HSP
HOSPITAL SKILLS PROGRAM

AGED CARE

MARCH 2010 VERSION 1.1

NSW Institute of Medical Education and Training
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Aged Care Module Version 1.1.
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Acknowledgements

This document is a curriculum that identifies capabilities required of doctors working in clinical areas related to the care of older people in NSW. It will be a key supporting document for implementing the Hospital Skills Program, which aims to improve the safety, efficiency and quality of healthcare in NSW Hospitals.

This document is the version of the Aged Care Module approved by the HSP State Training Council on 28 July 2009. It was prepared by the HSP Aged Care Module Development Working Group, facilitated by Dr Jan Potter.

Membership of the Module Development Working Group comprised:

Dr Jan Potter	Director of Acute Geriatric Services
Prof Kichu Nair	Director, Centre of Medical Professional Development, HNEAHS
Dr Janelle Farrar	Career Medical Officer, HNEAHS
Dr Melanie Wroth	Geriatrician
Mr Peter Davy	Curriculum Developer, NSW IMET

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Background

The Hospital Skills Program (HSP) Aged Care Curriculum is a framework which identifies the capabilities or competencies required of doctors working in clinical areas relating to the care of older people in NSW. Doctors participating in the HSP will be expected to have greater than two years of clinical postgraduate experience and not be currently participating in a specialist vocational training program.

The HSP curriculum has been developed by IMET, on behalf of NSW Health, as part of the broader Hospital Skills Program for this group of doctors. The curriculum aims to guide doctors, their employers and educators with regard to training needs, workplace responsibilities and clinical tasks. The HSP Aged Care Curriculum has drawn on existing work in this area (References: 1 – 6).

In particular, the HSP framework was developed with reference to the Australian Curriculum Framework for Junior Doctors (ACFJD), prepared by the Confederation of Postgraduate Medical Education Councils (1). The HSP curriculum has a similar structure, comprising the categories of Clinical Management, Communication and Professionalism capabilities. The HSP curriculum also identifies common illness problems and conditions which are likely to be dealt with by HSP participants and describes the clinical skills and procedures to be achieved by HSP participants.

The HSP Aged Care Module

This document is the version of the Aged Care Curriculum approved by the HSP State Training Council on 28 July 2009. It was prepared by the HSP Aged Care Curriculum Working Group, facilitated by Dr Jan Potter. An initial draft was distributed for the purpose of obtaining feedback on its accuracy and comprehensiveness and responses were received from 6 individuals and organisations. This version has been prepared with regard to the feedback received. However it is expected as the HSP is implemented there may be further curriculum revision and development work required to ensure that the HSP fulfils its goals in supporting the professional development needs of non-specialist doctors in NSW.

The curriculum comprises four sections:

Section 1:	Safe Patient Care
Section 2:	Patient Assessment
Section 3:	Patient Management
Section 4:	Common Problems and Conditions

The document outlines the capabilities required for clinical management in aged care contexts. It is intended that future versions of the HSP curriculum will also include suggested teaching and learning activities/resources to support the development of doctors' capabilities, as well as suggested assessment strategies and assessment tools to determine HSP participants' achievement of each capability. Where possible suggested teaching and learning activities/ resources and assessment strategies/tools will be made accessible via the IMET Online Learning Centre.

Across all four sections, each Aged Care capability will be allocated an HSP level. The three levels of the HSP (HSP 1, 2 and 3) address the increasing capability, knowledge and skills developed by doctors in line with their increasing level of workplace experience and training. Each of the three levels will broadly distinguish doctors in terms of proficiency, experience, and workplace responsibility.

