key areas of practice, the assessment toolkit comprises 10 domains which describe competency across a number of measurable performance indicators. Competency is outlined within 2 core levels of practice: **Essential** and **Specialist**.

EnCOP Domains

A. Values, Attitudes, Safe and Ethical Practice

B. Partnership Working and communication with older people, families, and others

C. 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 and supporting holistic physical health and wellbeing with older people

D4. Ageing Well – Promoting & Supporting Holistic Psychological Health & Wellbeing with Older People

D5. Ageing Well - Promoting & Supporting Independence, Autonomy & Community Connectivity for Older People

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

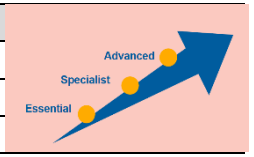
D7. End of life care: older people and frailty – Recognition, assessment & care planning

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 of their current practice.

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



Key Principles:

- Everyone should aim to achieve all competencies within the 'essential' level.
- Some individuals may have competencies from more than one level, relevant to their knowledge, skills and behaviours.
- Through competency assessment and review, areas for development can be identified. On an individual basis, this knowledge can support personal development and career progression.
- Advanced Level domains are optional 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 levels are completed.

EnCOP
Enhanced Care for Older People

Developing a valued workforce to meet the needs of older people....

Domain A. Values, Attitudes, Safe 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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Has awareness that older person's care should be evidence based to ensure quality and safety. Is aware that audit, research and other quality improvement methods may be used to inform safe care for older people.			
	b. Has awareness of society's portrayal of old age, the potential impact of internal or external discrimination on the older person and knows how to promote equality			
	c. Understands diversity within the older population, potentially underserved communities, and knows how to promote inclusivity			
	d. Is able to consider how someone might think or feel in the care environment and knows how to ensure dignity and privacy is respected and preserved at all times			
	e. Is able to consider individualised spiritual, religious, and cultural needs with older people, families, and others, and knows how to refer on as required to make sure these needs are met			
	f. Has an awareness that ethical dilemmas may arise in a range of situations, for example, between older people, families, and others. Knows how and when to access further advice and / or assessment			
	g. Understands relevant legislation, principles and guidelines that underpin the assessment of capacity on an informal basis to inform day-to-day care decisions.			
	h. Has awareness of 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			
	i. Has an awareness of the principles and relevance of lasting power of attorney for older people, families, and others			
	j. Recognises the importance of learning from good practice examples, incidents and complaints and how this can contribute to service developments which focus on safety and quality			
	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			

Domain A: Values, Attitudes, Safe and Ethical practice				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge of local, regional, and national drivers which influence strategy and service development in relation to the safe and effective management of care for older people			
	b. Is able to understand, use and encourage the application of evidence-based care practices for older people.			
	c. Is able to support others to use reflection to assess own strengths and areas for development. Recognises how and when to support, guide and offer feedback on values, attitudes and behaviours.			
	d. Uses knowledge and leadership skills to develop and promote a culture that supports equality and diversity for all older people			
	e. Has a broad knowledge and understanding of ethics and can apply this to complex decision making in a range of situations.			
	f. 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			
	g. Understands the principles of mental capacity assessment regarding complex or higher risk decisions. Knows how and when to refer for further specialist advice and support.			
	h. Demonstrates knowledge of lasting power of attorney. Can discuss with older people, their families, and others. Able to support and advise colleagues regarding advocacy			
	i. 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			
	j. Is able to contribute to understanding and learning from complaints, incidents, safeguarding concerns and other feedback to challenge inadequate practice and inform improvements in care or service delivery			
	k. 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			

Domain B: Partnership Working and communication with older people, families, and others

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. 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.

LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Can recognise if older people and family have additional communication needs such as health conditions affecting communication, language or cultural considerations. Is able to adapt styles and environment accordingly			
	b. Recognises the communication skills required to engage with all older people, about personal preferences, goals, and choices to enable shared decision making. Knows when and how to refer on for further information or advice			
	c. Appreciates the importance of listening to families and others, respecting them as partners in the care of older people, and values their input in communication and care processes			
	d. Is aware of the diversity of attitudes to accepting services and demonstrates partnership working with older people, families, others. Knows how and when to access further advice and support			
	e. Knows how and when to advocate and support older people, families, and others to exercise their rights.			
	f. Has an awareness of how care is funded, and how to signpost older people to local services when they need financial support and advice			
	g. Understands why and how older people are at increased risk of harm during transfers of care. Knows when and how to support older people and families during care transitions			

Domain B: Partnership Working and communication with older people, families, and others				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
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 a range of creative and effective communication methods during assessment and decision making to ensure that the voices of older people and families is heard and acted upon			
	c. Is able to support older people and families to collaboratively engage in care decisions. Knows when and how to share information, care decisions, plans and discussions sensitively, effectively, and proportionately			
	d. 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			
	e. Is able to apply advanced communication techniques to minimise miscommunication with older people and families, reduce repetitious communication and support the resolution of conflict			
	f. Is able to act as an advocate and provide relevant advice or signposting which match individual care needs, choices, and preferences with available care options. Can involve relevant advocacy services as needed.			
	g. 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 and families experience			
	h. Has a broad knowledge of funding of care provision for older people. Can actively advocate, assist and support older people and families in financial matters relevant to their care.			

Domain C: 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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Appreciates that their role and organisation sit within the wider integrated care system. Has awareness of relevant local services and care provision and how to signpost or refer to these			
	b. Is aware of the need for respectful and effective communication and collaboration with other people who they work with across the health and social care system			
	c. Is aware of the need to use effective communication skills to make sure relevant information regarding older people and their treatment and care decisions are shared accurately in a timely way to ensure common understanding			
	d. Recognises the impact of financial constraints of service provision and its contribution to the delivery and sustainability of services for older people			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge and understanding of local integrated care system provision for older people and their families			
	b. Is able to establish a professional cross- organisational network which supports relationship centred care delivery. Can address aspects of culture and practice which may present barriers to this at an individual and team level			
	c. Recognises the importance of shared accountability with other professionals and organisations for care outcomes			
	d. Is able to apply this knowledge and local system intelligence to facilitate, contribute to and support effective cross organisational working and shared decision making.			
	e. Demonstrates and supports others in the effective use of communication, record keeping 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. Promotes a culture of enquiry, change and improvement			
	g. Demonstrates confidence and effective leadership skills within local multi-disciplinary and/or inter-professional meetings or forums			
	h. 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			
	i. Is able to apply experience and knowledge of teaching, coaching, appraisal, and/or the assessment of others to facilitate or contribute to workforce development			
	j. Is able to use approaches to service development, evaluation and/ or improvement, to inform changes in practice. Can consider and promote the involvement of older people, families, and others in relation to this			

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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Is aware of a range of factors across a person's life course that can influence their health and wellbeing as they become older and recognises how to empower individuals to make positive choices about health and lifestyle			
	b. Can describe frailty as a health state and can describe the physical characteristics of frailty			
	c. Has awareness of factors which may contribute to the development and severity of frailty and how this impacts the lived experiences for some older people			
	d. Is aware of recognised assessment tools to identify the presence of frailty and classify the severity of frailty an older person is living with			
	e. Knows that if recognised early, there are interventions that can prevent or slow the onset and progression of frailty, improve quality of life, and increase resilience			
	f. Understands that older people might not like to recognise themselves as living with frailty and may be unwilling to acknowledge or disclose problems			
	g. Recognises how frailty can fluctuate and can describe common factors or situations which can influence this			
	h. Is able to identify the five frailty syndromes, and understands their significance within older person's care			
	i. Is aware of local frailty care pathways and knows when and how to access local MDT advice or specialist services			

Domain D1. Ageing Well – Understanding Frailty - Prevention, Identification and Recognition				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
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. Is aware of the importance of both opportunistic and systematic methods of frailty identification. Is able to confidently identify level of fitness to frailty in older people using evidence based tools.			
	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. Uses principles of personalised care and individual levels of fitness to frailty to guide care and support planning for older people. Can identify those who will benefit most from Comprehensive Geriatric Assessment			

