Prevocational Training Term Description: Sub-Acute Geriatric Medicine

Date of term description version	April 2024
Date term last accredited	March 2021

Term Details

Facility	Canberra Health Services				
Term name*	Sub-Acute Geriatric Medicine				
Term specialty*	Internal Medicine				
Term location	University of Canberra Hospital				
Classification of clinical experience in term* (Highlight a maximum of 2)	Un-differentiated illness patient care	Chronic illness patient care	Acute critical illness patient care	Peri-operative/ procedural patient care	Non-direct clinical experience (PGY2 only)
Is this a service term? Service term is a term with discontinuous learning experiences including limited access to education program or limited access to regular within-unit learning activities or less/ discontinuous overarching supervision (e.g., relief term or nights with limited staff).				Yes	No
Term duration (weeks)*	12-14 weeks				
Term accredited for	PGY1 and PGY2			PGY2 Only	
Total number of prevocational training places	**2**	**Limitations/conditions** In some terms, the CRMEC will make limitations (e.g. skills mix or minimum numbers)		The RMOs must be informed of their specific term supervisor prior to commencement in the training term	

Term Supervision

Term Supervisor (name and position) Term supervisor is responsible for conducting term orientation, discussing the PGY1/2's learning needs with them, and conducting and documenting a midterm and end-of-term assessment. Term supervisors must complete mandatory training and commit to a code of conduct outlining their responsibilities.		Dr Manoj Saraswat Dr Sabari Saha Dr Malith Ramasundara Dr Hasibul Haque
Clinical team supervision	**Primary/Immediate Clinical Supervisor (name and position)** Clinical supervisor is a consultant or senior medical practitioner (PGY3+) with experience in managing patients in the relevant discipline. They are readily accessible for support, provide	Dr Manoj Saraswat Dr Muhammad Choudhry Dr Kyaw Thu Dr Nuttaya Chavalertsakul Dr Nyoka Ruberu Dr Sasikala Selvadurai Dr Sabari Saha

	education, conduct EPAs and contribute to assessment.	Dr Hasibul Haque Dr Emily Walsh Dr Malith Ramasundara Dr Zita Hilvert-Bruce JMOs are allocated to one of the primary clinical supervisors listed above who is generally one of the consultants leading their allocated team.	
	Additional Clinical Supervisors (positions) Position of others (PGY3+) responsible for day-day clinical supervision, including after-hours supervisors.	Registrars and Advanced Trainees rotate through the unit and provide day-to-day supervision.	
	EPA Assessors Name and position of others (PGY3+) who have completed training to undertake EPA assessments.	All Clinical supervisors in this term can undertake EPAs including registrars who have undertaken EPA training.	
Clinical Team Structure* Highlight the team model, identify and describe the clinical team structure including how PGY1/2s are distributed amongst the team.	Ward Based	Team Based	Other
	In this term JMOs will be allocated to Majura ward (a 30-bed subacute Geriatric rehabilitation unit) at the University of Canberra Hospital (UCH). In addition, two consultants and one registrar (usually and Advanced Trainee in Geriatric Medicine) will also be allocated to Majura, UCH. One JMO will work alongside the registrar and one of the consultants to care for half of the patients on Majura ward and the other JMO allocated will also work with the registrar and the other consultant to care for the other half of patients on Majura ward.		

Commencing the Term

Requirements for commencing the term* If there are any specific requirements (e.g., courses, procedural skills or e-learning requirements) provide details of how the prevocational doctor will receive this training/will be assessed.	No specific extra skills related to this position required.
Orientation Include detail regarding the arrangements for orientation to the term, including who is responsible for workplace orientation and any additional resource documents such as clinical policies and guidelines required as reference material. **The term supervisor is responsible for orienting the JMO to the term requirements and clinical expectations within the first week of starting the term**	Orientation will be provided by the term supervisor (or one term supervisor for both JMOs) at 8:00 am on the first day of the term (usually a Monday) in Majura ward. JMOs will be expected to get a complete hand-over of the patients they will be looking after from the preceding JMO. Please arrange a meeting with the term supervisor to discuss term expectations and set performance goals within the first two weeks of starting the term.

