MOUNT SINAI HOSPITAL GERIATRICS ROTATION GUIDE

WELCOME TO OUR GERIATRICS ROTATION!

Dear Medical Students, Residents, and Fellows,

We would like to take this opportunity to welcome you to the Geriatric Medicine rotation at the Sinai Health System (SHS) and the University Health Network (UHN) Hospitals. We hope you enjoy your time with us.

This detailed orientation manual has been prepared to help you understand how the rotation and clinical services are structured and how to get the most out of this learning experience. The guide starts by outlining the philosophy and components of geriatric assessments. It then provides a detailed orientation to the various elements of our multi-site and multi-component rotation that you will be exposed to including the Interprofessional Inpatient Consult Service, our Outpatient Clinics and Community Programs.

Accompanying this document are your detailed rotation schedules that have been personalized for you, and also includes the date and time of your in-person orientation. If you see any conflicts or need to make any changes, please contact Libby Mendonca at extension 17-6641 or libby.mendonca@sinaihealthsystem.ca. Furthermore, we have also enclosed essential articles and other documents that should help facilitate your learning on this rotation.

Your rotation schedules, orientation and reading materials mentioned above are located on our geriatrics trainee website for easy access at http://sinaigeriatrics.ca/orientation/. The password will be communicated with you via email.

If you have not already completed your registration with medical education and SHS/UHN, please complete your registration and computer training on the first day of your rotation, including obtaining your dictation pin and passwords.

We are always looking to improve this rotation and so we always welcome any comments or feedback you could provide.

Welcome once again and enjoy your geriatrics rotation!

Yours Sincerely,

Dr. Vicky Chau, MD, MScCH, FRCPC
Geriatrics Education Coordinator
Sinai Health System & University Health Network

Dr. Samir K. Sinha, MD, DPhil, FRCPC
Director of Geriatrics
Sinai Health System & University Health Network

SHS/UHN GERIATRICIAN BIOS

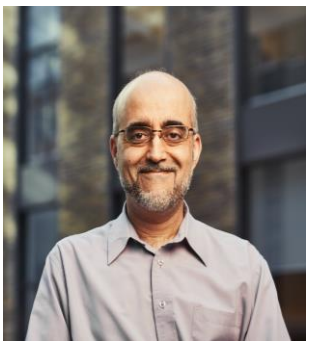
Dr. Samir Sinha

Dr. Samir Sinha, MD, DPhil, FRCPC is the Director of Geriatrics at Mount Sinai and the University Health Network (UHN) Hospitals in Toronto and an Assistant Professor of Medicine at the University of Toronto and the Johns Hopkins University School of Medicine.

A Rhodes Scholar, Samir is a highly regarded clinician and international expert in the care of older adults. Specifically, he enjoys working with older adults in acute care, outpatient and home-based settings and in developing integrated models of care that ensure older adults get the best possible care across the overall care continuum. He has consulted and advised governments and health care organizations around the world and is the Architect of the Government of Ontario's Seniors Strategy. In 2014, Maclean's proclaimed him to be one of Canada's 50 most influential people and its most compelling voice for the elderly

Dr. Barry Goldlist

Dr. Barry Goldlist is a Professor of Medicine and the former head of the Division of Geriatric Medicine at the University of Toronto. He has served as President of the OMA section on Geriatrics, president of the Canadian Geriatrics Society (CGS), Chief examiner, Geriatrics, for the Royal College and was the long time editor in chief of the CGS continuing education journals. His particular area of interest within Geriatrics is dementia.



Dr. Shabbir Alibhai

Dr. Shabbir Alibhai is a Clinician Scientist and an Associate Professor in the Department of Medicine, the Institute of Health Policy, Management, and Evaluation, and the Institute of Medical Sciences at the University of Toronto. His research interests are in geriatric oncology, understanding the impact of disease and treatment on the quality of life and functioning of older adults as well as optimal treatment in older adults with cancer. As of early 2015, he is also the medical lead for the recently established geriatric oncology demonstration project at Princess Margaret Cancer Centre, Canada's largest academic cancer centre.

Dr. Reva Adler

Dr. Adler is a Professor of Geriatric Medicine at University of Toronto. Her interests include practice and research in complexity medicine, system design for integrated health systems, the interface between culture and ageing, and the effects of trauma on health in later life. From 2000-2011, she served as Medical Director, At-home Supports, Vancouver Coastal Health Authority, and Medical Director, Vancouver General Hospital Short Term Assessment & Treatment Centre for older adults. In addition, she held the post of Medical Director of the Snider Campus for Jewish Seniors since from 1994 – 2008.

