IASLT | *The* Irish Association *of* Speech + Language Therapists

Speech and Language Therapy Provision for People Living with Frailty

Drafted by IASLT Board:	September 2022
Date approved by IASLT Board:	September 2022
Date for review:	2024

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1.0 Executive Summary

The Irish Association of Speech and Language Therapists (IASLT) is the recognised professional body for Speech and Language Therapists (SLTs) in Ireland. The purpose of this document is to set out the association's position in relation to provision of Speech and Language Therapy services to people who live with frailty in Ireland. Frailty refers to a generalised weakening of multiple bodily systems which is usually associated with ageing (Sheehan & O' Sullivan, 2020).

The IASLT has identified the following key recommendations regarding the development and provision of Speech and Language Therapy services for people living with frailty:

1. Equal access to Speech and Language Therapy provision for people living with frailty is critical, regardless of geographical area. This will be achieved through ensuring Speech and Language Therapy is included on all frailty intervention teams across all service areas, such as emergency departments and/or community services.

2. SLTs working in the area of frailty and ageing are specialists within the field and should be recognised as such. Given the advanced knowledge, clinical reasoning and decision making required to work in this area, the IASLT recommends SLT roles on frailty services/teams are filled at a Clinical Specialist grade.

3. SLTs should actively promote their role and contribution in the area of frailty and ageing. It is recommended that SLTs should be consulted and involved in the development of all related national care pathways and education programmes. The *Irish National Frailty Education Programme* should be updated to include information and modules on the impact of frailty on both communication and Feeding, Eating, Drinking and Swallowing (FEDS).

4. Frailty should be assessed and managed in accordance with best practice guidelines. The Comprehensive Geriatric Assessment is considered the gold-standard in frailty management. It should be provided in a multidisciplinary setting, including access to specialist SLT assessment and management of swallowing and communication impairments. This will maximise the quality of life for people presenting with frailty and their families.

5. SLT's currently working in the area of frailty can make a significant contribution in developing the evidence base and improving the quality of care provided. SLTs should continually monitor and evaluate the impact of Speech and Language Therapy provision in frailty teams using audits, service evaluations and quality improvement initiatives. Further national research is needed to provide evidence of the added value of Speech and Language Therapy provision in frailty.

2.0 Introduction and Background

This document sets out the position of the IASLT in relation to Speech and Language Therapy provision that should be available for people living with frailty. Frailty refers to a generalised weakening of multiple bodily systems which is usually associated with ageing (Sheehan & O' Sullivan, 2020). This document highlights the central role that SLTs have within frailty assessment and intervention and offers guidance to SLTs working within these roles. Current research indicates that frailty affects 12.7% of adults aged over 50 years (TILDA, 2020), with Ireland's rapidly growing ageing population suggesting 1 in 5 Irish residents will be 65 years or older by 2030 (TILDA, 2020).

The objective of Speech and Language Therapy services is to improve service users' quality of life by optimising their ability to communicate and/or swallow in their natural environment. SLTs work with people across the lifespan, who present with disorders of communication and/or FEDS. Therefore, SLTs have unique and specialised experience in providing services to those who attend age related services.

Given the growth of the ageing population, there have been significant and rapid changes in age related healthcare nationally, specifically in the identification of frailty. This has led to a marked increase in the number of specific frailty teams in Ireland. These multidisciplinary teams focus on high quality service provision and are sited in different care settings. An example is the Frailty Intervention Therapy Teams (FITT) who work in emergency departments in a number of hospitals across the country. There has been an associated increased recognition of the integral role SLTs play as part of multidisciplinary teams in the assessment and management of frailty. Despite this progress, funding and SLT allocation on frailty teams remains inconsistent.

This is the first IASLT position paper published in relation to Speech and Language Therapy provision for people living with frailty. The purpose of this document is to identify the fundamental role of SLTs in supporting people living with frailty across all healthcare services.

While the foundations of this paper are supported by a national and international evidence base, it is not within the scope of the document to provide a detailed appraisal of the literature. A brief summary has been provided to give the paper context. This paper aims to support future development of Speech and Language Therapy guidelines, standards of practice and care pathways for Speech and Language Therapy provision. It makes a number of key recommendations for change and advocates for Speech and Language Therapy services for all people living with frailty.