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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Has awareness of why individualised information regarding the older person, their family and others is crucial to ensure effective assessment and care and support planning			
	b. Is aware of Comprehensive Geriatric Assessment (CGA) and why it is important as an effective approach to assessment and care planning for some older people			
	c. Recognises the importance of individualised risk assessment for older people and has awareness of a selection of commonly used evidence-based tools which contribute to this			
	d. Knows how to recognise a carers psychological and physical needs and the particular difficulties older carers may encounter. Is aware of carers entitlements and the local referral pathways and services that support the needs of families/carers			
	e. Is aware of the importance of providing all older people with the opportunity to discuss, explore and share their future care needs and wishes			
	f. Recognises the contribution they make to the CGA process and how to communicate effectively with the Multi-Disciplinary Team in relation to progress			

Domain D2: Ageing Well – Assessing, Planning, Implementing and Evaluating Care & Support with Older People				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge of Comprehensive Geriatric Assessment (CGA). Can describe the key principles of this approach to care for older people living with frailty.			
	b. Is able to initiate or undertake a multi-professional, multidimensional comprehensive geriatric assessment (CGA)			
	c. Is able to fully involve the older person, their families in identifying a stratified problem list, meaningful goals and personalised care and support plan			
	d. Is able to use appropriate outcome measures jointly agreed with the older person, their families, and others to determine success against identified goals			
	e. Demonstrates broad knowledge of the needs of informal carers and is able to initiate or facilitate a formal assessment to address these			
	f. Has a broad understanding of personalised care. Knows when and how to refer or signpost into local pathways to support effective care for older people and their families			
	g. Demonstrates broad understanding of proactive care. Knows when and how to refer or signpost into local pathways to support effective care for older people and their families			
	h. Is able to apply this knowledge to support shared decision making with older people.			

Domain D3: 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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Has awareness of common physical changes that are associated with normal ageing			
	b. Has awareness of a range of preventative services relevant to older people			
	c. Is aware of a range of physical health issues that older people commonly experience			
	d. Is aware of the impact that both normal ageing and physical health issues can have on the lived experience of older people.			
	e. Recognises that physical health issues may present differently in older people which can impact physical, functional and / or cognitive health			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates understanding that there may be a range of physical and psychosocial factors that can influence and impact how people experience physical ageing			
	b. Demonstrates broad knowledge of preventative care and demonstrates the ability to provide or facilitate access to preventative services wherever care is being delivered			
	c. Demonstrates understanding of the complex interplay between normal ageing changes, frailty, and acute or chronic physical health problems			
	d. 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			
	e. 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			
	f. Is able 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			

Sub-Domain D3.1: Assessment & management of pain				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Recognises the differences between acute and chronic pain. Is aware of a range of risk factors, causes and symptoms of pain in older people.			
	b. Recognises when and what to sensitively ask about pain during routine care and support. Is able to recognise and respond to any verbal or non-verbal signs of pain from the older person.			
	c. Understands that evidence-based guidance supports early identification, risk assessment and management of pain. Has awareness of local pathways to signpost to.			
	d. Recognises how to support older people and their families to optimise simple strategies to prevent, alleviate or manage pain			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
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. 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			
	c. Is able to undertake or facilitate access to 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			
	d. Is able to initiate or facilitate access to evidence-based care planning to identify, facilitate or implement person- centred pain management strategies			

Sub-Domain D3.2: Falls prevention, risk assessment and management				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Is aware of a range of risk factors, symptoms and underlying causes which contribute to falls in older people			
	b. Recognises when to sensitively ask about falls in routine care and support.			
	c. Understands that evidence-based guidance supports early identification, risk assessment and management of falls. Has awareness of local pathways to signpost to.			
	d. Is aware of the psychological impact of falls and how 'fear of falling' can impact on everyday function			
	e. Understands how to support older people and their families to use simple strategies to reduce the risk of falls.			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge of key risk factors, underlying causes, and evidence-based management of falls			
	b. 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			
	c. Is able to initiate or facilitate access to multifactorial falls risk assessment in partnership with the older person, their family, and others			
	d. 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			
	e. 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			