From July 2011 – January 2015, Dr. Adler was VP Medicine and Academic Affairs at Bridgepoint Hospital. She has served as Lead in developing the clinical model for the Bridgepoint 2020 strategy, been a member of the TC-LHIN Advisory Committee for Primary Care, and led the Orthopaedic Integration initiative in partnership with Mount Sinai Hospital. She is on the Steering Committee of the Don-Valley Health Link for the

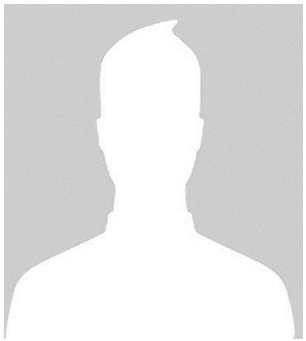
TC-LHIN. Her latest publications are the books *Doorway Thoughts: Cross-cultural Care for Older Adults, Volumes 1 & 2*, published by Jones and Bartlett.

Dr. Arielle Berger

Dr. Arielle Berger graduated from Sackler School of Medicine in Tel Aviv, Israel and completed Internal Medicine and Geriatrics residency training in New York City. She has been a staff geriatrician at the Sinai Health System (SHS)/University Health Network (UHN) Hospitals since 2014 focusing her clinical work on the geriatric rehab population. Her academic interests are focused on medical education, particularly on fostering professionalism among post-graduate medical trainees.

Dr. Vicky Chau

Dr. Vicky Chau is the Educational Site Lead (Education Coordinator) for Geriatric Medicine at SHS/UHN. She is also the Fellowship Director for Geriatrics and an Assistant Professor with the Department of Medicine at the University of Toronto. Although based at Mount Sinai Hospital (MSH), her clinical activities involve acute care geriatrics and rehabilitation across the SHS/UHN hospitals. Her main interest is in medical education, and it led her to complete a Masters in Health Professional Education as well as the Eliot Phillipson Clinician Educator Training Program at the University of Toronto. Her educational and scholarly activities focus on curriculum development and evaluation.



Dr. Dan Liberman

Dr. Dan Liberman is the Medical Leader for the Geriatric Rehabilitation Program at the Toronto Rehabilitation Institute (TRI). His responsibilities include management the geriatric consultative services, the Geriatric Rehabilitation Unit and the outpatient clinics. He is the interim clinical director for the Independence at Home (IAH) Community Outreach Team.

His clinical duties include being a geriatric consultant at TRI, UHN, and MSH, as well as being an attending on the Clinical Teaching Units at MSH. His areas of interest include education, exam development, medical history, incontinence and hypertension in the elderly. His office doors are always open and you are always welcome for a chat!

Dr. Karen Ng

Karen Ng has been a Clinician-Teacher at Sinai-UHN since 2012, with a general geriatrics clinic at Mount Sinai, a collaborative care practice supporting both clinic-based and home-based care at the Mount Sinai Family Health Team, and participation in covering the inpatient consult service. With a particular fondness for the collaborative care milieu, she hopes this model becomes more widespread. She also has an interest in capacity building, with a desire to work toward helping instil the "geriatric lens" across the spectrum of care for frail older adults.

Dr. Asenath Steiman

Dr. Asenath Steiman is happy to return to her hometown of Toronto to serve as a geriatrician after completing her medical degree at Tel Aviv University's Sackler School of medicine and Internal and Geriatric medicine training in New York City's Beth Israel Medical Center. She looks forward to continuing her clinical work at SHS/UHN with the geriatric rehabilitation population and especially enjoys the opportunity to visit patients' in their home through the Independence at Home Community Outreach Team.

CONTACT INFORMATION

Contacts:	Office:	Pager:	Home/Cell:
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Dr. Arielle Berger	(416) 597-3422 ext. 3204	(416) 790-0083	(647) 515-0093
Dr. Vicky Chau	(416) 586-4800 ext. 8902		(647) 390-0819
Dr. Barry Goldlist	(416) 586-4800 ext. 6641	(416) 790-9619	(416) 926-9577
Dr. Dan Liberman	(416) 597-3422 ext. 3027	(416) 715-0140	(647) 221-5502
Dr. Karen Ng			(416) 505-4418
Dr. Samir Sinha	(416) 586-4800 ext. 7859	(416) 380-5450	(647) 924-6016
Dr. Asenath Steiman	(416) 597-3422 ext. 3852		(647) 225-7671

Residents on the Geriatric Service:

THE UNDERLYING PHILOSOPHY OF GERIATRICS ASSESSMENTS

Although there is a list of learning objectives for this rotation, our ultimate goal is to provide you with an opportunity to learn how to perform Comprehensive Geriatric Assessments (CGAs).

The CGA can be defined as "a multidisciplinary diagnostic process intended to determine a frail elderly person's medical, psychosocial, and functional capabilities and limitations in order to develop an overall plan for treatment and long-term follow-up" (Rubenstein, 1982).

In other words, one of the most important goals of a Geriatrician is to identify a frail older person's abilities and those diseases/illnesses that limit their abilities. We then make recommendations related to the delivery of a person's health and social care and identify any rehabilitation goals that might minimize limitations and maximize a person's abilities and overall quality of life.