References

1. Confederation of Postgraduate Medical Education Councils (2006) Australian Curriculum Framework for Junior Doctors, Version 2.1 www.cpmec.org.au/curriculum
2. Safety and Quality Council (2005) National Patient Safety Education Framework. The Australian Council for Safety and Quality in Healthcare, Commonwealth of Australia. www.patientsafety.org.au
3. IMET NSW Institute of Medical Education and Training (2007) A Hospital Skills Program for Staff Medical Officers (Non-Specialist Medical Staff) of NSW (Blueprint)
4. Royal Australasian College of Physicians (2009) Draft Physician Training Curriculum in Geriatric Medicine
5. World Health Organisation (2001) International Classification of Functioning Disability and Health in patient assessment (WHO ICF)
6. Joint Royal Colleges of Physicians Training Board (2007) Specialty Training Curriculum for Geriatric Medicine

The following is a summary of the criteria on which the HSP levels have been determined.

	HSP 1	HSP 2	HSP 3
E	Has limited workplace experience in this discipline.	Has moderate to large workplace experience in this discipline.	Has substantial workplace experience in this discipline.
CP	Reliably recognises familiar situations and key issues. Has a good working knowledge of the management of these. Decision-making is largely bound by protocol. Demonstrates effective clinical decision making and clinical proficiency in defined situations.	Recognises many atypical presentations, recognises case specific nuances and their relational significance, thus reliably identifies key issues and risks. Decision-making is increasingly intuitive. Fluent in most procedures and clinical management tasks.	Has an intuitive grasp of a situation as a means of linking understanding of a situation to appropriate action. Able to provide a large repertoire of management options. Has a comprehensive understanding of the hospital service, referral networks and the links to community services.
R	Uses and applies integrated management approach for all cases; consults prior to disposition or definitive management; and arranges senior review of the patient in numerous instances, especially serious, complex, unclear or uncommon cases. Observes family conference discussions about care planning and discharge planning if requested by senior clinician (and permitted by the family/carer(s)).	Autonomously able to manage simple and common presentations and consults prior to disposition or definitive management for more complex cases. Conducts family conference discussions about care planning and discharge planning under supervision of senior clinician.	Works autonomously, consults as required for expert advice and consults admitting team about patients who require admission and other medical specialists as required. Autonomously conducts family conference discussions about care planning and discharge planning under supervision of senior clinician.
PS	Level 2	Level 2 – 3	Level 3

It is assumed that doctors will practise medicine with the degree of autonomy that is consistent with their level of experience (E), clinical proficiency (CP) and responsibility (R) to ensure patients receive care which is appropriate, effective and safe. The levels are cross referenced with levels described for Patient Safety (PS) competencies in the National Patient Safety Education Framework (2).

KEY

E	Level of Experience
CP	Clinical Proficiency
R	Responsibility
PS	Patient Safety
SRMO	Senior Resident Medical Officer
CMO	Career Medical Officer

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SECTION 1: Safe Patient Care

1.1 SYSTEMS

1.1.1 Manage the complex aged care environment to the advantage of a patient in a holistic and ethical manner (HSP 2).
1.1.2 Make the appropriate use of systems and methods that minimise error e.g. use of clinical protocols (HSP 1).
1.1.3 Actively participate in continuous quality improvement to medical practice as appropriate e.g. clinical audit (HSP 1).

1.2 RISK AND PREVENTION

1.2.1 Demonstrate an awareness of risk in the workplace (HSP 1).
1.2.2 Recognise and implement responses to reduce or remove the effects of personal limitations that may contribute to risk and error (HSP 2).
1.2.3 Identify and report potential risks to patients and staff (HSP 1).

1.3 ADVERSE EVENTS AND NEAR MISSES

1.3.1 Document and report adverse events in accordance with local incident reporting systems (HSP 1).
1.3.2 Identify and manage adverse events and near misses (HSP 1).
1.3.3 Evaluate and respond to the harm caused by errors and system failures (HSP 2).
1.3.4 Practice the principles of "open disclosure" when communicating errors with patients and managers (HSP 1).

1.4 PUBLIC HEALTH

1.4.1 Promote strategies for healthy ageing in the community (HSP 2).

1.4.2 Advocate on behalf of older persons on aged care health issues (HSP 2).

1.4.3 Inform authorities of 'notifiable diseases', if these are detected (HSP 1).

1.4.4 Demonstrate timely and appropriate management of a disease outbreak (HSP 2).

1.5 MEDICATION SAFETY

1.5.1 Describe and anticipate risks with particular medications likely to adversely affect older persons (HSP 2).

1.5.2 Collaborate with clinical pharmacists within hospitals and community pharmacists to reduce medication errors and to educate patients about the appropriate use of prescribed medication (HSP 2).