Sub-Domain D3.3: Risk assessment, prevention and management of malnutrition and dehydration				
LEVEL	**Performance Indicators**	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Has awareness of common factors associated with reduced oral intake in older people			
	b. Recognises when to ask about oral health, nutrition, hydration and swallowing in routine care and support			
	c. Understands that evidence-based guidance supports early identification, risk assessment and management of oral health. Has awareness of local pathways to signpost to.			
	d. Understands that evidence-based guidance supports early identification, risk assessment and management of under-nutrition or malnutrition. Has awareness of local pathways to signpost to.			
	e. Understands that evidence-based guidance supports early identification, risk assessment and management of sub-optimal hydration and dehydration. Has awareness of local pathways to signpost to.			
	f. Understands that evidence-based guidance supports early identification, risk assessment and management of swallowing difficulties. Has awareness of local pathways to signpost to.			
LEVEL	**Performance Indicators**	Self - Assessment	Achieved Date/ Sign	Evidence
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. Has broad understanding of the complexity of managing expectations and potential distress for older people, their families, with regards to oral intake, swallowing and weight loss			
	d. Is able to initiate or facilitate access to a multifactorial assessment related to nutrition, and hydration			
	e. Is able to initiate or facilitate access to evidence-based care and support planning for older people regarding nutrition and hydration. Knows when and how to refer to local MDT or specialist services			

Sub-Domain D3.4: Assessment & management of bowel & bladder health				
LEVEL	**Performance Indicators**	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Is aware of a range of common risk factors, symptoms, and underlying causes, related to altered bowel function, associated with older people			
	b. Is aware of a range of common risk factors, symptoms, and underlying causes, related to altered bladder function, associated with older people			
	c. Understands that evidence-based guidance supports early identification, risk assessment and management of bowel and bladder health. Has awareness of local pathways to signpost to.			
	d. Is aware of the different types, causes and impacts of urinary & faecal incontinence.			
	e. Recognises when to sensitively ask about bowel and bladder function, in routine care and support.			
	f. Understands how to support older people and their families to use simple strategies to optimise bowel and bladder health.			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge of risk factors, underlying causes and evidence-based management of bowel conditions that commonly affect older people			
	b. Demonstrates broad knowledge of risk factors, underlying causes and evidence-based management of bladder conditions that commonly affect older people			
	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			

Sub-Domain D3.5: Assessment & management of skin health				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Has awareness of common risk factors, symptoms, and underlying causes that relate to skin conditions that may affect older people			
	b. Recognises when to sensitively ask about skin health, in routine care and support			
	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. Understands that evidence-based guidance supports early identification, risk assessment and maintenance and management of skin integrity. Has awareness of local pathways to signpost to.			
	e. Recognises when and how to offer advice to older people and their families to maintain healthy skin, prevent skin damage and seek early advice regarding skin changes			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
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 D4: 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 well				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Has an awareness of the psychological and social changes that are usually associated with normal ageing. Can describe common risk factors which can impact mental health and wellbeing of older people			
	b. Recognises the impact that loneliness and/ or social isolation has on mental health and wellbeing. Is able to support older people to access social opportunities and engage with others in a way that is meaningful.			
	c. Is aware that mental health conditions may present differently in older people, which can impact physical, functional and/or cognitive health			
	d. Understands that an older person with mental health needs may experience internal and/ or external stigma and prejudice and recognises opportunities to challenge this			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad understanding that there may be a range of physical and psychosocial factors that can influence and impact how people experience psychological ageing			
	b. 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			
	c. Demonstrates broad knowledge of the complex interplay between frailty, multi-morbidity and acute / chronic mental health problems			
	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. 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			
	f. Demonstrates ability to formulate or facilitate access to an evidence-based care planning. Knows when and how to make referrals, and/or initiate escalation plans			