During this rotation at the Sinai Health System and University Health Network Hospitals, you will gain experience in conducting CGAs with the support of an interprofessional team amongst older patients in a variety of inpatient, outpatient, and home-based settings.

COMPONENTS OF A COMPREHENSIVE GERIATRICS ASSESSMENT

When requested to see an older patient in consultation, Geriatricians always look beyond the admitting diagnosis to complete a broader assessment that also encompasses the full medical, psychosocial, and functional capabilities and limitations of the individual in order to develop an overall plan for treatment and long-term follow-up that supports the work of their primary care providers during a hospital admission or within the context of their community living situations.

While an inpatient medical team may rightfully focus around the main admitting diagnosis – e.g. pneumonia – the Geriatrician looks to address other potential geriatric syndromes that may complicate an admission or preclude a durable return to the community. Oftentimes, this will require additional collateral information from caregivers and/or health care professionals. The issues we often focus on in our assessments include amongst other things:

1. **Problems Common to Older Adults** *(Delirium/Dementia; Falls; Polypharmacy; Incontinence; Weight Loss, Acute/Chronic Pain, Failure to Thrive, etc.)*
2. **A Recent Decline in Functional Abilities or Mobility Issues**
3. **Diagnostic/Treatment Challenges**
4. **Complex Social Issues** *(Caregiver Burnout, Elder Abuse etc.)*
5. **Goals of Care and/or Disposition Planning** (*includes assessment and referrals to Outpatient Clinics and Home-Based Services, such as the House Calls Program*)

There are many ways to organize a CGA. The following framework is one way to organize and document your assessments. **Please see the trainee resource website for each site-specific CGA template**.

1. Patient Identification and Reason for Consultation
2. Past Medical History
3. Chief Complaint and History of Presenting Illness (*includes brief summary of admission and hospital course)*
4. Medication History (*includes allergies, prescription & non prescription medications e.g. sleeping aids, vitamins and supplements*)
5. Functional History (*includes basic and instrumental activities of daily living*)
6. Social History (*includes current living situation, family and community supports, previous occupation and level of education, advance care directives, powers of attorney, and general financial situation, and recreational drugs e.g. alcohol and addictive agents*)
7. Geriatric Review of Systems (*includes functional review of cognition, mood, vision/hearing, falls, nutrition, bowel & bladder incontinence, pain, and sleep)*
8. Cognitive Assessment (*includes screening for Dementia, e.g. MMSE, MoCA and RUDAS; Depression, e.g. Geriatric Depression Scale; Delirium, e.g. Confusion Assessment Method where appropriate*)
9. Physical Examination (*includes orthostatic vitals and gait assessment along where appropriate*)
10. Relevant Laboratory and Diagnostic Information
11. Impression and Plan (*includes brief summary, impression, and usually no more than 5 recommendations*)

SHS & UHN GERIATRIC MEDICINE PROGRAM

The SHS and UHN Geriatric Medicine program provides a comprehensive set of services for older adults across the inpatient, outpatient and community settings. However, learners spend most of their time on the inpatient geriatrics consultation service. There are three inpatient consultation services located on University Avenue, Toronto Western Hospital (TWH), and Toronto Rehabilitation Institute (TRI), respectively. **Your primary learning experience takes place on the "University Avenue" inpatient geriatric medicine consultation service, based at Mount Sinai Hospital (MSH), 4th floor, Suite 475.**

This experience will be complemented by other clinical activities (e.g. ambulatory clinics), multidisciplinary rounds, and teaching opportunities to help you become accustomed to geriatrics and the various services available to older adults. Thus, **it is important to review your *personalized* rotation (and if applicable, day-time on-call) schedule accompanied with this package on a *daily* basis.** If you see any conflicts or need to make any changes, please contact Ms. Libby Mendonca at extension 17-6641 or via libby.mendonca@sinaihealthsystem.ca.