1.5.3 Advise junior doctors and nurses on the best use of medications with older patients (HSP 3)

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SECTION 2: Patient Assessment

2.1 PHYSIOLOGY OF AGEING (UNDERPINNING BASIC MEDICAL SCIENCE ESSENTIAL FOR THE ASSESSMENT OF OLDER PEOPLE)

2.1.1 Recognise the physiological changes that occur in all organ systems as a consequence of ageing (HSP 1).
2.1.2 Apply relevant theories of ageing to medical practice (HSP 2).
2.1.3 Differentiate between normal and abnormal ageing (HSP 1).
2.1.4 Describe the effect of ageing on the special senses (HSP 1).
2.1.5 Describe how pharmacokinetics and pharmacodynamics are altered by physiological changes associated with ageing (HSP 1).

2.2 COMPREHENSIVE GERIATRIC ASSESSMENT

2.2.1 Conduct a comprehensive assessment of the older person, including full system review, cognition, mental health, mobility and gait, bone health, continence, sexual health, nutritional wellbeing, immunisation status, medications and alcohol use (HSP 2).

2.2.2 Describe how acute illness in old age often presents in an atypical manner (HSP 1).

2.2.3 Describe the benefits for and possible discomfort experienced by elderly patients undergoing investigations (HSP 1).

2.2.4 Recognise that the age of the patient may affect the interpretation of investigation results (HSP 1).

2.2.5 Recognise that age may affect the carrying out and interpretation of investigations more difficult (HSP 1).

2.2.6 Recognise that heterogeneity in the older patient may affect the likelihood of false positive and false negative results (HSP 1).

2.2.7 Describe how there may be more than one condition present, and how many conditions may have multifactorial causes (HSP 1).

2.2.8 Summarise how different conditions interact, in terms of disease-disease, disease-drug and drug-drug interactions (HSP 1).

2.2.9 Describe the natural history of common illness problems and conditions affecting the older person outlined in Section 4 (HSP 1).

2.2.10 Describe how acute illness and immobilisation may cause other problems (HSP 1).

2.2.11 Demonstrate a willingness to go outside of the hospital or consulting room environment in practising medicine with elderly patients (HSP 2).

2.3 ROLE OF AGED CARE ASSESSMENT TEAMS OR SERVICES (ACAT/ACAS) AND OTHER LOCALLY AVAILABLE SERVICES

2.3.1 Identify and utilise assessment services in the patient's community (HSP 2).

2.3.2 Identify the structure and function of Aged-Care Assessment Teams/Services, including governance and financing issues (HSP 2).

2.3.3 Describe and support the role of geriatricians (including legal aspects) in the ACAT/ACAS (HSP 2).

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SECTION 3: Patient Management

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3.1 COMPREHENSIVE GERIATRIC MANAGEMENT

3.1.1 Implement a holistic and ethical approach to patient centred management (HSP 1).

3.1.2 Recognise and demonstrate support of patients' desire for independence (HSP 2).

3.1.3 Recognise that the natural history of disease is likely to have effects on each patient management decision (HSP 1).

3.1.4 Recognise how competing co-morbidities will require individualised management (HSP 2).

3.1.5 Recognise that best available medical evidence regarding management may not apply to each patient (HSP 1).

3.1.6 Recognise that behavioural changes in older patients may require treatment of the underlying cause(s) (HSP 1).

3.1.7 Conduct ongoing monitoring, review and management modification as required (HSP 2).

3.1.8 Demonstrate a willingness to provide management of older people's problems across a range of settings (e.g. home, community, and hospitals) (HSP 2).