The IASLT Working Group for People Living with Frailty was established in June 2021 in response to an emergence of clinical skill and experience of SLTs working within frailty Intervention Teams. The aim of this group was to develop a position paper on the role of SLTs working with people with frailty as a first step to develop clinical services for this population.

3.0 Defining Frailty

Frailty can be defined as a clinically recognisable state of increased vulnerability that results from an age related decline in function and reserve such that the person's ability to cope or adjust to an everyday or acute stressor is compromised (Xue, 2021). An older person may present with vague symptoms (e.g. feeling lethargic) which may mask a more serious or complex underlying problem, like an infection. This is where the concept of the 'Frailty Syndromes' arose, which were formerly known as the '5Ms'; (mind, mobility, medications, multi-complexity and matters most) or the 'Geriatric Giants'; (iatrogenesis, immobility, instability, incontinence and impaired cognition)

(Hughes, 2018). The degree of frailty is typically classified using either the Phenotype Model (Fried at al., 2001) or the Cumulative Deficit Model (Rockwood at al., 2005).

Currently, frailty is considered to encompass the following 'syndromes':

1. Immobility
2. Instability
3. Incontinence
4. Delirium and cognitive impairment
5. Sarcopenia
6. Anorexia of ageing
7. Polypharmacy
8. Dysphagia (Turner & Clegg, 2014; Smithard, 2016).

The impact of frailty amongst the older population in Ireland is significant, with prevalence rates reported by The Irish Longitudinal Study on Ageing (2020) as follows:

- 1 in 5 adults aged over 70 years
- 20.3% of women aged over 70 years versus 17.5% of men
- 25% of people over 75 years
- 46% of people over 85 years (TILDA, 2020)

4.0 The Impact of Frailty on Communication

Communication deficits in older people can be perceived as a normal part of ageing (Zehnhoff-Dinnesen et al., 2010) and frail older persons themselves may be unaware that their communication abilities are declining (Hickson et al., 1996). Communication impairment in frail older adults can result in a number of potential negative sequelae including increased social isolation, increased reliance on others, and difficulty making their will and preferences known (Finch & Duggan, 2020). Research also shows that people with communication impairment are three times more likely to experience adverse events in hospital (Bartlett et al., 2008). A higher

frequency of referrals for Speech and Language Therapist input has been correlated with increased Clinical Frailty Scale (CFS) (Boyle et al., 2019). Hemsley et al. (2019) identified communication impairment as a causal factor in falls in some people. Stransky et al. (2018) showed that adults with communication impairment often experience more difficulties accessing timely healthcare.

In Ireland, the paucity of Speech and Language Therapy services in older person's services (e.g. memory clinics), suggests that older people and their carers have few opportunities to explore suspected communication impairments with a trained clinician. *The Irish National Frailty Education Programme* (Lang et al., 2017) outlines the following frailty syndromes particularly relevant to communication; cognitive impairment, polypharmacy, social isolation, multiple chronic disease processes and delirium.

A cognitive impairment can impact attention, memory, executive functioning, and information processing, all of which are the foundations for comprehension and expression of language. Furthermore, pragmatics and word finding difficulties can hinder the quality of communication interactions, resulting in social isolation and negatively impact wellbeing.

Delirium is one of the most common presenting symptoms of medical illness in older persons and should be recognised as a medical emergency. It may result in an acute onset of impairments in attention, insight, and variable cognitive functioning which can subsequently impact the ability to communicate.

As the population ages, multi-morbidity increases and the prevalence of medical conditions with known communication symptoms can be anticipated. Green et al. (2018) notes that in addition to frailty; stroke, progressive neurological conditions and delirium are also recognised as affecting communication competency. Additionally, Primary Progressive Aphasia is described as a type of frontotemporal dementia, a cluster of disorders which results from the degeneration of the frontal or temporal

lobes of the brain and affects the neurological centres for speech and language. Whilst the onset of Primary Progressive Aphasia and subsequent symptoms may begin gradually, typically symptoms progress and exacerbate over the age of 65 years. Prevalence of Primary Progressive Aphasia is reported to be as high as 20% in persons diagnosed with dementia (Mesulam, 2001).