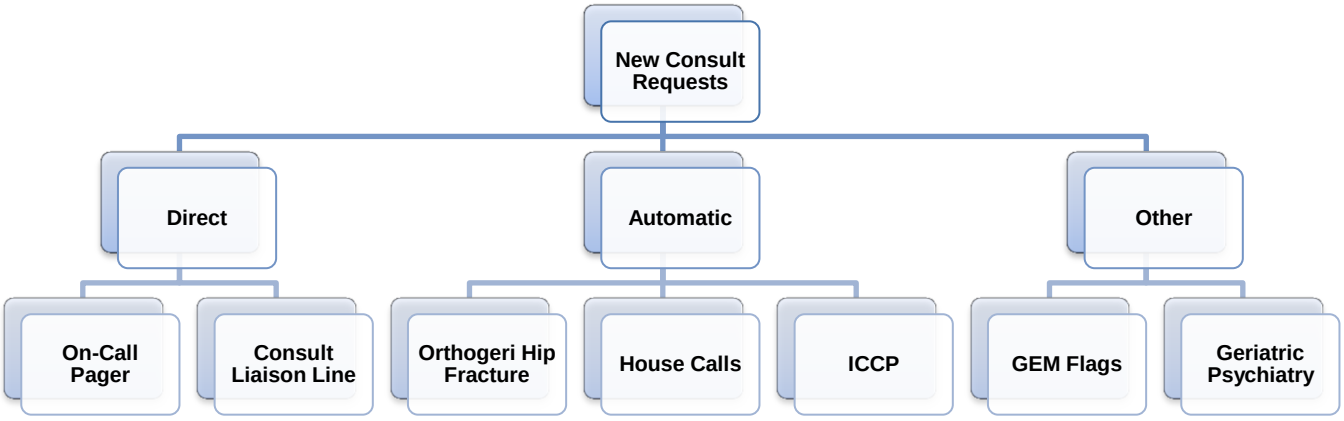
UNIVERSITY AVENUE INPATIENT GERIATRIC CONSULTATION SERVICE

The "University Avenue" Geriatric Consultation service is a multi-site service that provides geriatric support to MSH, Toronto General Hospital (TGH), and Princess Margaret Hospital (PMH). It is also interprofessional and is comprised of a Nurse Practitioner (Nga Truong/Mary Ann Hamelin), Geriatric Pharmacist (Christopher Fan-Lun), Social Worker (Carmelina Marziliano), Physiotherapist (Natasha Bhesania/Maegan Bell), and Geriatrician (You!).

Residents are assigned to the **Day Time On-Call Schedule** to receive consultation requests between 8am to 5pm from Monday to Friday, while the Staff Geriatrician and the Geriatric Medicine Fellow handle consults and calls after 5pm on weekdays and during weekends. You may be the On-Call Resident during clinic. If there are significant conflicts, please contact Ms. Libby Mendonca at extension 17-6641 or via libby.mendonca@sinaihealthsystem.ca

As the On-Call Resident, you may receive direct requests traditionally through your **On-Call Pager**. However, new referrals can be received through a number of mechanisms. (See *Figure 1*)

Figure 1. **Consultation Requests**



Direct Requests

Consultations can be directly requested to the Geriatrics team through the resident's **On-Call Pager** and/or the **Geriatric Medicine/Psychiatry Consult Liaison Line** (extension 8419). Jeanette Villapando/Connie Kim manages the liaison consult line. When a Geriatric Medicine consult is requested, Jeanette will notify the On-Call Resident and also send an e-mail to the University Avenue consult team.

Automatic Requests

At the SHS, the Geriatrics team receives automatic consultation requests from the **Orthogeriatrics Hip Fracture**

Service, and the **House Calls (HC)** and **Integrated Client Care Program (ICCP)** in the community. This is because Geriatrics takes a *proactive* approach in these high-risk patients who are at risk of cognitive and functional decline while they're hospitalized.

Generally, the Staff Geriatrician receives an automatic e-mail notification of new hip fracture referrals, and also when HC and ICCP patients are admitted into hospital. The Geriatrician will then notify the On-Call Resident and Geriatrics team of the consultation request. For HC and ICCP patients, the On-Call Resident is expected to call the relevant admitting team to see if they require additional geriatric support in co-managing the patient in conjunction with the admitting team during their hospitalization. If additional geriatric support is accepted, an e-mail notification (see below) is sent to the University Avenue consult team. Consultation requests may also be called directly to the Geriatric Medicine/Psychiatry Consult Liaison Line (x8419).

Orthogeriatrics Hip Fracture Service

Geriatrics sees all patients aged 65 years and over with hip fractures. These include those who have suffered fragility (low-trauma) fractures, but not peri-prosthetic or pathological fractures unless specifically requested. These patients with hip fractures are at high risk for complications, such as delirium, and often have other undiagnosed or untreated issues like dementia and osteoporosis.

Patients with hip fractures are co-managed by Orthopaedics, the Hospitalist team [Drs. Christine Soong, Hedieh Ghanbari, or Jordan Pelc] who are the Most Responsible Physicians (MRPs)], and Geriatrics. Occasionally, the Medical Consults team may be involved for medically complex issues to provide after hours supports. Overall, Geriatrics typically focus on geriatric-related issues, and the Hospitalist and/or Medical Consults team focus on medical-related issues. See *Table 1*. Frequently, diseases contribute to geriatric syndromes are co-managed collaboratively.