Sub-Domain D4.1: Cognitive Impairment: Recognition and Assessment				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Is aware of a range of signs and symptoms which may indicate cognitive impairment. Has awareness that new or worsening cognitive impairment can be due to a range of underlying causes.			
	b. Is aware of a range of signs and symptoms which may indicate cognitive impairment. Has awareness that new or worsening cognitive impairment can be due to a range of underlying causes.			
	c. Recognises when and what to sensitively ask about cognition during routine care or support			
	d. Understands the importance of early and accurate assessment when cognitive impairment is suspected. Has awareness of local assessment pathways and how to refer or signpost to these			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
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 broad knowledge of evidence-based screening tools for older people. Is able to select and apply these appropriately with the older person when cognitive impairment is suspected			
	c. Is able to obtain collateral history to aid accurate assessment, diagnosis and care planning with older people experiencing cognitive changes			
	d. 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			
	e. Is able to initiate or facilitate access to evidence-based care planning. Knows when and how to refer on for further MDT or specialist mental health assessment			

Sub-Domain D4.2: Dementia Care: Assessment and Person-Centred Management				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Can describe the difference between mild cognitive impairment and dementia			
	b. Recognises the importance of understanding the type of dementia the older person is living with and can identify the most common types of dementia in the UK			
	c. Has an awareness of the impact of stigma, myths and stereotypes associated with dementia. Recognises how to challenge negative views and misconceptions			
	d. Understands that dementia is progressive and has awareness of common signs, symptom and presentations of early, middle and later stages of dementia			
	e. Recognises the importance of supporting people with dementia to live well			
	f. Is aware of the central role that home, housing and immediate community play in enabling an older person to live well with dementia			
	g. Has awareness of how attitudes and behaviours of others can impact on older people living with dementia. Recognises how to consider and respond to an older person's feelings and perceptions in all interactions			
	h. Recognises that an older person's behaviour or change in behaviour may indicate distress. Can describe a range of strategies aimed at recognising and responding to distressed behaviours			

Sub-Domain D4.2: Dementia Care: Assessment and Person-Centred Management				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad understanding of the main types of dementia in the UK. Has broad knowledge of underlying causes, primary symptoms and disease progression.			
	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 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			
	d. Demonstrates broad knowledge of the benefits, criteria, and limitations of pharmacological interventions that may enhance memory or support symptom management			
	e. 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			
	f. Demonstrates broad knowledge and understanding of a wide range of distressed behaviour presentations and a range of underlying causes			
	g. 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			
	h. Is able to initiate or facilitate access to evidence-based assessment and care planning for older people living with dementia. Knows when and how to access MDT advice/ assessment or specialist services			

Sub-Domain 4.3: Mood disorders in later life: Recognition, assessment, and management				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Can describe both anxiety and depression and is aware of common risk factors, signs and symptoms associated with these in older people			
	b. Understands that evidence-based guidance supports early identification, risk assessment and management of mood disorders with older people and has awareness of local pathways to signpost to			
	c. Recognises when to sensitively ask about mood during routine care and support			
	d. Has awareness of risk factors for suicide and self-harm within the older population			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge of signs, symptoms and behaviours that may indicate mood disorder in older people, and understands the similarities 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 D4.4: Delirium: Recognition, assessment, and management				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Essential	a. Can describe what delirium is and the common symptoms of hypoactive delirium, hyperactive delirium, and mixed delirium			
	b. Is aware of the factors which may increase the risk of delirium and of how to minimise risk and short and/ or long-term impacts			
	c. Understands that evidence-based guidance supports early identification, risk assessment and management of delirium with older people and awareness of local pathways to signpost to			
	d. Is aware of the skills required to provide advice and support to older people experiencing delirium, their families, and others			
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad knowledge of key risk factors, presentations and possible underlying causes, of delirium in older people			
	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. Is able to initiate or facilitate access to evidence-based care planning to treat the underlying cause(s) of delirium and manage associated symptoms, behaviours, and emotions			
	e. 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 D5: 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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Appreciates the importance of promoting independence and empowering self-care and self-management for older people			
	b. Understands what recovery, rehabilitation and reablement are in relation to older persons care. Has awareness of local service provision and how to signpost to these locally.			
	c. Knows how to support the older person to express their feelings, fears, grief and expectations about factors which may impact their independence and autonomy			
	d. Recognises when and what to ask about functional ability, mobility and activity in routine care and support			
	e. Understands environmental impacts on function and well-being and simple strategies to minimise risks and optimise independence for older people.			
	f. Is aware of the differences between telecare, telehealth, and telemedicine. Has awareness of how these can contribute to supporting older people's independence and autonomy			