Overview of the Unit

The role of the unit and range of clinical services provided, including an outline of the patient case mix, turnover and how acutely ill the patients generally are	The Geriatric Medicine Unit, within Rehabilitation Aged and Community Services (RACS) provides a wide range of services spanning the Geriatrics Medicine wards, the Orthogeriatric Unit and the Community Geriatric (RADAR) Unit at the Canberra Hospital, as well as the Subacute Geriatric Unit (SAGU) at University of Canberra Hospital (UCH). This unit also provides geriatric consultation services to other specialties units in both Campuses. **Subacute Geriatric Medicine Unit (these positions)** • This comprises a 30-bed unit in Majura ward at UCH. Majura ward is managed by 2 consultants, a registrar and 2 JMOs (these positions). • The Unit provides step-down care of elderly patients who are severely deconditioned due to recent acute illness. • It provides slow stream rehabilitation and multidisciplinary input to ensure the continuity of the patients' wellbeing and safe discharge planning. • The patients are usually referred from the Geriatric wards and orthogeriatric service at the Canberra Hospital. They may also be referred from North Canberra Hospital, private and interstate hospitals community teams and other specialties. **Acute Geriatric Medicine** The following is provided for information only as JMOs will often receive referrals from this team and may interact with this team. There are 4 separate JMOs allocated to this team, located at The Canberra Hospital (TCH). • The Unit comprises 2 wards: 11A and 11B. • There are two teams (A and B). Each team includes 3 consultants, 2 registrars and 2 JMOs and the teams separate into A1, A2, B1 and B2. • The Unit provides comprehensive, patient-centered multidisciplinary diagnostic approach to improve the patient's medical, psychological aspects and functional capacity focusing on maintaining independence. • The aim is to develop a coordinated management plan to ensure a safe discharge with appropriate supports. **Community Geriatric Unit (including RADAR service)** The following is provided for information only as JMOs will often receive referrals from this team and may interact with this team. There is one separate JMO allocated to this team, located between TCH and Mullangarie Unit. • This service provides comprehensive geriatric specialist service for elderly patients referred by GPs and Discharge Liaise team of The Emergency Department of The Canberra Hospital. • This unit is managed by a consultant, a registrar and a JMO. • It also provides follow up of the management plan for those elderly patients discharged recently from various specialist units in The Canberra Hospital. • The JMOs in this team also provide medical support for patients in Transitional Therapy and Care Program (TTCP): The program has 15 in-

	patient beds at Mullangarie Unit, Red Hill. • The JMO attached to this Unit is expected to assist with the management of in-patients at TCH when not at Mullangarie. The Geriatrics department is also involved in the education of medical students.
Clinical responsibilities and tasks of the prevocational doctor Provide an overview of the routine duties and responsibilities	**GERIATRIC PATIENT ADMISSIONS** • A Geriatric Medicine admission is a comprehensive assessment that includes: ○ Detailed history of the presenting complaint, including any corroborative history from caregivers or informants. ○ A full medication history and documentation of home medications ○ Detailed social history (education level, past occupation, role of relevant family members, formal and informal care providers, services and ACAT approvals, Enduring Powers of Attorney (EPOA) or Guardian(s)) ○ Details of baseline function including instrumental and personal activities of daily living ○ Cognition ○ Specific attention to continence, falls, osteoporosis. ○ Resuscitation status and goals of patient care • All patients must have a complete admission done including. ○ A medication review – including indication and need for ongoing prescription / contraindications. ○ Medical issues list. This list should be updated on DHR as active hospital problems being addressed. ○ Formulation of a problem-oriented management plan ○ Screening blood tests including TFT, B12/folate, LFTs, PTH, Vit D, Ca/Mg/PO4 if not done recently. ○ Where relevant assessment of falls risk, delirium (Confusion Assessment Method [CAM], cognition (Mini-mental state examination [MMSE], Rowland Universal Dementia Assessment Scale [RUDAS], Montreal Cognitive Assessment [MoCA] etc.), mood (Geriatric Depression Scale [GDS]), continence, nutrition, pressure area and medication review. ○ Goals of care discussed on admission and patient wishes reflected on DHR. ○ Referral to appropriate allied health team • The aim of the admission is to: ○ Complete a comprehensive geriatric assessment. ○ Optimise physical function. ○ Prevent complications and functional decline. ○ Formulate and action a comprehensive discharge plan.