Table 1. **Geriatrics vs. Hospitalist/Medical Consult Roles**

Geriatrics	Hospitalist and/or Medical Consults

• Cognition (e.g. Delirium, Dementia, Depression)
• Falls & Bone Health
• Pain, Nausea, Constipation
• Medication Rationalization
• Disposition Planning
	• Perioperative Risk Assessment & Optimization
	• Medical management
	  ○ Cardiorespiratory issues (e.g. Afib)
	  ○ Anticoagulation
	  ○ Glucose & Electrolyte abnormalities
	  ○ Acute kidney injury

Please refer to the "Hip Fracture" primer and/or hip fracture template on the trainee resource website for further details to help focus your consult.

HC & ICCP Patients

SHS works in partnership with both the HC and the Toronto Central-CCAC ICCP program. HC offers comprehensive home-based primary care through an interprofessional team; and ICCP offers intensive case management through a CCAC coordinator of the most medically complex older adults in the community. These programs work in close collaboration with Geriatric Medicine and Psychiatry. The overall goal is to ensure these patients access and receive appropriate and integrated care, experience smooth transitions, and are supported to remain at home for as long as possible. Emma Anderson is the HC nurse practitioner; and Jennifer Thomas is the ICCP CCAC Coordinator, who closely liaises with the inpatient geriatric medicine consultation service

When additional geriatric support is requested, a consultation is completed and the patient is followed until disposition. These patients are discussed weekly with Emma and Jennifer during Monday Geriatric Team Rounds (see below). Collateral information may also be requested from these representatives to assist you with your consult. When HC and ICCP patients are discharged, we fax our geriatric consultation and follow up notes in addition to the discharge summary to HC [(416) 481-2590] and ICCP [(416) BLANK], respectively.

New patients may also be referred to the HC and/or ICCP program should they meet the program criteria. In the same vein, these patients should be discussed at weekly Monday team rounds; and when discharged, the appropriate

paperwork and completed new referral forms are faxed to their respective contacts.

Other Requests

In line with our proactive geriatric approach, the Geriatrics consult team may become involved in patients who have been identified at SHS by the **GEM Flag System** and/or the **Inpatient Geriatric Psychiatry Service**.

GEM Flag System

Our Emergency Department Geriatric Emergency Management (GEM) Nurses identify certain patients admitted to hospital at high risk for complications. These patients are "flagged" under the "GEM Tab" in Powerchart. Under the "Clinical Notes" Tab on the left sided Menu List, the On Call Resident is expected to review the patient's GEM Nursing Assessment note to identify geriatric issues that may require follow up. The resident is then expected to call the relevant admitting team to see if they require additional geriatric support to help co-manage these patients with the admitting team while hospitalized. If additional geriatric support is accepted, an e-mail notification (see below) is sent out to the University Avenue team.

Inpatient Geriatric Psychiatry Service

The Geriatrics team works collaboratively with the SHS Geriatric Psychiatry Service, as many cases require dual involvement of these services. *See Figure 2*.

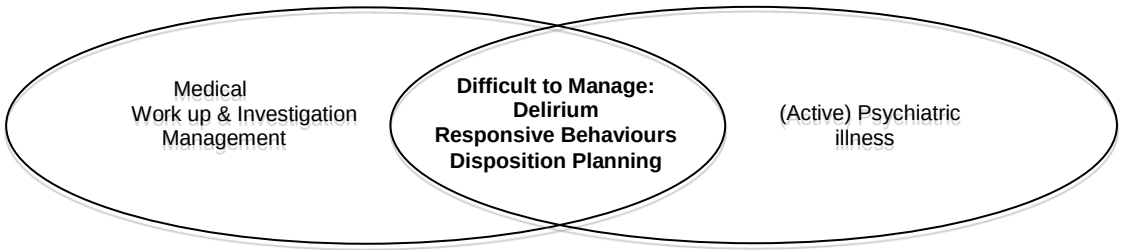


Figure 2. **Geriatric Medicine & Geriatric Psychiatry Co-Management**

Geriatric Psychiatry may directly request additional geriatric support and vice versa. If we feel Geriatric psychiatry support is required, the admitting service is asked to directly call the consult liaison line x8419. At TGH and PMH, there is no inpatient Geriatric Psychiatry Consultation Service. Psychiatry consultation is requested through the General Psychiatry Consultation-Liaison Service.

Overall, if there are any questions about the appropriateness of the consult, or around which service should handle a consult, please speak with the consult staff geriatrician before communicating further with the referring service.

CONSULTATION LOGISTICS

Figure 3. **Consultation Process**

E-Mail Notification of New Referrals

Because we work in a collaborative interprofessional team, all new referrals are notified in person and via the respective group e-mail (e.g. MSH vs. TGH/PMH) notification. By now, you have received an e-mail asking you to save the group e-mail notification for both SHS and TGH. In the e-mail notification, minimal identifiers are used, including initials, MRN, location, reason for referral and any geriatric issues identified. Please use the site appropriate group e-mail notification. For example, new referrals from TGH are sent to the TGH Geriatrics Consult service.