Domain D5: Ageing Well - Promoting & Supporting Independence, Autonomy & Community Connectivity for Older People				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad understanding of the concepts of recovery, rehabilitation and reablement in relation to older persons care across the frailty continuum			
	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			
	c. Is able to apply this knowledge and local system intelligence to facilitate, contribute to and support effective ' home first' approaches to care and support planning with older people			
	d. Recognises the value of positive risk taking. Is able to work with older people and their families to explore risk, benefit, consequences, and appropriate goals			
	e. Is able to optimise independence and self-care for older people, their families, and others. Is aware of a range of strategies which can be used with older people, families, and others to promote 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 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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Understands the importance and principles of safe medicines management and associated risks for older people.			
	b. Recognises when to ask about medicines management during routine care and support. Has awareness of local pathways and how to refer or signpost locally			
	c. Has awareness of the importance of regular medication review. Recognises when and how to support an older person to access a planned or unplanned medication review			
	d. Has awareness of common groups of medications that are time critical and should never be omitted without first seeking clinical advice			
	e. Understands that medication management may require Multi-Disciplinary Team decision-making in accordance with the Mental Capacity Act. Recognises when and how to access specialist support			
	f. Has awareness of a range of side effects of medications which can commonly affect older people. Knows how to recognise, respond and report suspected Adverse Drug Event's (ADE's) appropriately			

Domain D6. Ageing Well – Promoting & Supporting Older People with Medicines Optimisation				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
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 use knowledge and skills to support risk assessment and advocacy in all aspects of medication management. Knows when and how to undertake or facilitate access to medication review			

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	Self - Assessment	Achieved Date/ Sign	Evidence
Essential	a. Has an awareness that, for older people, disease pathways can be complex, and patterns of decline for older people living with Frailty, Multiple Long-Term Conditions and / or Dementia may be different			
	b. Recognises 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. Recognises the range and benefits of specialist advice, support, and therapeutic interventions available locally.			
	d. Is aware of the principles, legal and ethical aspects of advance care planning and is aware of all related local or regional documentation			
	e. Has an awareness of the impact of bereavement on family, friends and others and is aware of local services to enable advice and signposting			

Domain D7. End of life care: older people and frailty – Recognition, assessment & care planning				
LEVEL	**Performance Indicators**	**Self - Assessment**	**Achieved Date/ Sign**	**Evidence**
Specialist	a. Demonstrates broad understanding of end-of-life care in relation to older people. Is aware of evidence-based guidance aimed at enabling the identification of older people who may be in the last 12 months of life			
	b. Is able to initiate or facilitate access to caring conversations with older people, and families, about wishes, preferences and concerns about end of life.			
	c. Demonstrates broad understanding of advance care planning. Demonstrates awareness of local guidance & documentation. Knows when and how to ensure that plans are shared and coordinated			
	d. Recognises the importance of frailty or dementia specific advice or guidance at the end of life. Knows how and when to initiate or facilitate access to specialist advice or support			
	e. Is able to apply knowledge of ethics and the principles of realistic medicine to inform end of life decisions. Knows how and when to refer for specialist advice or support			
	f. Recognises the importance of understanding individualised spiritual, religious, and cultural end of life needs. Know when and how to refer on as required to ensure these needs are met			
	g. Is able to undertake or facilitate access to a holistic assessment of end-of-life care needs in partnership with the older person, and their family			
	h. Is able to initiate or facilitate access to the development of evidence-based end of life care planning. Knows when and how to refer on for local MDT or specialist management			
	i. Knows when and how to provide or facilitate holistic bereavement support for family, friends, staff, and/ or other service users			

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Section Two - EnCOP Advanced Domains

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.