- An aged care admission:
  - Takes time.
  - Is crucial to formulating a complete and accurate picture of the patient.

WARD ROUND AND PROGRESS NOTES

- Progress notes should be documented clearly as they are vital for:
  - Clear communication to other team members
  - Giving clear instructions to afterhours staff and updating the DHR handover as required
  - Treating team reflection on diagnosis, investigations, and progress
  - Used for medico-legal purposes.

- Ward round notes should detail:
  - All members of the team present during the clinical review (including consultant and whether it is an **initial** or **subsequent** review). Please use smart text in DHR to assist and the built-in prompts. If you wish to use your ow template, please include smart text **@ACTIPCHARGING@**
  - Problem list should be reviewed at each clinical review of a patient and updated. Resolved items should be marked as resolved and new problems added as they arise.
  - New information gathered, issues list, examination findings, decisions made, plan for ongoing care.
  - Please always take note of patient's observations, fluid intake, bowel chart and document when intravenous cannulas and indwelling catheters inserted.
  - Investigation results
  - Changes in a patient's condition
  - Changes in a patient's management especially to a palliative approach
  - Discussions with patients, family members and GP
  - Issue's list should be updated daily.
  - Goals of care to be updated if not already done.

MEDICATION CHARTS

- Please ensure home medications are reviewed for all patients and reconciled appropriately with inpatient medication list.
- Please ensure an indication is documented for each medicine.
- For antibiotics requiring
- AMS codes – please ensure this is done in a timely fashion – before the weekends and public holidays.

CONSULTS FROM OTHER SPECIALTY TEAMS

- These MUST be requested by 1300hrs, at the latest to enable the registrars from other units' time to see the patient on the same day. Please place the request through DHR as an order then phone the on-call person for that team. The order request should contain adequate detail for the consultation to be performed.

DISCHARGE SUMMARIES

- Please review the discharge medication list prior to completing the discharge summary. A discharge summary must be completed for all patients, including

	those who are deceased. Discharge summaries should be completed by at least the day prior to discharge date for all patients. • All discharges need to be completed before transfer to UCH. • **Purpose of discharge summaries:** • Summary of inpatient events for the hospital file and coding • A clear list of discharge medications • Details to the general practitioner listing issues for ongoing care. • Plans for future care including follow-up appointments. • **Tips for a good discharge summary** • Address issues dealt with and what was done about each rather than a chronological summary. • Limit investigation results to the most important ones and relevant to ongoing care and recent basic blood tests at time of discharge • Include cognitive assessment (e.g., MMSE, RuDAS, MoCA, ADAS-Cog, Addenbrooke's, Neuropsychology assessment etc.) • Include allied health input and their recommendation. • Include functional (ADLs) and mobility changes at the time of the discharge. • Comment on any medication changes made and why. • For drugs requiring authority (e.g., Olanzapine, Alendronate, Donepezil) ensure provisions for ongoing prescribing are included. • Clearly document plans for medication (e.g., Oxycontin – wean as pain improves) • Make note of any medication NOT started (e.g., Warfarin in a patient with AF and risk of bleeding) or not to be restarted. • Include Resuscitation orders, Advanced Care Directives, and details of Enduring Power(s) of Attorney • Include discharge destination (home, rehabilitation, other hospital, or nursing home) **DEATH CERTIFICATION** • The details of the diagnosis of patients who are receiving end of life care should be documented in the progress notes and handed over to afterhours JMOs. • The hand over should include the diagnosis of the death and issues leading to the death. • The cause of death as listed on the death certificate must be discussed with the admitting consultant or registrar. • Discharge summary for each death should be completed within 24 hours of the death. • **A phone call to the patient's GP is essential on discharge from hospital especially:** • In the event of a patient's death, as relatives will usually consult the GP and will expect them to be fully aware of the circumstances. • If you would like the GP to see the patient within a week • If there are complex or significant issues to be followed up on • If there have been significant changes to medications
Work Routine Provide an overview of the work routine	Work routine and tasks are outlined in more detail in the Rover guide.