Consultation – Review – Follow Up

When a consult is requested, each patient receives a CGA and is screened by the rest of the interprofessional team. This ensures you receive appropriate allied health support for your overall assessment and allows the older patient to receive the specialized care that they may require. Please note that there are no geriatric allied health professionals at TGH and PMH. However, you are welcome to seek the advice of the interdisciplinary team based at MSH.

At the SHS and TGH/PMH, we use the blank **pink** and **yellow** consultation notes, respectively, to document our initial assessment and recommendations. **Please see the trainee resource website for a CGA template for guidance**. We encourage the use of the blank consultation notes, as the CGA template is not an approved hospital form though is currently under review. **If you choose to use the CGA template, please use the appropriate site-specific template**. Your consultation notes should always be stamped and/or labelled. It should also record the consultation date, and start and stop times of your assessment for accurate medical documentation.

Reviewed and completed consultation notes are left in the patient chart. Additionally, we remove all carbon copies of the consultation and file the stapled consultation note in alphabetical order in the middle drawer of the filing cabinets, located just outside the resident office. This carbon copy ensures that the patient is seen and provides information to the inpatient consult team when needed. **If the CGA template is used, please ensure that you <u>photocopy</u> your consult note and file it in the same manner described**.

All geriatric medicine consults are typically completed and reviewed within 24 hours of receiving the consultation at a mutually convenient time between the University Avenue Staff Geriatrician and the trainee. If the trainee is unable to see an urgent consult (e.g. acute delirium), the trainee should speak directly with the attending geriatrician to determine the appropriate next step.

Trainees follow the patients that they have seen throughout their hospital stay to provide continuity. Occasionally, you may pick up and/or a follow up a patient that you have not seen previously. Every time you assess your follow up patients, a progress note is written. Patients should be seen a minimum of twice a week (usually before consult rounds) or more frequently as the situation requires.

Consult Recommendations

At SHS, all consultation recommendations are communicated with the referring service. We also offer to implement our recommendations directly on behalf of the team via Powerchart. This provides education to the referring service, and helps avoids medical errors and delays in patient care. On the *orthogeriatrics hip fracture service*, the geriatric team can use direct order entry for any geriatric related issue. Please note that the Orthopaedic team also refers non-hip fracture patients (e.g. peri-prosthetic fractures, elective surgeries). In these cases, the orthopaedic team is the MRP, and any patient care issues or recommendations are communicated with the Orthopaedic residents directly and documented in the chart.

At TGH/PMH, all consultation recommendations are similarly communicated with the referring service. We write "Geriatric Suggest" recommendations in the order sheet AND call the referring service. If the referring service is agreeable to our recommendations, we ask to input our orders directly into EPR. In the order sheet, we also note that our recommendations were agreed to by the referring service and entered into EPR.

Sign Out Lists

All University Avenue patients (including TGH and PMH) – new and follow up – are manually added and updated on the **<u>Mount Sinai</u> Sign Out List**. You are responsible for entering your patient's information (include past medical history, brief presentation and hospital course), the management plan, and any follow up issues identified. **Please ensure that the Geriatric Medicine Consult Service Sign Out Lists are kept up to date on a *daily* basis**. This ensures that issues are followed appropriately when trainees are on call and/or away (e.g. half day back, clinics).

The University Avenue Sign Out List is accessible through Powerchart or via the **MSH Intranet**. Under "Clinical Tools," click "Sign-out Page," then "Geriatrics SignOut." The password is "geriatrics." It is also accessible through the

UHN intranet homepage. On the left hand side menu, click "Useful Links," then scroll to the bottom of the page and click "Mount Sinai Hospital Intranet."

PATIENT CARE ROUNDS & EDUCATIONAL OPPORTUNITIES

Daily multidisciplinary rounds occur to ensure open communication about patient care related issues. See *Table 2*.

Table 2. **Rounds**

	Rounds
Monday	9:00am – Orthogeriatrics Team Rounds 11:00am – Geriatrics Consult Rounds • Attended by HC NP Emma Anderson and ICCP NP Jennifer Thomas
Tuesday	9:00am – Geriatric Consult Rounds
Wednesday	9:00am – Geriatric Consult Rounds 9:30am – Conjoint Geriatric Medicine & Psychiatry Consult Rounds
Thursday	9:00am – Geriatric Consult Rounds • Attended by Hospitalist team
Friday	9:00am: Geriatric Consult Rounds

* MSH Geriatric Consult Rounds – MSH 4th Floor, Room 475
* Ortho-Geriatric Team Rounds – MSH 2nd Floor, Room 212
* MSH Conjoint Geriatric Medicine & Psychiatry Consult Rounds – MSH 4th Floor, GIM Conference Room

Consult and ward rounds are focused on patient-centred teaching. Additionally, there are opportunities for formal education while on this rotation. See *Table 3*.