3.2 GERIATRIC PHARMACOLOGY

3.2.1 Summarise principles of geriatric pharmacology and how these principles underpin prescribing for older people (HSP 2).
3.2.2 Identify changes in pharmacokinetics related to normal ageing (HSP 2).
3.2.3 Describe the changes in pharmacodynamics with normal ageing (HSP 2).
3.2.3 Describe the significance of poly-pharmacy for older people (HSP 2).
3.2.4 State the prevalence and spectrum of adverse drug reactions (HSP 2).
3.2.5 Identify the limitations of evidence for prescribing for older people (HSP 2).
3.2.6 Describe the epidemiologic principles of the critical appraisal of reports of drug therapy for older people (HSP 2).
3.2.7 Summarise the compliance issues in the context of prescribing for older people (HSP 2).
3.2.8 Collaborate with hospital based and community pharmacists in prescribing and educating older patients about the appropriate use of medications (HSP 2).

3.3 HEALTHY AGEING

3.3.1 Promote cardiovascular health in older people via emphasising the importance of medical check-ups, regular exercise, avoidance of risky alcohol consumption, cessation of smoking, regular dental care and appropriate eating habits (HSP 2).
3.3.2 Promote healthy eating in older people through the provision of accurate and useful advice on dietary requirements (HSP 2).
3.3.3 Promote strategies for the physical and mental health of older people through the provision of information on the benefits of regular physical exercise and maintaining interests in hobbies, social interaction and other recreational activities (HSP 2).
3.3.4 Promote strategies for safety at home to prevent falls and fractures for older people (HSP 2).

3.4 REHABILITATION AND COMMUNITY CARE

3.4.1 Identify the factors that affect rehabilitation potential in the older person (HSP 2).
3.4.2 Identify the appropriateness and challenges in the conduct of comprehensive geriatric assessment in the context of rehabilitation and community care (HSP 2).
3.4.3 Compare the benefits and limitations of different rehabilitation settings and identify resource constraints (HSP 2).
3.4.4 Summarise the aims, options, available resources of discharge planning (HSP 2).
3.4.5 Identify factors which indicate that progress in rehabilitation is significant (HSP 2).
3.4.6 Describe the role of local needs assessors in the provision of access to supports and residential facilities (HSP 2).
3.4.7 List specific indications for different types of care facilities and community care packages (HSP 2).
3.4.8 Identify and effectively utilise facilities providing particular types of care in a given local region (HSP 2).

3.5 PALLIATIVE CARE

3.5.1 Provide empathic care and advice for patients and carers with the inevitability of death (HSP 2).

3.5.2 Display equanimity by maintaining appropriate professional distance while providing empathic care (HSP 2).

3.5.3 Describe the natural history of life-limiting disease (HSP 2).

3.5.4 Respect the patient's informed decisions regarding treatment options and, the content of advanced care directives (HSP 2).

3.5.5 Implement consensus decision making and utilise the Guardianship board when the patient is not legally competent to make their own decisions (HSP 2).

3.5.6 Summarise the concepts of palliative care (HSP 2).

3.5.7 Describe relevant legal issues pertaining to end of life decisions and palliative care including not for resuscitation documentation and withholding of tube feeding, antibiotics (HSP 2).

3.5.8 Summarise the difference between the "doctrine of double effect" (i.e. hastened death as a side effect of symptom relieving therapy) and euthanasia (i.e. hastened death as an aim of therapy) (HSP 2).

3.5.9 Implement palliative care in terminal cancer management (HSP 2).

3.5.10 Implement palliative care for non-cancer disease (HSP 2).

3.5.11 Provide effective pain management (HSP 2).

3.5.12 Provide management for symptoms other than pain (HSP 2).

3.5.13 Organise the implementation of institutional and community supports available for palliative care (HSP 2).

3.6 MULTI-DISCIPLINARY FAMILY CONFERENCE

3.6.1 Demonstrate caring, empathic respect for all, including patients, families and team members (HSP 2).

3.6.2 Display constructive communication in encounters with patients and their families and with colleagues and team members (HSP 2).

3.6.3 Describe the role of the family conference in care planning and discharge planning (HSP 2).

3.6.4 Identify and effectively employ the members of the multi-disciplinary team that contribute to the family conference (HSP 2).