Clinical handover procedure Provide an overview of the handover procedure and expectations in this training term	• HERO Handover – Daily – 0800hrs and 1600hrs – Majura Ward Doctor's Room on Namadgi ward. JMOs must attend HERO handover meetings. • SNAP Shot Meetings – Monday 0930hrs, Thursday 0930hrs – Majura Ward Meeting Room. JMOs must attend SNAP shot meetings. • MDT MEETING - Tuesday – 1415hrs to 1530hrs. Registrar and resident to present active issues of each patient. **WRITTEN HANDOVER - DHR** • It is advisable the teams update the handover documentation (Situation, Background, Assessment and Recommendation) in DHR. The Hospital Course should also be updated regularly as this will assist completion of the discharge summary for long-staying patients.
Safety	OH&S, occupational violence and safety in pregnancy are detailed in the JMO Handbook. The University of Canberra Hospital supports Speaking Up For Safety of patients and staff.
Opportunities for Indigenous Health	Aboriginal and Torres Strait islander peoples may present as patients within this term and JMOs will be able to engage the support of the Aboriginal Liaison Officer as required for patients and their families and improve their knowledge, and skills around cultural safety.

Education, Learning and Assessment

Term Learning Objectives
List the term-specific learning objectives*
	CLINICAL MANAGEMENT:
	On completion of the term, the JMO is expected to:
	• Have developed understanding and competency in the assessment and management of older patients.
	• Manage multiple complex medical, surgical, and psychosocial issues.
	• JMOs will be expected to understand and manage the following major geriatric syndromes:
	  ○ Delirium
	  ○ Dementia
	  ○ Continence
	  ○ Falls and osteoporosis
	  ○ Polypharmacy
	  ○ Functional assessment
	  ○ Wound management with an emphasis on pressure ulcer prevention
	  ○ Preventative management in the elderly including osteoporosis treatment
	  ○ Legal issues: e.g. competency assessment and duty of care

<table>
<tr><td></td><td colspan="4">JMOs will be expected to use various cognitive assessments e.g. MMSE, RUDAS, Addenbrooke's Cognitive Assessment and depression (GDS).</td></tr>
<tr><td>Detail education and research opportunities and resources <u>specific to this training term</u> that will be available to the JMO during the term.
Formal education opportunities should also be included in the unit timetable</td><td colspan="4">General Mandatory Education
• All interns are expected to attend the Tuesday afternoon teaching program. This is a requirement of CRMEC. The period from 1430-1600 on Tuesdays is protected time for JMOs.
• RMO teaching is Thursdays 1400-1500. This is protected time for RMOs.
• Venue and topics are confirmed by email earlier in the day. JMOs are expected to join by Microsoft Teams from UCH rather than in person.

Grand Rounds
All PGY1/2 are encouraged to attend Grand Rounds on Wednesdays. There may be occasions when the Consultant/Registrar is required to present on behalf of the Unit. The JMO may be asked to assist by presenting a case prior to the registrar or consultant presentation.

Term-Specific Training
• Unit Education Meeting – Tuesday – 1230hrs – Live streamed from TCH Main Auditorium to Tuggeranong Meeting Room, UCH on Channel 51
o Once a month, a Morbidity and Mortality Meeting is held in place of the Unit Education Meeting.
• RMO Teaching – Friday – 1245hrs - Brindabella, UCH

Educational Resources:
A list of common geriatric syndromes is listed in the practical guide. Further reading is also included.
The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) website at: <u>http://www.anzsgm.org/vgmtp/</u> covers the following topics:
• Delirium
• Dementia
• Falls and Balance
• Continence</td></tr>
<tr><td>During this term prevocational doctors should expect to complete the following EPAs* (Highlight all that apply)</td><td>EPA 1
Clinical Assessment</td><td>EPA 2
Recognition and care of the acutely unwell patient</td><td>EPA 3
Prescribing</td><td>EPA 4
Team communication – documentation, handover and referrals</td></tr>
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Term/Unit Timetable and Indicative Duty Roster*