5.0 The Impact of Frailty on Feeding, Eating, Drinking and Swallowing (FEDS)

Normal swallow function can be described in four distinct phases, the oral-preparatory phase, the oral phase, the pharyngeal phase and the oesophageal phase. These phases are dynamic and overlapping in terms of structure and function and the physiological ageing process can impact on one or more of these swallow phases. The medical term for impairment in swallowing function is dysphagia.

There is increasing research to suggest dysphagia meets the criteria to be classified as a Geriatric Syndrome (Smithard, 2016) and is associated with changes to physiology as adults age (Zimmerman & Sloane, 2018). Dysphagia may be a consequence of:

- Reduced cognition
- Increased dependency
- Reduced mobility and musculoskeletal changes
- Side effects of medication
- Multiple chronic disease processes
- Overt disease process

Dysphagia may result in:

- Overt intolerance before/during/after swallowing e.g. coughing, throat clearing
- Reduced satisfaction and/or social anxiety around mealtimes
- Dehydration
- Malnutrition

- Sarcopenia
- Weight loss
- Food, fluid or oral medication avoidance
- Discomfort swallowing
- Choking
- Mortality

Older people may unknowingly compensate for progressive changes in FEDS ability (Namasivayam-MacDonald & Riqueime, 2019). The risk of delayed identification of a dysphagia and onward referral to the SLT for assessment and intervention places the individual at risk of distress whilst swallowing, choking, food avoidance and malnutrition. There is also a clear role for Speech and Language Therapy in supporting eating and drinking in end of life care by aligning patients' personal preferences with managed risk with the support of the medical team (Leslie & Lisiecka, 2020).

6.0 Multidisciplinary Assessment of Frailty

Frailty can be measured using a standardised frailty tool such as the Clinical Frailty Scale (Rockwood et al., 2005). The use of these scales can predict adverse outcomes for the older population and streamline patients who would benefit from interventions. The Comprehensive Geriatric Assessment (CGA) is considered the gold-standard model of assessment for providing care for the frail older person. It is a multidimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological, functional, social and environmental functioning in order to develop a co-ordinated and integrated plan for treatment and long term follow up (Rubenstein et al., 1991). SLTs and their multidisciplinary colleagues complete the CGA in various settings. Substantial evidence shows that in hospital, those who receive inpatient CGA on specialist geriatric wards are more likely to return home, are less likely to have cognitive or functional decline and have lower mortality rates than those who are admitted to general wards (Ellis et al., 2011).

Additional benefits of completing the CGA include:

- Improved diagnostic accuracy and optimised person centred medical and rehabilitation treatment
- Facilitation of effective discharge planning to reduce length of stay and potential re-presentation to hospital
- Optimisation of care planning to target preventative measures to improve independence, reduce morbidity and mortality rates for our patients.
- Improved patient experience of healthcare and overall quality of life
- Enhanced healthcare signposting and referral to onward services e.g. audiology, dentistry, community support groups
- Improved adherence to medication modifications (Ellis et al., 2011)
- Increased patient support and engagement in capacity assessment, assisted decision making and the advanced care planning process. SLTs within age related services have a key role in promoting awareness of establishing level of communication ability and the impact of communication disorders on capacity assessments (IASLT, 2017).

7.0 Services and Settings

In Ireland, the location of Frailty Intervention Teams varies throughout each Community Healthcare Organisation (CHO) and hospital group. The composition of these teams varies across sites with various multidisciplinary team structures observed. The exact number of SLTs working in specific frailty teams in Ireland is not known. Irrespective of setting or composition of the team, the core principles of CGA and the need to identify frailty remain the same.

The first Frailty Intervention Team established in Ireland was based in the Emergency Department in Beaumont Hospital Dublin in 2015 and was named the Frailty Intervention Therapy Team or FITT. This team was established to aid admission avoidance for frail older persons and ensure patients were linked with the required

support services to maximise independent living in their community. That model has been coined as "Frailty at the Front Door". Since the emergence of this frailty intervention service, various models of frailty teams have been established and age related healthcare has expanded. The overreaching aim of all models of frailty care is to provide the right care at the right time in the right place for patients and is best exemplified by the "Last 1,000 Days" (Dolan & Holt, 2022) and "What Matters to You?" (Lang & Hoey, 2018) ethos.