3.6.5 Describe the legal requirement to obtain patients' consent to discuss their private affairs (HSP 2).

3.7 MULTI-DISCIPLINARY TEAM WORK

3.7.1 Display respect for all team members (HSP 2).

3.7.2 Demonstrate a willingness to contribute to the professional development of team members and also to learn from them (HSP 2).

3.7.3 Identify the roles of the members of the multi-disciplinary team (HSP 2).

3.7.4 Recognise the values of other clinical disciplines (e.g. physiotherapy, occupational therapy, speech pathology, neuro-psychology and specialist nursing) participating in health teams (HSP 2).

3.7.5 Describe the benefits of multi-disciplinary team approach and the importance of effective communication and leadership within the multi-disciplinary team (HSP 2).

3.7.6 Recognise the role of case-conferences as one of the means of optimising team function (HSP 2).

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SECTION 4: Common Problems and Conditions

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Common Problems and Conditions

NEURODEGENERATIVE AND MENTAL HEALTH DISORDERS IN OLDER PEOPLE

4.1 DEPRESSION IN OLDER PEOPLE

4.1.1 Describe the epidemiology of depression in older people (HSP 2).
4.1.2 List clinical features of depression, including atypical presentations and anxiety (HSP 2).
4.1.3 Summarise the consequences of depression including suicide risk, and the impact on recovery from other illnesses (HSP 2).
4.1.4 Describe the relationship between physical illness and depression (HSP 2).
4.1.5 Recognise that depression is not "inevitable" part of ageing and is treatable.
4.1.6 Describe the relationship between brain disease and depression (HSP 2).
4.1.7 Identify organic causes of depression e.g. hypercalcemia (HSP 2).
4.1.8 Recognise risk factors in the use of medications which may cause depression or make it worse (HSP 2).
4.1.9 Identify treatments of depression (including pharmacotherapy, supportive psychotherapy, electroconvulsive therapy) (HSP 2).
4.1.10 Identify side effects of therapy (HSP 2).
4.1.11 Summarise the relationships between depression and alcohol and other drugs which may be abused (HSP 2).

4.2 DELIRIUM IN OLDER PEOPLE

4.2.1 State the definition and the epidemiology of delirium, including its prognosis and recognise that delirium is not normal and requires urgent medical attention (HSP 2).

4.2.2 Recognise that delirium is potentially reversible and it is more common in patients with pre-existing brain damage and dementia (HSP 2).

4.2.3 Identify signs of substance abuse and withdrawal (HSP 2).

4.2.4 Identify factors for the supportive management of delirium (HSP 2).

4.2.5 Identify factors in the environment that may be modified to optimise delirium care (HSP 2).

4.2.6 Summarise the legal position of prescribing pharmacologic and/or implementing physical restraints (HSP 2).

4.2.7 Define the consent issues pertaining to delirium (HSP 2).

4.3 COGNITIVE IMPAIRMENT IN OLDER PEOPLE

4.3.1 Summarise causes of cognitive impairment (HSP 2).

4.3.2 Utilise appropriate investigations of cognitive impairment (HSP 2).

4.3.3 Describe the natural history and prognosis of cognitive impairment (HSP 2).

4.3.4 Describe the management of cognitive impairment including pharmacotherapy (HSP 2).

4.3.5 Summarise the effects of cognitive impairment on the patient, their family and society (HSP 2).

4.3.6 Describe the symptom management of cognitive impairment (HSP 2).

4.3.7 Describe disease modifying therapy for cognitive impairment (HSP 2).

4.3.8 Recognise the importance of and support the decision-making capacity in older people (for example with regard to wills, Advance Care Directives, Power of Attorney and Enduring Guardianship) (HSP 2).

4.3.9 Use community and other local social support structures for people with cognitive impairment (HSP 2).

4.3.10 Describe the effects of cognitive impairment on the ability to drive and the doctor's role in assessment, counselling and notification (HSP 2).