Include the **start time** and **finish times** of the shifts the prevocational doctor will be rostered to. Show the activities that the prevocational doctor is expected/rostered to attend – these include all **education opportunities** (both training facility-wide and term specific), ward rounds, theatre sessions, inpatient time, outpatient clinics, shift handover, morning handover from hospital night team, afternoon handover to hospital's after hours team. Please include the approximate times of activities wherever possible. If there are extended shifts or evening shifts attach four weeks of rosters for the whole team.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8.00 HERO Hand-Over Meeting 9.00 Consultant Ward Round 10.30 SNAP Shot Meeting 12.30 HERO Hand-Over Meeting 13.00 Ward Word 16.00 HERO Hand-Over Meeting	8.00 HERO Hand-Over Meeting 9.00 New Patients reviewed with consultant Registrar Ward Round 10.30 Ward Work 12.30 HERO Hand-Over Meeting 13.00 MDT Meeting 14.30-16.00 Intern Teaching 16.00 HERO Hand-Over Meeting	8.00 HERO Hand-Over Meeting 9.00 New patients reviewed with consultant Registrar Ward Round 12.30 HERO Hand-Over Meeting Grand Rounds 13.00 Ward work 16.00 HERO Hand-Over Meeting	8.00 HERO Hand-Over Meeting 9.00 Consultant Ward Round 10.30 SNAP Shot Meeting 1200-1300) HERO Hand-Over Meeting 13.00 Ward work MEU JMO Teaching 1400-1500 1600 HERO Hand-Over Meeting	8.00 HERO Hand-Over Meeting 9.00 New patients reviewed with consultant Registrar Ward Round 12.30 HERO Hand-Over Meeting RMO Teaching (Brindabella) 13.00 Ward work 16.00 HERO Hand-Over Meeting		

Patient Load Average Per Shift	Average 20 patients per JMO	
Overtime	Rostered overtime hours/week	4-8
	Unrostered overtime hours/week	4
After hours roster Does this term include participation in hospital-wide afterhours roster? If so advise: • Frequency of after-hours work, including evenings, nights and weekends (hours/week and weekends/month) • Onsite supervision available after hours If the JMO will be working outside this term on afterhours roster, provide details of the after-hours work and a four-week roster. The designated after-hours supervisor should be listed in the supervisory team.	PGY1/2 will be expected to work on the after-hours roster. Geriatric Medicine is part of Med Pod 2. All rostered overtime over weekends or late shifts during the week fall under Medical Pod 2. Weekend and evening shifts the pod is 2.1, which covers geriatrics. 2.2 is cancer and ambulatory services. For night shifts 2.1 and 2.2 merge to a single med pod 2 doctor. A week of night shifts may also occur during your term. The standard process is 7 nights rostered, followed by 7 days off – however the JMO is on call for days 6 and 7, unless taking annual leave after the days off. Alternatively, arrangements can be made to allow for leave provided adequate notice is provided (often prior to the start of term). Within your Pod you may have one or more weeks of evening shifts and a week of night shifts. For the evening shift you will receive handover from all PGY1/2 within Med Pod 2. As an evening PGY1/2 you may be called to commence work earlier in the day should the patient load require it. JMOs will also be expected to do approximately three to five Med Pod 2 weekend/public holiday shifts throughout the term (either Medical Pod 2.1 or Medical 2.2). By working after hours shifts, you will be part of a team providing 24-hour care for patients within your Pod. You will also be more aware of the specialist and registrar plans as you will be working in a small unit of specialties on a day-to-day basis. You will participate in more focused handover and utilise relevant discharge/case mix information more efficiently and you will be able to follow up relevant investigations and consultations more closely with a working knowledge of the various plans for each patient from their respective day teams. After Hours Support/Supervision is provided by the ward medical registrar and, if necessary, the on-call specialty physicians. As a working unit you will be expected to make additions to the discharge summaries of patients within a pod as important events take place over a twenty-four hour period to provide better communication with general practitioners and other external care givers. You will be able to provide up to date information to staff specialists during evening/afternoon ward rounds as required and participate in any bed side teaching conducted by the other specialties within your pod where possible. You may wish to also review the Med Pod 2 term description.	

List Other Relevant Documentation
Intern job description RMO job description JMO Handbook