Performance Indicators	Self-Assessment	Achieved? Date/Sign	Please document how the competence was determined (see evidence key)
a. Demonstrates comprehensive knowledge of biological, psychological , spiritual and social theories of ageing and dying			
b. Is able to apply comprehensive 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 comprehensive knowledge of the wider care system. Is able to confidently and respectfully challenge practice, systems and policies			
d. Is able to apply comprehensive understanding of assessment, investigation, legislation and professional guidance in recognising and managing adult safeguarding concerns.			
e. Is able to utilise this knowledge to lead or participate in the development, implementation, and evaluation of evidence- based clinical care models whch support health and well-being of older people			
f. Is able to lead comprehensive person-centred assessment and intervention (CGA), with older people offering clinical advice in complex interventions			
g. 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 advice on informed consent, capacity, and best interests and support staff when there are competing views. Is able to carry out formal capacity assessments where risks might be high and outcomes are likely to have lasting impact			
j.	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.			
k.	Demonstrates use of advanced communication skills including negotiation, conflict resolution and/ or defending own viewpoint, in complex decision making, relating to the planning of care for individuals conflict where there may be competing needs and priorities			
l.	Demonstrates advanced ability 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			
m.	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 people to remain in their preferred place of care			
n.	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			
o.	Demonstrates advanced leadership in promoting and supporting strengths-based , rehabilitative approaches. Is able to promote self determination, patient activation and postive risk taking.			
p.	Displays critical awareness of pharmacological evidence that can be utilised to enhance health and wellbeing of older people in relation to medicines management			
q.	Demonstrates autonomy in undertaking medication reviews, within scope of practice, ensuring that older people have access to timely person-centred medication review, taking opportunities to de-prescribe where appropriate			
r.	Demonstrates the provision or facilitation of advice and support towards MDT decision-making regarding complex pharmacological issues for the individual			
s.	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			
t.	Is able to offer clinical expertise regarding complex end of life care issues for older people living with frailty and / or dementia, including complex ethical considerations, to initiate discussions regarding prognosis, person – centred 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

Performance Indicators	**Self-Assessment**	**Achieved? Date/Sign**	**Please document how the competence was determined (see evidence key)**
a. Is able to demonstrate comprehensive knowledge of leadership and change theory and knows how to apply this in practice to enhance evidence-based care provision for older people			
b. 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			
c. Is able to recognise the profile and trends of older people locally, regionally, and nationally and be able to lead or contribute to the development of systems and inform policy development			
d. Recognises diversity and health inequalities within the older population and is able to work across agencies to develop, manage and review health programmes that promote living and ageing well for all older people, redressing inequitable service usage			
e. Is able to collaborate with and advocate on behalf of older people, families and others ensuring their views are represented at local, regional, and/ or national level.			
f. Demonstrates leadership by seeking and acting on opportunities to influence the commissioning, development and evaluation of care systems for older people that are effective, efficient, and sustainable			
g. Is able to inform or contribute to policy and designs of care environments that promote independence of older people and influence providers to enable all older people are able to access appropriate rehabilitation pathways and reach their potential			

h. Is able to motivate, co – ordinate and empower teams from a range of professions, agencies, and organisations. Promotes collaborative decision-making and problem-solving to address service delivery challenges and positively influence how care is delivered to older people across the care system			
i. Demonstrates ability to seek and act on opportunities to represent the inter-professional and inter-organisational team at local, regional, and/ or national platforms			
j. Is able to provide opportunities for colleagues to network and develop cross agency/organisational relationships to enhance effective care pathways for older people			

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.

Performance Indicators	**Self-Assessment**	**Achieved? Date/Sign**	**Please document how the competence was determined (see evidence key)**
a. Uses comprehensive knowledge of research methods and methodologies to analyse and synthesise evidence 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 health and wellbeing of older people, families, and others, through effective dissemination and application in practice			
c. Utilises comprehensive 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. Leads, motivates and encourage staff development in care of older people.			
d. Demonstrates ability to source and critically explore the evidence base to inform and evaluate the effectiveness of education and training strategies aimed at sustainable whole workforce development in the care of older people			
e. Recognises how to develop the workforce, maximising the capacity, opportunity, and motivation, to ensure all staff are provided and engaged with training and support to meet the multi- professional , multi – agency needs of older people			
f. 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. Contributes to cross organisational workforce development strategies which ensure a workforce skilled in the delivery of care with older people, this may be on a local, regional and / or national level			

h. Is able to undertake or contribute to research, to inform the development, implementation, evaluation and monitoring of evidence-based practice, standards and models relating to older people. Ensure the involvement of older people, families, and others where relevant			
i. 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			