4.3.11 Describe the manifestations of cognitive impairment including BPSD (HSP 2).

4.3.12 Utilise the ethics of consent and disclosure in treating people with cognitive impairment and liaising with their carers and family (HSP 2).

4.4 DEMENTIA IN OLDER PEOPLE

4.4.1 State the prevalence and incidence of dementia (HSP 2).
4.4.2 Summarise current theories of dementia syndromes, including molecular and genetic bases (HSP 1).
4.4.3 Demonstrate a willingness to treat people with dementia as worthy of help and invest the time it takes in providing treatment (HSP 2).
4.4.4 Recognise that people with dementia can have a good quality of life despite their diagnosis (HSP 2).
4.4.5 Recognise people with dementia have rights (HSP 2).
4.3.6 Demonstrate respect for people, even if they have dementia (HSP 2).
4.3.7 Describe the differentiation of dementia from other problems and conditions such as delirium and depression (HSP 1).

4.5 BEHAVIOURAL AND PSYCHIATRIC SYMPTOMS OF DEMENTIA (BPSD)

4.5.1 Recognise that BPSD is part of a disease process, rather than a manifestation of bad behaviour (HSP 2).
4.5.2 Carefully balance management options where there is conflict between patients' apparent interests and those of patients' caregivers (HSP 2).
4.5.3 Demonstrate a willingness to be the patients' advocate since patients with BPSD are generally unable to advocate for themselves (HSP 2).
4.5.4 Demonstrate a willingness to treat people with BSPD as worthy of help and invest the time it takes in treatment (HSP 2).
4.5.5 State the prevalence and incidence of BPSD (HSP 2).
4.5.6 Describe the clinical manifestations and features of BPSD (HSP 2).
4.5.6 Summarise current theories regarding the causes of BPSD (HSP 2).
4.5.7 Summarise the effects of BPSD on the patient, carers, family and society (HSP 2).
4.5.8 Describe appropriate investigations of BPSD (HSP 2).
4.5.9 Describe management of BSPD, including pharmacotherapy (HSP 2).
4.5.10 Describe the symptom management of BSPD (HSP 2).
4.5.11 Summarise consent issues for therapy, including use of restraints for people with BSPD (HSP 2).
4.5.12 Describe the natural history and prognosis of BSPD (HSP 2).
4.5.13 Describe social support structures for people affected by BSPD (HSP 2).
4.5.14 Recognise that hospital security staff and police can help manage violent disruptive patients with BPSD and utilise this support where appropriate (HSP 2).
4.5.15 Summarise issues related to decision-making in people with BSPD and state the role of decision making proxies and the role of the Guardianship Tribunal (HSP 2).

4.6 IMPAIRED HOMEOSTASIS AND REDUCED RESERVE

4.6.1 Summarise the concept of reduced homeostasis in older people, including describing the concept of reduced reserve and the fine balance of homeostasis (HSP 2).
4.6.2 Recognise the balance of homeostasis in the older person and typical ways in which homeostasis can be disrupted (e.g. postural hypotension due to medications, pressure ulceration due to sedation and immobilisation) (HSP 2).
4.6.3 Anticipate, recognise and manage the effects of prolonged immobilisation (e.g. deconditioning, pressure ulceration) (HSP 2).
4.6.4 Recognise the prevalence of sarcopenia in older age, chronic disease and obesity (HSP 2).
4.6.5 Summarise the effects of exercise on older people and the type and amount of exercise recommended (HSP 2)

4.7 MAJOR BONE DISORDERS IN OLDER PEOPLE

4.7.1 Demonstrate a proactive approach to prevention, diagnosis and management of major bone disorders (HSP 2).
4.7.2 Describe the prevalence, incidence and risk factors of osteoporosis, osteomalacia and osteoarthritis in older people (HSP 2).
4.7.3 Describe potential preventive strategies of major bone disorders (HSP 2).
4.7.4 Summarise the spectrum of treatment of major bone disorders (HSP 2).
4.7.5 Summarise the social and economic costs of osteoporotic fractures (HSP 2).
4.7.6 Describe the role of harm minimisation e.g. use of hip protectors in older people (HSP 2).
4.7.7 Recognise the silent epidemic of osteoporosis in older people (HSP 2).
4.7.8 Recognise the high prevalence of vitamin D deficiency in older people (HSP 2).