The settings where these teams are based include but are not limited to:

Emergency Department/Acute Medical Assessment Units

These teams work within an Emergency Department and/or Acute Medical Assessment Units to conduct CGAs and provide specific Health and Social Care Professionals (HSCP) interventions. They aim to both reduce hospital admission and to provide early intervention to those who may be admitted. Those who are discharged home are referred on to the appropriate community or outpatient services for follow-up their local area.

Ambulatory Care Hubs

An ambulatory care hub is a clinical site outside the acute setting which provides integrated team involvement for specialist care/clinics, e.g. falls assessments, memory clinics, specialist health and social care clinics. The aim is to provide multidisciplinary assessment, rehabilitation and education for patients and carers. Integrated care has emerged as an effective way to improve outcomes for older people with complex care needs (Briggs et al., 2018).

Acute Hospital Inpatient Care

Specialist wards, supported by access to medical, nursing and HSCP's with training and expertise in older person care, act as a fundamental component on the delivery of the CGA, to enable reduced hospital stay with the aim of returning patients as close

as possible to baseline functioning with discharge to appropriate rehabilitation, transitional care or long term living environment as appropriate.

8.0 The Role of the Speech and Language Therapist within a Frailty Team

As mentioned, the development of frailty services in Ireland in different settings has resulted in a number of teams adopting different models of care. The SLT who work on established teams adopt the model of care specific to their team with their primary focus always being on working with those who have communication and/or swallowing disorders. In some teams a transdisciplinary approach to patient care may also be taken where each discipline is upskilled in all areas to provide a high quality holistic perspective (Choi & Pak, 2006). Specific aspects of the role in this specialist area are discussed below.

8.1 Assessment:

The SLT provides specialist assessment for a person with communication and/or swallowing difficulties. The SLT collaborates with the older person's family and/or carers and MDT members to support and enable optimum levels of functioning. The SLT completes appropriate assessments (e.g. the CGA) and may also hold transdisciplinary roles relating to assessment as discussed previously.

The aims of Speech and Language Therapy assessment are:

- Triage patients suitable for assessment based on the service inclusion criteria.
- Complete a common screening/assessment tool that may require screening areas outside of specific discipline (e.g. polypharmacy).
- Completion of frailty outcome measures, such as the CFS to streamline patients who would benefit from interventions.
- Identify if there is a communication or swallow impairment and the aetiology of same.

- Identify severity of an impairment and advise strategies/interventions to reduce risk including psychosocial aspects of swallowing and/or communication impairments;
- Hypothesise aetiology of the swallowing or communication impairment and prognosis and trajectory of same ie. if acute, chronic or progressive;
- Provision of specific instrumental assessment of swallowing using Fibreoptic Endoscopic Evaluation of Swallowing (FEES) or referral for videofluoroscopy assessment of swallowing as appropriate.
- Identify and place onward referrals where indicated e.g. to neurology, gastroenterology, HSCP colleagues, primary care SLTs.

8.2: Intervention:

Interventions should be tailored to the patients' wishes and values, overall health condition, frailty severity, social circumstances and personal goals. SLTs, working as part of a wider MDT, should ensure a collective and shared approach to leadership to develop a service plan for the patient.

SLTs provide holistic intervention approaches which include:

- Case discussion with the wider MDT to support complex decision making and organise service plans for the older person.
- Provision of personalised communication strategies and rehabilitation
- Provision of communication compensatory strategies in dementia, partner communication training, communication passports and communication support groups as appropriate.
- SLTs may produce an individualised profile of communication skills, strengths and areas of need in conjunction with carers to reduce risk of communication breakdown and subsequent frustration or social isolation.
- Education on vocal hygiene and voice therapy.
- Developing longer term management solutions to continue on-going support for the frail individual ie. augmentative and alternative communication (AAC) systems, family education and training.

