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**JOB DESCRIPTION**

**Job Title:** ST1 and ST2

**Speciality:** Geriatric medicine/ general practice – Acute care of older people and community geriatric medicine (intermediate care)

**Duration of Post:** 6 months as part of the GP Specialist Training Programme.

**Base:** Salford Royal NHS Foundation Trust.

**Responsible to:** Consultants in Ageing and complex medicine (ACM)

**Working Hours:** 40 hours/week. 4 days Ageing and complex medicine ward, one day intermediate care unit.

**On-call: nil at present**

**Duties of the post- Ageing and complex medicine ward**

* Daily multidisciplinary board round
* To review frail older adults identified as requiring CGA with a consultant in Ageing and complex medicine.
* To complete clinical tasks associated with this review
* To liaise with members of the multidisciplinary team both on the unit and with the wider multidisciplinary teams including primary care/ intermediate care and multidisciplinary groups/ care co-ordinators
* To take a proactive approach to discharge planning for frail older adults including discussion with families regarding appropriate transitions of care
* Participation in regular weekly quality improvement/ clinical microsystems work focused on continual improvement of our services

**Duties of the post- intermediate care**

**Duties of the post- Community geriatric medicine**

* The post would involve
* One day per week an intermediate care (IMC) units in conjunction with a consultant in ageing and complex medicine.
* The weekly IMC attendance would include being part of the MDT meetings with nursing, social care, therapy professionals.
* A ward round/ review of patients in the units and their medical conditions. How clinician experience is different reviewing patients in a community as opposed to an acute setting
* There would be supervised discussion around DNACPR and advance care planning.
* Experience of comprehensive geriatric assessment in a community setting.

**Areas of competence mapped to the curriculum**

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|  | **Curriculum area** | **Learning opportunities** |
| **1** | Primary care management   * Working with colleagues and in teams. * Clinical management. | * MDT approach with daily MDT in ward area involving doctors, nurses, therapists, social work, pharmacy. * Working with MDT in intermediate care setting |
| **2** | Person centred care   * Communication & consulting skills | * Multiple opportunities to take histories from older patients with cognitive and sensory impairment. This will highlight importance of collateral histories and involvement of families in care. |
| **3** | Specific problem-solving skills   * Data gathering interpretation. * Making a diagnosis/making decisions | * Daily review of investigations with senior support available for decision making and how this may differ when dealing with frail older adults. * Wide range of exposure to medical investigations in both primary and secondary care. |
| **4** | Comprehensive approach   * Managing medical complexity | * Patient population will be frail, have complex co-morbidity and polypharmacy. Opportunity to participate in comprehensive geriatric assessment (CGA) |
| **5** | Community orientation | * Intermediate care units offer a community based setting to participate in comprehensive geriatric assessment. * Exposure to older people presenting to acute care settings, exploring reasons for this, prompt discharges and linking with community teams |
| **6** | Holistic approach | * Working in multidisciplinary teams who take a holistic approach to patients who are frail and in many cases approaching end of life . Focusing on physical, mental and spiritual health and quality of life. Including discussion with family/ carers where appropriate. |