4.8 FALLS AND THEIR SEQUELAE AND OLDER PEOPLE

4.8.1 Advocate for system change to prevent and reduce the incidence of falls, within homes, community settings, hospitals and residential care facilities (HSP 2).
4.8.2 Demonstrate a proactive approach to diagnosis and management (HSP 2).
4.8.3 Describe the prevalence, incidence and aetiology of falls (HSP 2).
4.8.4 Summarise the physical and psychological consequences of falls.
4.8.5 Summarise fall reduction strategies (HSP 2).
4.8.6 Describe the social and economic costs of falls (HSP 2).
4.8.7 Recognise the role of harm minimisation e.g. use of hip protectors in older people (HSP 2).
4.8.8 Describe strategies to minimise risk of falls in hospital (HSP 2).
4.7.9 Summarise the legal aspects of falls, including the need to report falls that lead to death (HSP 2).

4.9 URINARY INCONTINENCE AND RETENTION IN OLDER PEOPLE

4.9.1 Actively include assessment of continence as part of the routine history (HSP 2).
4.9.2 Demonstrate sensitivity in management (HSP 2).
4.9.3 Describe the prevalence, incidence and aetiology of the various forms of urinary incontinence and retention (HSP 2).
4.9.4 Describe the pharmacological, behavioural and multi-disciplinary approach to management of urinary incontinence and retention (HSP 2).
4.9.5 Summarise the role of medication and surgery in the management of urinary incontinence and retention (HSP 2).
4.9.6 Summarise the use of appropriate aids and appliances in the management of urinary incontinence and retention and the relative costs of these (HSP 2).
4.9.7 Summarise the social and psychological effects of incontinence (HSP 2).
4.9.8 Recognise the clinical indications for in-dwelling catheters and their adverse effects.

4.10 CONSTIPATION AND FAECAL INCONTINENCE IN OLDER PEOPLE

4.10.1 Demonstrate sensitivity in management of constipation and faecal incontinence (HSP 2).
4.10.2 Actively include the assessment of continence as part of the routine history (HSP 2).
4.10.3 Describe the physiology of defecation (HSP 2).
4.10.4 Describe the prevalence, incidence and aetiology of constipation and faecal incontinence (HSP 2).
4.10.5 Summarise the role of pharmacological and non-pharmacological management of constipation and faecal incontinence (HSP 2).
4.10.6 Summarise the social and psychological impact of constipation and faecal incontinence (HSP 2).
4.10.7 Summarise the use of appropriate aids and appliances in the management of faecal incontinence and the relative costs of these (HSP 2).
4.10.8 Recognise the risk situations for development of constipation and implement preventative actions (HSP 2).

4.11 VASCULAR DISEASE IN OLDER PEOPLE

4.11.1 Describe the incidence, prevalence and spectrum of vascular disease in older people (cardiovascular, cerebrovascular, renovascular and peripheral vascular) (HSP 2).

4.11.2 Summarise the effects of vascular disease on the physical and mental function of older people (HSP 2).

4.11.3 Describe the primary and secondary prevention of vascular disease in older people (HSP 2).

4.11.4 Describe the evidence based pharmacological and non-pharmacological management of vascular disease affecting older people (HSP 2).

4.12 WOUNDS AND ULCERS IN OLDER PEOPLE

4.12.1 Summarise the principles of ulcer healing and moist wound management, including the use of a multifactorial approach, where indicated (HSP 2).