- Supporting advanced care planning in relation to personal matters such as health or finances.
- Cognitive stimulation therapy groups may be run by SLTs in conjunction with other team members e.g. occupational therapists.
- Provision of individualised dysphagia rehabilitation programmes to support optimal swallow function.
- Consideration of diet and/or fluid modifications (consistency and/or quantity) to support comfort and reduce the risk of aspiration and/or choking.
- Advice regarding optimising the meal-time environment and addressing positioning, physical and sensory issues.

SLTs can also support the individual with frailty to manage their condition proactively. SLTs have a key role in advocating for and supporting the frail older person to participate in decision making and advanced care planning. This role will become more prominent on frailty teams in the context of the Assisted Decision Making (Capacity) Act (2015). A SLT holds a unique skillset which will support a person with communication needs to communicate their wishes, preferences and values during a capacity assessment. Furthermore, SLTs provide essential information on the communicative competency of the person with frailty in capacity assessments.

Interventions offered should be reviewed regularly to ensure these are in line with the person's personal goals and/or best interest and no distress and/or dissatisfaction or adverse events are a concern e.g. risk of thickening fluids and patient dislike of same which can impact hydration and well-being (O'Keefe et al., 2021). A key focus for SLTs should be early diagnostics and interdisciplinary interventions to help maintain function and delay the progression of symptoms.

8.3 Education and Training:

SLTs should act as a clinical resource in the area of frailty and older person care by providing training and education to students, new graduates and therapists new to working within the area. Education on the role of SLT services for people living with

frailty is required for all stakeholders, including SLTs in training, medical, health and social care professionals, service users and the wider public. The *Irish National Frailty Education Programme* should also be updated to include information on the impact of frailty on Communication and swallowing/FEDs. Evidence suggests that proactive intervention with community dwelling older people and those presenting to acute hospital at risk of frailty can reduce frailty's prevalence and improve patient outcomes (Puts et al., 2017, Cameron et al., 2013). SLTs role within the CGA process and discipline specific interventions supports:

- Upskilling the wider MDT to support transdisciplinary model of care with an emphasis on early diagnosis and improve outcomes for older people with swallow difficulties and communication needs, while ensuring specialised contribution to the team is recognised.
- Support patients to access healthcare treatment and information through supporting the provision of accessible information and promoting a total communication approach.
- Provide individualised specific patient and carer training for communication needs, oral care and swallowing difficulties.
- Maximising communication and/or meal-time environments.
- The SLT also considers the holistic communication network surrounding the client to maximise communication opportunities e.g. social/support groups to support mental health, independent management of long-term conditions, and inclusion.

8.4 Research and Leadership

SLTs currently working in the area of frailty and ageing can make a significant contribution in developing the evidence base and improving the quality of care provided to this population. SLTs should:

- Promote and implement initiatives to ensure advancements of standards.

- Actively participate in frailty network groups to ensure standards are consistent nationally.
- Lead research agendas specifically focusing in the benefit and role of SLT in frailty and ageing.
- Actively appraise the impact of the role of Speech and Language Therapy in the assessment and management of frailty by completing regular audits, service evaluations and/or quality improvement projects within the area for frailty and older person care.
- Engage in the development of national care pathways and service planning for persons living with frailty

To achieve all of these objectives, it is recommended that SLT roles are appointed at a clinical specialist level.

9.0 Specific Speech and Language Therapist skills and competencies for Frailty

This paper does not provide specific competencies for SLTs working in frailty. The National Clinical Care Programme for Older Persons has highlighted the need for developing and implementing core competences for inter-professional working and have set up a steering group which has Speech and Language Therapy representation. SLTs should be aware of local policies in relation to MDT working and ensure they only work within their scope of practice as defined by IASLT and CORU. Engaging in continued professional development in line with IASLT and CORU standards will enable the SLT working in frailty to provide evidence based patient centred care. The SLT should complete specific training modules on frailty, for example:

- *The Irish National Frailty Education Programme* in conjunction with the National Clinical Programme for Older People (NCPOP)
- Online training resources (e.g. British Geriatric Society e-learning frailty module)

10.0 Speech and Language Therapist membership of Frailty teams in Ireland

An audit of the frailty teams in Ireland in May 2022 (See Appendix A) has highlighted the inconsistency in Speech and Language Therapy provision across these teams with varying whole time working equivalents and grades (i.e. senior and clinical specialist) observed. It is acknowledged that this may not be an exhaustive list. Of the 18 identified frailty teams, 30% have no SLT allocation. Of those who have an SLT role, only 36% of these teams have appointed the SLT at a clinical specialist grade. Two teams have basic grade allocations which is significantly below the grade expected. It is the position of IASLT that all frailty teams should have Speech and Language Therapy provision at a clinical specialist level.

