Frailty Tier 2 clinical competency

Health, social care staff, volunteers and those who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

Name:	Role:
Base:	

Competency Statement:

The participant demonstrates clinical knowledge and skill in Frailty without assistance and/or direct supervision.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
The Participant will be able to:				
Capability 1 **Understanding Frailty**				
a. To demonstrate an understanding of the concept of frailty as a long-term condition and its stages e.g. • Pre Frailty • Mild Frailty • Moderate Frailty • Severe Frailty				
b. To demonstrate and understanding of the 5 common presentations of frailty (Frailty Syndromes) • Delirium • Recurrent falls • Sudden deterioration in mobility • New or worsening incontinence • Medication side effects To demonstrate an understanding that the syndromes maybe the first signs of frailty and the importance of early recognition.				
c. To demonstrate an understanding of the importance of identifying frailty early on.				
Capability 2 **Frailty identification and assessment**				
a. To demonstrate an understanding as to why it is important to recognise frailty and the importance that planning appropriate care and intervention can play.				
b. To be able to sensitively communicate what frailty is to the individual in a way that is appropriate to them respecting their diversity.				
c. To demonstrate an understanding of when to assess for frailty and why this would be done.				

Credit to Joshua Hammond, Abigail Barkham and Claire Eastick (Project Leads for Competency task and finish group)

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d. To demonstrate an understanding of the evidence base in the use of common frailty tools. To understand their application across the .professions and within local policy. • Gait Sped Test • Timed UP and Go • PRISMA-7 • Edmonton Frail Scale • Clinical Frailty Scale (Rockwood)				
e. To be able to demonstrate and understand the need for accurate clinical documentation in assessment. To know who to communicate onward referrals to (post assessment) applying a multi disciplinary approach.				
Capability 3 **Person centred approaches**				
a. To understand and demonstrate competency in the skills required to enable a holistic assessment (CGA-Comprehensive Geriatric Assessment) holding a person centred approach.				
b. To understand and demonstrate that assessment is a strength based, dynamic process understanding that individuals needs and wishes change over time.				
c. To demonstrate a working knowledge of key legislation relevant to; • Mental capacity • Deprivation of liberties • Equality • Human rights				
Capability 4 **Communication**				
a. The individual will be able to demonstrate an understanding of the impact of how their communication methods may have on the individuals that they support. The individual will demonstrate an understanding of how to alter their communication to meet the needs of the individual				
b. The individual will demonstrate a range of techniques and methods that facilitate clear and effective communication with all individuals.				

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
c. To understand how different customs and preferences, including religious and cultural customs, may impact communication				
d. To be able to recognise when and how to seek help or refer a person for support with communication needs.				
Capability 5 **Families and carers as partners in care.**				
a. To demonstrate an understanding of the skills required to working in partnership with significant others caring for the individual living with frailty.				
b. To be able to recognise and escalate carer needs as appropriate for assessment and /or signposting to further agencies.				
c. The individual will understand, recognise and validate the complexity of the caring role/relationships and the impact this may have on the individual (positive or negative).				
d. The individual will understand and demonstrate that carer needs are separate to those of the person living with frailty and the factors that may influence that such as socio-cultural differences.				
e. To demonstrate the ability to be able to gather information about a persons history and preferences from family and carers				
Capability 6 **Families and carers as partners in care.**				
a. To be able to work in partnership with others, exploring and integrating the views of wider multi-disciplinary teams to deliver care in a co-ordinated way, showing an understanding the role of others, to meet the needs of people living with frailty and those important to them.				
b. To be able to share information including that which relates to a persons wishes in a timely and appropriate manner with those involved in a person's care considering issues of consent, confidentiality and insuring that information is readily available.				

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Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
Ensuring that the person is not asked to provide the same information repeatedly.				
c. Working within your scope of personal and professional practice you are able to demonstrate your understanding of referral criteria and pathways of care to meet the needs of people living with frailty and when to seek more specialist help and support.				
Capability 7 Managing Frailty				
a. To be able to demonstrate how to act on day-to-day interactions with people to encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. 'Making Every Contact Count'				
b. To be able to demonstrate effective communicate and enable individuals to access sources of health promotion and support.				
Capability 8 Living well with Frailty				
a. To be able to demonstrate and understand how to adapt activities and the home to promote independence, privacy, maintain orientation, thermal comfort, safety and contributions of assistive technology.				
b. To be able to demonstrate how to make appropriate referrals to experts where required for those living with frailty.				
c. To demonstrate and understand the concept and principles of a community development, asset-based approach to care and support for people living with frailty.				
Capability 9 Physical and mental health and wellbeing				
a. To be able to demonstrate how to provide basic advice for a health diet for a person living with frailty, and respond appropriately if signs of dehydration are recognised or problems with swallowing.				
b. To be able to demonstrate how support a person to optimise their				

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
mobility and know how to access specific support regarding strength, balance and falls prevention.				
c. To understand the signs of dementia, delirium, anxiety, depression and chronic pain and know how to seek help in addressing these factors				
d. To understand and demonstrate that acute illness may present differently in people living with frailty, be able to recognise these signs and respond appropriately.				
Capability 10 **Managing medication**				
a. To be able to administer medication safely and appropriately in consultation with people living with frailty.				
b. To be aware of the potential adverse impact of polypharmacy for people living with frailty, including the increased risk of frailty syndromes.				
c. To be aware that physical changes associated with frailty, e.g. kidney and liver function can change the effects of medication.				
d. To understand that falls, sedation, constipation, abnormal electrolytes and cognitive impairment may be indications of adverse drug reactions.				
e. To understand the importance of recording and reporting side effects and/or adverse reactions to medication.				
f. To know when and how to access a medication review by an appropriate prescriber.				
Capability 11 **Care and Support Planning**				
a. To understand the content of a person's care and support plans (and advance care plans) and the impact this has on the care and support offered.				
b. To be able to co-create a person centred plan of care where appropriate. Or sign post to an experienced				

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
professional.				
c. Understand the importance of care and support planning being a 'holistic' and person-centred process.				
d. To understand how a person's beliefs, customs, faith, lifestyle, religion, social norms, spirituality and values may affect care and support planning				
e. To understand when a palliative, end of life or advance care plan would be appropriate and be able to identify people who may benefit from these plans				
f. To understand that people and those important to them have a choice regarding with whom they choose to discuss care and support planning				
g. To understand why care and support plans need to be reviewed regularly and in partnership with others, including the person and those important to them, taking account of the changing needs and wishes of the person				
h. To understand that some people will not wish to be involved in the care and support planning process, and respect this decision				
i. To be able to communicate and share information in a person's care and support plan or advance care plan effectively with their permission with appropriate others				
Domain D Underpinning Principles				
Capability 12. Law, Ethics and Safeguarding	**As per organisational guidance**			
Capability 13. Research and Evidence Based Practice	**As per organisational guidance**			
Capability 14. Leadership in Transforming Services	**As per organisational guidance**			

Date all elements of Competency Tool completed to level 3_____

Name _____ Signature _____ Status _____ Date _____

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in Tier 2 Frailty clinical competency

Assessor _____ Signature _____ Status _____ Date _____

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Review Dates:	Competent Yes / No	Signature of delegate	Verifier signature	Comments