Table 3. **Educational Opportunities**

	Educational Seminars & Rounds	
	MSH	***TWH***
Geriatric	Geriatric Giants Seminar – Thursdays Geriatric Psychiatry (Optional) –1st Thursday Geriatric Medicine Journal Club – Last Friday Allied Health Seminars – Monthly • Polypharmacy • Gait aids • Community Services	Dementia Seminar – Monthly Allied Health Seminars – Monthly • Consent & Capacity • Elder Abuse • Wound Care
GIM	GIM Rounds – Daily Medical Grand Rounds – Wednesdays Osteoporosis Rounds – Thursdays	
Medical Consults Teaching (*Orthopedic Residents Only*)	Harvey Simulator Teaching Rounds – Mondays Medical Consults Evidence-Based Medicine Rounds – Tuesdays Medical Consults Staff Teaching Rounds – Wednesdays	

As part of your orientation, we have also included a selection of review articles on the common topics in geriatric medicine as well as additional resources available online at the trainee resource website http://sinaigeriatrics.ca/orientation/. If you are interested in additional formal teaching, please speak with your attending.

OTHER ROTATION LOGISTICS

Geriatrics Residents' Office

The University Avenue geriatrics residents' office is located at the SHS, 4th floor, Suite 475. This is your workspace, which has been equipped with two networked computers and a phone (416) 586-4800 x7741. Trainees may also leave their belongings while seeing patients. A key may be requested with a $20 deposit from Dr. Sinha's administrative assistant that must be returned at the end of your rotation. **Please keep this space neat and tidy; and also lock the door behind you if you are the last one to leave the office at any time**.

Orthogeriatrics Residents

Orthogeriatrics residents spend two weeks on the inpatient Hospitalist service focusing on perioperative assessment and management of geriatric orthopedic patients; and two weeks on the Geriatric Medicine service focusing on geriatric assessment and management of surgical patients. This experience is complemented by the TRI Falls Prevention Clinic and/or the Geriatric Day Hospital Program (see below). The Staff Hospitalist provides orientation to the Hospitalist service on the first day of the rotation.

Physiatry Residents

Physiatry residents spend two weeks at the SHS inpatient geriatrics consultation service to gain exposure to acute geriatric care. The resident then spends 6 weeks on the inpatient geriatrics consultation service in the rehabilitative setting with a large proportion of their time spent on the Geriatric Rehabilitation Unit. This experience is supplemented with additional ambulatory care, rehabilitative programs, and community experiences. The TRI Staff Geriatrician provides orientation to the TRI service when the resident begins their TRI post acute care experience.

Weekend Call

Orthopedic and Physiatry residents participate in 1 weekend home-call shift (Friday 17:00 until Monday 08:00) throughout their rotation, which provides coverage for both the SHS and UHN Hospitals. The Weekend On-Call Resident's main contact is the Weekend On-Call Staff Geriatrician, so the resident is responsible for contacting the Staff Geriatrician on call and exchanging contact information prior to their weekend shift.

Residents are usually on-call with a PGY4 or PGY5 Geriatric Medicine resident (who covers city-wide call) and the Staff Geriatrician. Orthopedic and physiatry residents do not take first call. Geriatric medicine residents are first call to new consultation requests and patient care issues. The Staff Geriatrician is second call (first call, if a geriatric medicine resident is unavailable).

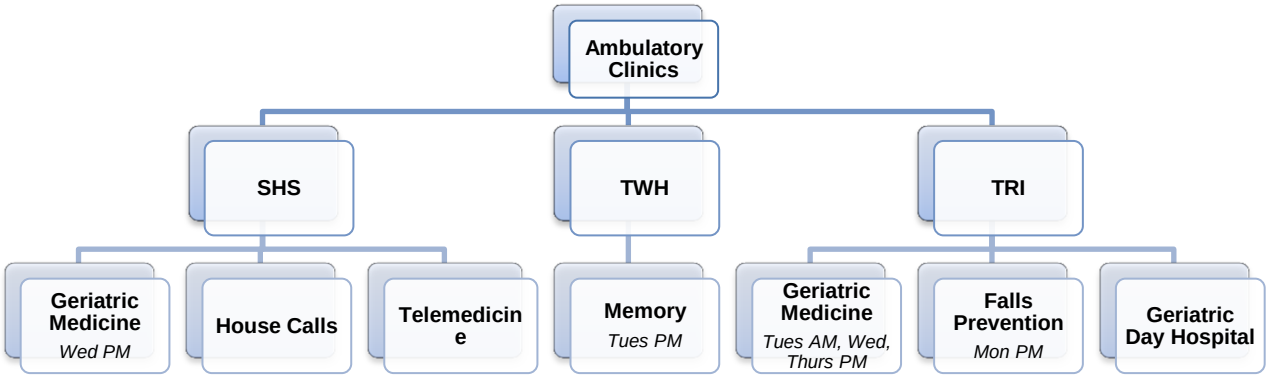
Residents' main responsibilities are to see new hip fracture and/or urgent surgical consultations over the weekend. Again, the Staff Geriatrician is usually the first to receive weekend notifications of new hip fracture patients at SHS and TWH. The Staff Geriatrician will notify residents of new hip and/or surgical consults that will be seen and reviewed

Once a consultation is reviewed, the resident is expected to follow the above procedures regarding consult recommendations and updating each sites respective sign-out list. If you have access to the site-specific resident geriatric office, please file the carbon copy of your consultation note accordingly. If not, please leave the consultation in the chart and the daytime team will file the carbon copy of the consultation note during the next business day.