There are numerous benefits of providing a Speech and Language Therapy service within a Frailty Team and many risks to excluding the profession from these multidisciplinary teams:

10.1 Benefits of Providing a Speech and Language Therapy Service

- Specialist assessment of communication difficulty to inform differential diagnosis
- Use of supportive communication techniques and strategies to maintain a person's autonomy in decision making.
- Specialist early assessment and management of dysphagia to facilitate oral intake
- Maximise swallowing function and safety to minimize risk of adverse events, including aspiration pneumonia, weight loss, and probable prolonged length of stay.
- Delivery of specific dysphagia and communication education programmes to maximise safety and independence in communication and swallowing.
- Empowering self-management of frailty at home with specialist support from community services and interventions

- Educating carers and families to maximise each person's communication potential to create positive communication exchanges and support safe management of dysphagia (Thompson et al, 2007).
- Contribution to the development of future care planning and decision making, including consent to different aspects of care and decision-making

10.2 Risks of Not Providing a Speech and Language Therapy Service

- Delayed and/or limited access to specialised swallowing and communication assessment which will result in delayed or missed identification of a swallowing and/or communication impairment.
- Without appropriate support to target and maximise swallowing and communication function, the person living with frailty may become prematurely dependent.
- Social exclusion and loss of confidence due to undiagnosed speech, language or communication difficulties.
- Limited opportunity for support/management of communication difficulties, resulting limited access to care, exclusion from decision-making and service planning and limited opportunities for expression of care preferences.
- Without specialist support by an SLT, a person with communication difficulty may demonstrate reduced engagement with therapies, medical interventions and increased frustration and fear due to an inability to communicate effectively.
- Reduced quality of life, psychosocial wellbeing, sense of identity and quality of relationships for the person and their families/carers due to limited opportunities for specialist advice/education on supportive communication. The loss of meaningful interaction and conversation places increases pressure on the caring relationship (Nolan et al., 2002).
- Increased risk of hospital attendances and repeated admissions due to limited access to specialist Speech and Language Therapy services in the community setting. SLTs need to identify swallowing difficulties in a timely manner to avoid

the negative consequences of swallowing difficulties (Namasivayam-MacDonald and Riquelme, 2019).

- A systematic review and meta-analysis completed by Cunha et al., (2019) determined an increased length of stay for frail older adults (13.5 days) compared with pre-frail (10.5 days) and non-frail (8.3 days). A state of frailty at hospital admission is a risk factor for in-hospital mortality, prolonged hospital stays and functional decline at discharge, a risk which is further heightened in the absence of a specialist SLT service to implement timely dysphagia intervention.

11. Future Considerations

Communication and swallowing impairment in frail older adults can lead to adverse outcomes and have a significant impact on overall quality of life. Specialist intervention and training from experienced SLTs should be prioritised in frailty attuned services. Emphasis should also be placed on the training of healthcare professionals to identify those at risk of swallowing and/or communication difficulties and refer to SLT for timely specialist intervention.

SLTs working in this specialist area should actively appraise and promote the role and contribution of SLT in frailty assessment and intervention at local and national level, to ensure equal access to Speech and Language Therapy provision for people living with frailty. This document also highlights the need for further development of the evidence base. Further research should focus on the patient benefit of specialised Speech and Language Therapy intervention within frailty teams to support further involvement of SLT in national frailty services.