4.12.2 Recognise the risk situations for development of ulceration with the view of prevention (HSP 2).

4.13 SLEEP DISTURBANCES IN OLDER PEOPLE

4.13.1 Describe the aetiology and management of sleep disorders both pharmacological and non-pharmacological (HSP 2).

4.13.2 Describe the effect of sleep disturbance on performance status and the risk of delirium and depression.

4.13.3 Summarise the hazards and limited efficacy of medications commonly used for insomnia (HSP 2).

4.14 VISUAL AND HEARING IMPAIRMENT IN OLDER PEOPLE

4.14.1 Advocate the use of management strategies which optimise the quality of life for older people with visual and/or hearing impairment (HSP 2).

4.14.2 Show willingness to make extra effort to communicate with people who have visual and/or hearing impairment (HSP 2).

4.14.3 Describe the incidence, prevalence and aetiology of visual and hearing impairment in older people (HSP 2).

4.14.4 Describe the natural history of conditions that cause visual and hearing impairment and potential for therapy (HSP 2).

4.14.5 Summarise the prevention strategies for visual and hearing impairments.

4.14.6 Describe the assistive services, devices and aids which help those with visual and/or hearing impairment (HSP 2).

4.14.7 Summarise the social, psychological and physical consequences of sensory deprivation (HSP 2).

4.15 NUTRITIONAL PROBLEMS IN OLDER PEOPLE

4.15.1 Describe the optimal nutritional state (HSP 2).

4.15.2 Describe the methods of nutrition assessment with older people (HSP 2).

4.15.3 Identify common micronutrient and vitamin deficiency in older people (HSP 2).

4.15.4 Describe the incidence, prevalence and aetiology of obesity and malnutrition in older people (HSP 2).

4.15.5 Summarise the consequences of obesity and malnutrition in older people (HSP 2).

4.15.6 Summarise the nutrition and dietary issues in culturally and linguistically diverse groups (HSP 2).

4.15.7 Promote appropriate nutrition for older people (HSP 2).

4.15.8 Manage obesity and malnutrition in older people (HSP 2).

4.15.9 Recognise the ethical considerations around tube and artificial feeding (HSP 2).

4.16 DENTAL PROBLEMS IN OLDER PEOPLE

4.16.1 Describe the common dental problems in older people (HSP 2).

4.16.2 Summarise the consequences of poor dentition and oral health (HSP 2).

4.16.3 Summarise the preventive strategies for optimising dental health in older people (HSP 2).

4.16.4 Advocate for older people's access to dental services (HSP 2).

4.16.5 Show a willingness to arrange dental services as required for older people (HSP 2).

4.16.6 Describe how dentures and plates/ prostheses work and their limitations.

4.17 ELDER ABUSE

4.17.1 Describe the diagnosis and management of elder abuse (HSP 2).

4.17.2 Describe the incidence, prevalence and risk factors of different types of elder abuse (verbal, financial and physical), and neglect (HSP 2).

4.17.3 Demonstrate an awareness of and a high index of suspicion regarding elder abuse (HSP 2).

4.17.4 Demonstrate the willingness to invest the time and energy required to assess possible elder abuse (HSP 2).

4.17.5 Seek multidisciplinary team help as required (HSP 2).

4.17.6 Summarise management options for responding to elder abuse, including legal avenues (HSP 2).

4.17.7 Summarise aspects of the complex relationships between abused and abusers and recognise that abuse may go unreported by victims (HSP 2).

4.17.8 Recognise that both abusers and the abused may need help (HSP 2).

4.18 SEXUALITY AND SEXUAL DYSFUNCTION

4.18.1 Describe the physiological changes in sexuality that occur with age (HSP 2).

4.18.2 Explain the multidisciplinary approach to responding to unwanted or "inappropriate" sexual behaviour (HSP 2).

4.18.3 Describe the approaches to the effect of illness and medication sexual function (HSP 2).

4.18.4 Take history and conduct examination of older people to assess sexual dysfunction (HSP 2)

NSW Institute of Medical Education and Training (IMET)

Building 12 Gladesville Hospital
GLADESVILLE NSW 2060
Tel: (02) 9844 6551
Fax: (02) 9844 6544
Email: info@imet.health.nsw.gov.au
Post: Locked Bag 5022, GLADESVILLE NSW 1675

IMET
NSW Institute of Medical Education and Training

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