North Simcoe Muskoka Specialized Geriatric Services

Comprehensive Geriatric Assessment – CGA
Core Interprofessional Competencies

SGS Practice Area	Behavioural Statements
Core Geriatric Knowledge Demonstrates fundamental understanding of physiological and biopsychosocial mechanisms of the aging process, age-related changes to functioning, and the impact of frailty.	a) Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to geriatric clinical practice, including but not limited to: i. Normal aging ii. Frailty iii. Atypical presentation of disease or medical conditions in the elderly iv. Geriatric management of the older adult with multiple, complex medical conditions v. Falls and mobility vi. Immobility and its complications vii. Cognitive function viii. Mild cognitive impairment (MCI) ix. Dementias including behavioral and psychological symptoms (BPSD) x. Delirium xi. Mood disorders and other psychiatric manifestations xii. Pain management xiii. Nutrition/Malnutrition xiv. Bowel and bladder management xv. Bone disorders xvi. Metabolic disorders
	b) Demonstrate skill in working with older adults with significant functional deficits and communication challenges (e.g. cognitive impairment, sensory impairment, behavioral problems or ethno-cultural pluralities).
	c) Demonstrate knowledge of medications management, including but not limited to: i. Complete a detailed Best Possible Medication History and perform medication reconciliation. ii. Promote adherence to a prescribed drug regimen iii. Identify potentially inappropriate medications for an elderly patient iv. Recognize polypharmacy
	d) Demonstrate knowledge of currently accepted recommendations for primary and secondary prevention of common geriatric syndromes.
	e) Demonstrate an awareness of the limitations of the scientific literature with regard to generalizability and applicability to a frail older population.
Screening, Assessment, and Risk Identification Gather patient medical and social history and clinical data in sufficient depth to inform care planning and effective clinical decision making.	a) Identify and explore issues to be addressed in a patient encounter including the patient's context and preferences.
	b) Conduct an assessment within identified domains of the CGA using clinical acumen in conjunction with standardized, valid, reliable instruments as appropriate.
	c) Recognize important clinical indicators to promote patient safety (e.g. signs and symptoms, laboratory tests, adverse effects).
	d) Assess an older person with multiple physical, medical, cognitive/psychiatric, functional, and/or social problems.

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	e) Identify reliable sources of information to inform the patient history (e.g. Cumulative Patient Profile, involved family etc.).
	f) Compile a history, drawing from reliable sources, that is relevant, clear, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis, treatment and/or management.
	g) Gather information about a patient's beliefs, concerns, expectations and illness experience.
	h) Collect a collateral history; supporting details from a close source who knows the patient's daily routines and function accurately (e.g. family member or caregiver).
	i) Recognized the significance of behavioural observations in dementia care.
	j) Assess an older person for their capacity to consent to treatment and make personal decisions.
	k) Recognize and identify risk factors for and assess the presence of abuse/neglect (i.e. financial, physical, emotional, sexual).
	l) Perform and interpret an environmental safety screen.
	m) Identify specific patient vulnerabilities across the social determinants of health (e.g. lack of family support, lack of primary care, and chronic mental health issues, financial challenges etc.) that increase the risk the patient's needs will not be met.
	n) Identify and assess caregiver burden.
Analysis and Interpretation Conduct accurate analysis of assessment findings and clinical information to develop a complete understanding of the patient's story. Integrate assessment findings, within and across domains to formulate a cohesive clinical impression.	a) Synthesize relevant information from multiple sources including perspectives of patients and families, colleagues, and other professionals.
	b) Analyze and interpret results against age-appropriate and patient-specific norms.
	c) Analyze and take appropriate action related to important clinical indicators (e.g., signs and symptoms, laboratory tests, adverse effects) to promote patient safety.
	d) Evaluate the reason for change from baseline pre-morbidity to current functional status.
	e) Evaluate the restorative potential of the older patient.
	f) Demonstrate the ability to deal effectively and efficiently with clinical complexity by prioritizing problems.
Care Planning and Intervention Demonstrate expertise in treatment, education, goal setting, future and advanced planning. With patients and their identified support network, formulate comprehensive, collaborative care plans focused on optimization of function and quality of life. Demonstrate knowledge of community resources and appropriate referral sources and mechanisms to access	a) Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care.
	b) Evaluate the level of engagement and capabilities of caregiver(s) to meet the needs of older patients.
	c) Include interventions to alleviate caregiver burden in the care plan.
	d) Apply evidence-informed interventions appropriate to a geriatric population.
	e) Use information about behavioural observations to inform a patient centred goal-based care plan.
	f) Develop care plans that include the use of preventive, adaptive and therapeutic interventions in collaboration with interprofessional team members.
	g) Negotiate and construct timely care plans reflecting a patient's goals, beliefs, concerns and expectations in the context of their health trajectory.
	h) Clearly synthesize the agreed interventions and responsibilities including follow up actions.