**Learning opportunities linked to the contextual and clinical statements**

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| **2.01The GP consultation in practice** | Learning opportunities |
| * Consultation and communication skills | Multiple opportunities to take histories from patients and their families including from patients with cognitive impairment.  Supervised opportunities for communication in difficult/ sensitive areas such as end of life care. |
| * Ethics and values | Opportunities across several areas including end of life, resuscitation decisions, advance care planning, mental capacity assessment. |
| * Promoting equality and valuing diversity | Promoting equality for frail older people including those with psychiatric illnesses and/ or cognitive impairment |
| * Carers relatives and families | Multiple opportunities for discussions with families and their involvement in care which is key to decision making for frail older adults. Opportunities to observe senior clinicians including allied health professionals interact with carers, relatives and families both in person and in telephone consultations |
| **2.02 Patient safety and quality of care** |  |
| * Clinical governance and quality improvement | We have a strong culture of quality improvement in Salford Royal. The trainee would be expected to complete one QI project during their post. These include projects on transition of care and handover to general practice |
| * Information management and technology | The post would include use of electronic patient records both with the hospital and the care homes practice. |
| **2.03 The GP in the wider clinical environment** |  |
| * Evidence based practice and statistics | Our quality improvement work is based on core NICE clinical standards for health and social care. The post holder would learn about statistics and measurement techniques used in QI projects such as run charts |
| * Research and academic activity | Both the ACM wards and intermediate care regularly submit academic work including journal articles and posters for clinical conferences |
| * Teaching and learning skills | The ACM team has year 4 students from Manchester medical school on a regular basis and delivers high quality training as recognised by the undergraduate department. The trainee would assist in the teaching of medical students under the supervision of consultants who have expertise in the field of medical education. |
| **3.03 Care of acutely ill people** | The ACM wards involve the care of acutely unwell older adults– mainly focusing on patients presenting with frailty syndromes such as falls, delirium and mobility problems. It will also involve liaison with community facing services such as rapid respond teams.  Within intermediate care review of potentially unwell patients using clinical skills to see if they are well enough to be managed in a community setting or if they require admission to hospital. |
| **3.18 Care of people with neurological conditions** | The trainee will gain experience in common neurological issues affecting older adults including fits/ faints/ collapses, dizziness, vertigo and Parkinson’s disease. This will be gained acutely on the ACM wards and in intermediate care units |
| **3.05 Care of older adults** | The trainee will gain experience in all of the domains outlined in this section specifically including; falls, delirium, continence, polypharmacy, dementia and end of life care. |
| * Fitness to practice | Recognition that intensive treatments or invasive investigations may not be the most appropriate course of action in frail older adults. Trainees would gain experience in these complex decisions in liaison with families, GPs and consultants |
| * Maintaining an ethical approach | Opportunities across several areas including end of life, resuscitation decisions, advance care planning, mental capacity assessment, deprivation of liberty as well as death certification/cremation and discussion with coroners officers. |
| * Communication and consultation | Multiple opportunities to take histories from patients and their families including from patients with cognitive impairment.  Supervised opportunities for communication in difficult/ sensitive areas such as end of life care. |
| * Data gathering and interpretation | Trainees would gain experience in assessing prognosis for frail older adults including those currently stable in the care home population and those who are acutely unwell.  Trainees would gain experience in assessing for polypharmacy and the complications of this in conjunction with pharmacists on both the ACM wards and in IMC.  Trainees would gain experience in the management of common older age related conditions such as falls, delirium, Parkinson’s disease dementia and cancer.  Trainees would gain an understanding of the various local services that care for older people |
| * Managing medical complexity | Trainees will gain experience in the multidisciplinary management of older patients both in the acute hospital and in the community setting |
| * Making decisions - Holistic decision making and problem based approach | Trainees would gain experience in the evidence based practice of comprehensive geriatric assessment as part of a multidisciplinary team. They will gain experience in the functional assessment of older people and the importance of producing holistic problem lists with management plans that cross primary secondary and intermediate care services. |
| * End of life care | Trainees would gain experience in complex decision making at end of life as well as recognition and management of patients at the end of life. |

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|  | **Curriculum Area** | | **Learning opportunities** |
| **CONTEXTUAL STATEMENTS** | | | |
| **1** | **Knowing yourself** | | * Patient centred medicine in a variety of clinical settings including outpatient clinic and the ward. |
| **2**  **3** | **Patient Safety and Quality of Care**  **The GP in the Wider Professional Environment** | | * The Department is committed to driving improvement and the trainees are encouraged to be involved in QI and audit projects. * Participation in bi-monthly clinical governance meetings and will have the opportunity to present audit and QI projects as well as Morbidity and Mortality reviews. * The trainee will get insight into community based practice and rehabilitation. |
| **4** | **Enhancing professional knowledge** | | * Weekly Tuesday lunch-time meeting with Ageing & Complex Medicine Department. * Trainees will be supervised on a 1:1 basis during both COPE and IMC attachments allowing for excellent feedback on clinical skills, reasoning and decision making * Weekly MDT within IMC with health a social care professionals. * Opportunity to have supervised discussions around end of life decisions and plans * Opportunity to attend specific end of life training run by the end of life facilitators including advance care planning and universal DNACPR decision making. |
| **CLINICAL STATEMENTS** | | | |
| **1** | Promoting health and preventing disease. | * Management of chronic diseases and promotion of health in frail older adults * Review of older people presenting to acute care and reasons for this – can further admissions be prevented. | |
| **2** | Care of acutely ill people | * Acute care of older people presenting to the emergency department and EAU. * Triage and clinical review of acutely unwell intermediate care patients including strategies for admission avoidance | |
| **3** | Care of Children and Young People | * This will not be covered in this placement. | |
| **4** | Care of Older Adults | * This placement is an excellent opportunity to enhance knowledge of the care of older people working with specialist teams across the primary/ secondary care. * Complex discharge planning. * End of life care * Mental and physical health problems * Application of comprehensive geriatric assessment * Working with the MDT to deliver evidence based best practice. | |
| **5** | Musculoskeletal problems | * Management of patients presenting with falls and fractures that do not require orthopaedic intervention ( vertebral fractures/ humeral fractures) * Assessment and management of pain in older people. * Working with therapy teams to improve and maintain mobility including use of mobility aids/ equipment. | |
| **6** | End of Life Care | * This will incorporate discussion of end of life preferences, creation of advance care plans, discussion and creation of U-DNACPR orders and management of patients who are the end of life with the care homes, working with our specialist teams. | |
| **7** | People with mental health problems and intellectual impairment. | * Early identification and management of patients with delirium. * Review of pateinst with depression, delirium and dementia. | |
| **8** | Cardiovascular health  Respiratory health  Digestive health  Neurological problems  Skin problems  Metabolic problems | * Acute and chronic disease management of general medical problems in frail older patients in both an acute and community setting. This includes assessing how quality performance indicators are applied to a frail older population. * Assessing and managing malnutrition in this vulnerable group * Management of acute problems associated with frail older adults including falls, delirium, reduced mobility and urinary and faecal incontinence | |