Throughout this document a number of recommendations have been made. These key recommendations are listed below

1. Equal access to Speech and Language Therapy provision for people living with frailty is critical, regardless of geographical area. This will be achieved through ensuring Speech and Language Therapy is included on all frailty intervention teams across all service areas, such as emergency departments and/or community services.
2. SLTs working in the area of frailty and ageing are specialists within the field and should be recognised as such. Given the advanced knowledge, clinical reasoning and decision making required to work in this area, IASLT recommends SLT roles on teams are filled at a Clinical Specialist grade.
3. SLTs should actively promote their role and contribution in the area of frailty and ageing. It is recommended that SLTs should be consulted and involved in the development of all related national care pathways and education programmes. The *Irish National Frailty Education Programme* should be updated to include information on the impact of frailty on communication and swallowing/FEDS
4. Frailty should be assessed and managed in accordance with best practice guidelines. The Comprehensive Geriatric Assessment is considered the gold-standard in frailty management. It should be provided in a multidisciplinary setting, including access to specialist SLT assessment and management of swallowing and communication impairments. This will maximise the quality of life for people presenting with frailty and their families.
5. SLTs currently working in the area of frailty can make a significant contribution in developing the evidence base and improving the quality of care provided. SLTs should continually monitor and evaluate the impact of Speech and Language Therapy provision in frailty teams using audits, service evaluations and quality improvement initiatives. Further national research is needed to provide evidence of the added value of Speech and Language Therapy provision in frailty.

Appendix 1:Audit of Existing Frailty teams May 2022

It is acknowledged that this may not be an exhaustive list. Efforts have been made to ensure the accuracy of this information however there may be unintentional omissions or inaccuracies.

Setting	Location of Frailty Team	Speech and Language Therapist Allocation	Grade	Whole Time
Mater Hospital	Emergency Department	Yes	Clinical Specialist	1.0
University Hospital Kerry	Emergency Department	Yes	Clinical Specialist	1.0
Cork University Hospital	Emergency Department	Yes	Clinical Specialist	1.0
South Tipperary	Integrated Care	Yes	Clinical Specialist	1.0
Roscommon University Hospital	Medical Assessment Unit	Yes	Senior	0.8
Tallaght University Hospital	Emergency Department	Yes	Senior	1.0
Cavan General Hospital	Emergency Department	Yes	Senior	0.5
Beaumont Hospital	Emergency Department	Yes	Senior	1.0
Regional Hospital Mullingar	Emergency Department	Yes	Senior	0.5
Tullamore General Hospital	Emergency Department	Yes	Senior	0.5
Wexford General Hospital	Emergency Department & AMAU	Yes	Basic Grade	0.5
St. Columcille's Hospital, Loughlinstown	AMAU	Yes	Basic Grade	0.5
St Lukes Hospital, Kilkenny	Emergency Department	No		
St James Hospital	Home First Team	No		

Waterford Regional Hospital	Emergency Department	No		
Limerick University Hospital	Emergency Department	No		
Our Lady of Lourdes Hospital, Drogheda (OPAL)	Emergency Department linked to outpatient service	No		
Naas General Hospital	Emergency Department	No		

Appendix 2: Working Group Membership

This position paper has been written on behalf of the Irish Association of Speech and Language Therapists by members of the IASLT Working Group for People Living with Frailty:

- **Orla Boyle (Chair),** Senior Speech and Language Therapist, Gerontological Emergency Department Intervention (GEDI) Team, Tallaght University Hospital.
- **Anne Claffey,** Senior Speech and Language Therapist, Mullingar Regional Hospital, Mullingar. Co. Westmeath
- **Aifric Conway,** Senior Speech and Language Therapist, St. Columcille's Hospital, Loughlinstown, Co. Dublin previously Senior Speech and Language Therapist on the FIT team, Beaumont Hospital, Dublin
- **Áine Murphy,** Clinical Specialist Speech & Language Therapist, Frailty Intervention Team, Mater Misericordiae Hospital, Dublin
- **Anne Dolan,** Senior Speech and Language Therapist, HSE Cavan/Monaghan CHO1
- **Vanessa Gilleran**, Senior Speech and Language Therapist, Roscommon Frailty Intervention Team, Roscommon University Hospital
- **Maria Cremin**, Clinical Specialist Speech and Language Therapist, Frailty Intervention Therapy Team, University Hospital Kerry
- **Jennifer Maher,** Jennifer Maher, Clinical Specialist Speech & Language Therapist, South Tipperary Enablement Programme for Older Persons (STEP), Our Lady's Campus Cashel and Tipperary University Hospital, Clonmel, Co. Tipperary

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