SGS Practice Area	Behavioural Statements
them. Conduct iterative and ongoing review and revision of the care plan and adjust interventions and modify goals as needed.	i) Assure that individual responsibilities in a specific care plan are explicit and understood.
	j) Check for patient and family understanding, ability and willingness to follow through with recommended interventions within recommended time frames.
	k) Encourage participation in health promotion and disease prevention activities.
	l) Promote safety while respecting patient autonomy in care planning decisions.
	m) Propose a safety plan in response to abuse, in conjunction with clinical team and others (e.g. police).
	n) Mediate situations of conflict between older adults and their family members in relation to care planning.
	o) Conduct follow-up consultation(s) to evaluate the therapeutic effectiveness of care plans.
	p) Assess acceptance, tolerance, safety, and adherence to the care plan.
	q) Continue to refine interventions based on patient response and goal attainment.
	r) Demonstrate the ability to promote integrated care of older patients, especially those with complex needs, and ease transitions across the variety of settings where they may receive services.
	s) Identify the role of specialized geriatric services in providing case management for the frail senior.
	t) Identify and appropriately discharge patients whose specialized geriatric service goals have been met.
	u) Reinforce the importance of advance care planning and discuss with patients and families the implications of their illness to allow patients and their families to prepare a robust advanced care plan.
	v) Support patients and their families to access timely and appropriate end-of-life care consistent with their belief systems.
Interprofessional Practice Demonstrate and support interprofessional geriatric practice. Recognize and engage in inter-organizational collaboration through understanding of the roles of internal and external team members, and demonstrate the ability to identify appropriate opportunities to refer to collaborating teams/individuals.	a) Demonstrate both knowledge of critical concepts and the skills needed for the effective functioning in multidisciplinary/interprofessional clinical teams
	e) Identify and describe the training, role and expertise of members of the interprofessional team in the care of patients.
	c) Demonstrated insight into limits of own expertise.
	u) Demonstrate the skills needed to address potential differences and misunderstandings between professionals.
	f) Regularly reflect on dynamics and productivity of self and interprofessional team.
	g) Cooperate with and show respect for all members of the interprofessional team by: i) Making expertise available to others. ii) Sharing relevant information. iii) Contributing to identification of shared areas of concern and strategies and priorities of patient care to address those concerns.
	h) Participate in defining team goals and objectives.
	i) Effectively collaborate with others, including primary health care providers and other partners: i. To provide quality care. ii. In research, education, program review or administrative responsibilities. iii. To promote health and wellness in the community.

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Professional Practice Demonstrate core values, behaviours and skills required to provide comprehensive, team based geriatric care. Demonstrate confidence in evaluating and maximizing own professional scope to optimize geriatric practice.	a) Demonstrate compassionate and patient-centered care
	b) Facilitate older adults' active participation in all aspects of their own health care (i.e. access to information, right to self-determination, right to live at risk, access to information and privacy).
	c) Respect and promote older adults' rights to dignity and self-determination
	d) Demonstrate leadership and accountability for providing follow-up on identified patient needs or directing follow-up as appropriate.
	e) Discuss with the patient the ongoing responsibilities of the geriatric assessor, patient and other health care professionals.
	f) Understand and apply the principles of capacity for decision making and informed consent.
	g) Follow procedures for voluntary consent or proxy decision making (e.g. Substitute Decision Maker, Public Guardian and Trustee etc.) that arise from aging issues.
	h) Obtain informed consent throughout assessment, care planning and interventions.
	i) Evaluate the impact of family dynamics on client's health, safety, and therapeutic goals
	j) Respect diversity and difference, including but not limited to the impact of gender, sexual identity, family dynamics, religion and cultural beliefs on decision-making.
	k) Address challenging issues effectively, such as obtaining informed consent, sensitively discussing a diagnosis/prognosis, addressing emotional responses, confusion and misunderstanding.
	l) Identify and appropriately respond to relevant ethical issues arising in the care of older adults.
	m) Maintain the patient's health record as per organizational policy and legislated requirements
	n) Document and share within the circle of care, the patient goals, appropriate findings of patient assessment, recommendations made, responsibilities of involved parties and actions taken.
	o) Document communication with patient and health care professionals across the broad care team in the appropriate locations (e.g. patient record and/or care plan) including connections with inter and extra agency team members, telephone calls of a clinical nature etc.
	p) Evaluate self and demonstrate an understanding of the importance of and the process of continuing professional development. i. Critically reflect on own practice. ii. Assess own learning needs. iii. Develop a plan to meet learning needs. iv. Seek and evaluate learning opportunities to enhance practice. v. Incorporate learning into practice. vi. vi. Act as a preceptor/mentor for IP team and students.

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