****

**JOB DESCRIPTION**

**Job Title:** ST1 and ST2

**Speciality:** Interface geriatrics/ general practice – Acute care of older people and care home medicine

**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) and General practitioners in Salford care homes practice. (ACM consultant would be educational supervisor)

**Working Hours:** 40 hours/week. 4 days in acute geriatric unit, 1 day in Salford care homes practice.

**On-call: nil**

**Duties of the post- acute care of older people (COPE unit)**

* Daily multidisciplinary board round at 0830 to identify patients requiring comprehensive geriatric assessment (CGA)
* 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
* To identify and review frail older adults presenting to the emergency departments under the supervision of a consultant in ageing and complex medicine
* Participation in our regularly weekly quality improvement/ clinical microsystems work focused on continual improvement of our services

**Duties of the post- Salford care homes practice**

* The trainee would be paired with a general practitioner based at Salford care homes practice. The GP’s have a list of care homes that they visit each week. The trainee would accompany the GP on their weekly rounds and develop a case load of patients who they would manage under supervision of the GP for their 6 month placement.
* This would involve chronic disease management in a complex frail older population including both physical and mental health issues. The trainee would be supervised in discussions about end of life care including the assessment of mental capacity, issues around Deprivation of liberty orders, the creation of advanced care plans discussions around resuscitation decisions and activities following death such as discussions with coroners officers, death certification and cremation forms.. Other opportunities within the practice include spending time with a specialist dementia nurse, attending MDT with consultants in old age psychiatry, discussions with consultant geriatricians and medication reviews with the practice pharmacist. There would be opportunities to undertake clinical audit and quality improvement projects within this area
* The trainee would spend some time as part of the acute triage team for Salford care homes practice, supervised by a GP. This would involve being part of the team that manages acute calls to the practice, triaging and reviewing patients including admission avoidance strategies.

**Areas of competence mapped to the curriculum**

|  |  |  |
| --- | --- | --- |
|  | **Curriculum area** | **Learning opportunities** |
| **1** | Primary care management   * Working with colleagues and in teams. * Clinical management. | * MDT approach with daily MDT in COPE area involving doctors, nurses, therapists, social work, pharmacy. * Working with MDT in care homes – ACM consultants, pharmacists, old age psychiatry teams. |
| **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 | * Salford care home practice offers a unique opportunity to experience a specialised primary care service dedicated to managing the complex needs of care home residents. * 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**

|  |  |
| --- | --- |
| **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 the COPE unit with weekly microsystems/ QI meetings and several PDSA cycles ongoing at any stage. 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 COPE unit and SCHP regularly submit academic work including journal articles and posters for clinical conferences |
| * Teaching and learning skills | The COPE unit 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 COPE unit post involves the care of acutely unwell older adults on the EAU and in the emergency department – 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.  At Salford care homes practice the post would involve taking part in the acute, on the day triage of care home residents under the supervision of a general practitioner. This will include telephone triage and acute visits to decide on management and escalation decisions in the context of frail care home residents, including supervised decisions for end of life care where appropriate. |
| **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 COPE unit and chronic disease management via the care homes practice supported by GPs and community geriatricians. |
| **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 EAU and in SCHP.  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 including types of residential accommodation and an in depth knowledge of the care home sector. |
| * Managing medical complexity | Trainees will gain experience in the multidisciplinary management of older patients both in the acute hospital and in the care home 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 | Salford care homes practice have a structured approach to this including decision making for treatments at end of life including advance care planning and do not resuscitate decisions. This is backed up by input from end of life care facilitators and community geriatricians. 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. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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 a an innovative model of general practice that focuses specifically on the holistic management of care home residents. |
| **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 SCHP attachments allowing for excellent feedback on clinical skills, reasoning and decision making * Weekly MDT with psychiatrists from old age team will help in management of mental health issues in frail older adults * 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 care home residents 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 | * Involvement with a caseload of frail care home residents over the 6 month period. * 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. | * Approximately 70% of patients registered at Salford care homes practice have a diagnosis of dementia so most of the patients that trainees come into contact with will have this illness. * Management of patients with dementia in care homes including specialist dementia facilities in conjunction with consultant old age psychiatrists and specialist dementia nurse. * Salford care homes practice also cover 2 supported living facilities for younger adults with intellectual impairment and learning disabilities. * Early identification and management of patients with delirium. | |
| **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 primary care 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 | |