GERIATRIC AMBULATORY CLINICS

There are various outpatient and community services available to the older adult population at the SHS and UHN. See *Figure 4*. During your geriatrics rotation, each trainee receives as many clinic experiences as possible to complement their inpatient experience.

Figure 4. **SHS & UHN Geriatric Ambulatory Clinics**



If you are scheduled for clinic, please arrive on time as patients have been scheduled for you in advance. If you are unable to attend clinic, please notify the attending staff. **Please also ensure you obtained a SHS and/or UHN dictation code at the beginning of your rotation.**

Table 4. **General Clinic Locations & Contact Information**

	Location	***Contact***
SHS (*Drs. Goldlist, Ng, Sinha*)	Fourth floor, Room 475	Stephanie Silva (416) 586-4800 x8563
TWH (*Drs. Berger, Goldlist, Liberman*)	West Wing, Fifth floor	
TRI (*Drs. Alibhai, Berger, Chau, Liberman, Steiman*)	Ground floor, Outpatient Clinic Area (Elm Street entrance)	UC Outpatient Clinic Administration (416) 597-3422 x4200

Geriatric Medicine Clinics

At the Geriatric Medicine Clinic, trainees have an opportunity to complete a comprehensive geriatric assessment (75-90 minutes) in the ambulatory environment. Patients are seen for a variety of reasons but these are often similar to the inpatient consult service; however, patient acuity is of lesser intensity. One or two new patients will be booked for you to see. You may also spend 30-45 minutes each with one or more follow-up patients.

Geriatric Medicine Clinics are also multidisciplinary. At SHS, a Geriatric Pharmacist (Christopher Fan-Lun) supports the clinic. The Pharmacist initially reviews a new patient's medication(s) and helps prepare a take home medication list for the patient at the end of the visit. During this time, the trainee can review the new patients medical records that were supplied in advance prior to their assessment. The Geriatrics Social Worker (Carmelina Marziliano) and/or Geriatrics Physiotherapist (Natasha Bhesania/Maegan Bell) is also available for additional support and can be paged to assist you at the current and/or follow up visit. At TRI, a Geriatric Nurse (Brenda Le/Ramona Gheorghe) and Geriatric Social Worker (Katie Stock) are available for additional support and can be located in the "Fish Bowl" area of the outpatient clinic.

Memory Clinic

The UHN Memory Clinic is a collaborative, multi-disciplinary clinic where patients with memory complaints are

assessed by geriatric medicine, geriatric psychiatry, and behavioural neurology within an intperofessional team. Overall, three new patients are assessed in clinic. You will complete a medical assessment for one patient; and observe a detailed cognitive assessment and neurological (including mental status) examination. This is followed by a multidisciplinary case conference. Further details will be provided on the first day of clinic at **13:00h sharp**. Please refer to the trainee resource website for a more detailed introduction to the Memory Clinic.

Falls Prevention Clinic

The UHN Falls Prevention Clinic is a collaborative, multi-disciplinary clinic where older patients with one or more falls in the past year (or who are at high risk of falling) are assessed by geriatric medicine, nursing, physiotherapy, and pharmacy. The multidisciplinary team determines if the patient is an appropriate candidate for the 12-Week Falls Prevention Program that is run weekly by nursing and PT. Four new patients are assessed at each clinic. You will assess two new patients in clinic and learn how to take a focused falls history and relevant physical examination. Clinic orientation will be provided at **13:00h sharp in the clinic conference room 1-004-27**. Please refer to the resident resource website for a more detailed introduction to the Falls Clinic.

Geriatric Day Hospital Clinic

The UHN Geriatric Day Hospital (GDH) is a collaborative multidisciplinary clinic comprised of interprofessional members (including RN, OT, PT, SLP, SW, and Recreational therapy) and a Geriatrician. This interdisciplinary team assesses frail older patients with cognitive, functional, and psychosocial issues and determines if the patient is appropriate for the 12-Week GDH Outpatient Rehabilitation Program. The Outpatient Rehabilitation Program occurs twice a week for rehabilitation (e.g. group physiotherapy for falls prevention) with ongoing geriatric follow up. One to two new patients are typically assessed at each clinic.