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Section Three - Templates and Proforma's

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**

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 EnCOP competencies are expected to:

- Be familiar with the EnCOP framework and its domains and relevant levels and show willingness to be self-reflective, working collaboratively with their facilitator(s) to determine level of competence within each domain
- Identify their learning needs in collaboration with their facilitator and demonstrate commitment to undertake any learning/development plans identified as part of the EnCOP process 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

Expectations of Competency Development Facilitator (CDF): CDF's, who are supporting the assessment and learning and development of others, are expected to:

- Consider all sources of evidence that encompass knowledge, skills, and attitudes and assess the staff member's competence against the performance indicators identified in the assessment framework
- Provide support and constructive feedback to assist staff to learn from reflective practice.
- Assist the assesse to identify opportunities for learning and practice experience and support the formation and ongoing review of a learning and development plan in collaboration with the assessee
- 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 and 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
- 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.
  NB Usual lines of accountability and responsibility don't change

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

Signed **Date:** **Signed:** **Date:**

1:1 EnCOP Introductory Planning Meeting					
Date & Time	**Date of initial 'EnCOP Getting Started' Session:**		**Agree together –** **CDF Signature Sheet Signed YES/NO** **Agree and sign learning contract YES/ NO** **Action plan and notes – timescales** -	**Agree and book future meeting date(s)**	**Signed**
	Recap and check understanding of ⬇	**Yes / No**			
	Background/purpose of EnCOP				
	Local support/ organisational structure				
	Domains & levels of competence				
	Levels, achievement, and progression of competence				
	Process of assessment/ review				

Progress summary notes:

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

Progress summary notes continued:					
Date & Time	**Performance Indicators Reviewed**	**Competency achievement, Progress and Notes**	**Learning and Development needs identified**	**Next meeting date / time**	**Signed**

Progress summary notes continued:					
Date & Time	**Date / Time / Location**	**Date / Time / Location**	**Date / Time / Location**	**Date / Time / Location**	**Date / Time /**

Evidence List

No.	Description/ title of Evidence	Type of Evidence
1	**Personal and professional reflective discussion linked to current and previous roles and experience**	**RD**
2		
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Evidence Key			
Reflective Discussion	**RD**	**Feedback**	**FB**
Reflection	**R**	**Case Based Discussion**	**CBD**
Observed Practice	**OP**	**Formal Qualification**	**FQ**
Discussion	**D**	**Work Product**	**WP**
Other	**Oth**	**EnCOP Facilitation & resources**	**EF**

Domain Title and Numbers for reference against evidence grid

A Values, attitudes, safe & ethical practice

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

C 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 and supporting holistic physical health and wellbeing with older people

D4 Ageing well: Promoting and supporting holistic psychological health and wellbeing with older people

D5 Ageing Well: Promoting & supporting independence, autonomy, & community connectivity for 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		
	Staff Member Initial	Assessor Initial	Staff Member Initial	Assessor Initial	
Domain A: Values, Attitudes and Ethical Practice					
Domain B Partnership working and communication with older people, families and others					
Domain C: 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 holistic physical health and wellbeing with older people					
Domain D4: Ageing well: Promoting and supporting holistic psychological health and wellbeing with older people					
Domain D5: Ageing Well – Promoting and supporting independence, autonomy, & community connectivity for 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					

Advanced Competence can be recorded by domain achieved directly below

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 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

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, electronic or verbal.

Staff Name: **Work Location:** **Date of Feedback:** **Location of Experience:**	**Feedback from - Name (if appropriate e.g., colleague):** **Person's role (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 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

Enhanced Care for Older People

Assessment Toolkit

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

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