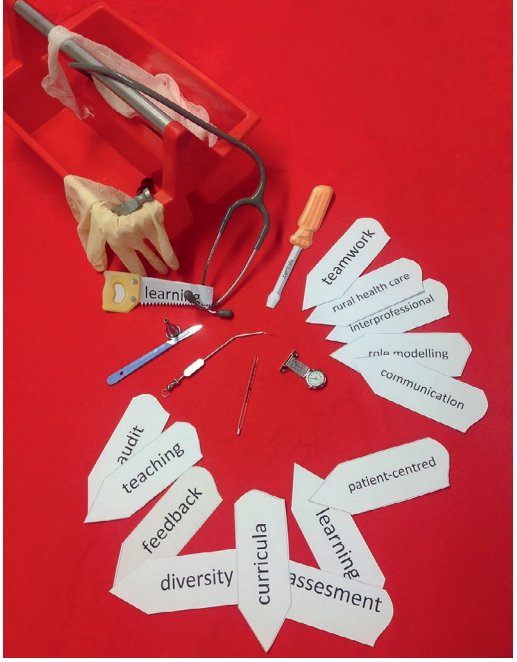
The Clinical Teacher's Toolbox



Medical students in residential aged care: A guide

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Editor's note: Clinical settings for health professional education should not be restricted to the more traditional locations, such as hospital wards and clinics, and community-based primary care surgeries. This toolbox article explores the potential for learning offered by residential aged care facilities (RACFs), also known as care homes. In these facilities students from different professions may come together to interact with elderly people, who frequently have several long-term conditions. The authors write from their experience of placing senior medical students in RACFs in Tasmania, Australia, and discuss what they and the students have learned from these attachments. The curriculum is flexible to help students understand the context in which the RACF is situated, be that in a large city or a small rural town. Learning outcomes include palliative care of residents with dementia, working with the frail elderly and medication use, encompassing the ethical and legal issues of prescribing. The importance of nurse mentors and GP tutors is stressed. There are opportunities the observation of and participation in interprofessional practice. Evaluation has shown that students are able to contribute meaningfully to resident care. The toolbox finishes with recommendations for readers interested in developing and sustaining similar attachments.

INTRODUCTION

Residential aged care facilities (RACFs), also known as care homes, aged care homes or old people's homes, can provide unique and valuable medical student clinical learning opportunities (clerkships), including in interprofessional practice (IPP), but the literature suggests that this practice is limited to the Netherlands, the USA and Australia.[1–4] Based on our 8-year experience of delivering a 5-day RACF clerkship to Australian senior medical students,[5] we explain why an RACF clerkship should be considered for all medical programmes, and describe aspects of our RACF medical curriculum, including IPP.

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an acute orientation to the care offered, and we therefore hope that our recommendations for developing and sustaining a similar RACF clerkship in your medical programme will be widely adopted.

WHY IT IS IMPORTANT FOR SENIOR MEDICAL STUDENTS TO UNDERTAKE AN RACF CLERKSHIP

In Australia, newly graduated hospital-based doctors and most specialties, including general practice, will care for residents of RACFs, or people who transfer to a RACF after hospitalisation, and therefore understanding this unique environment is important for patient care.

Residential aged care facilities (RACFs) provide permanent or respite care for 9% of Australians,[6] whereas many people living in their homes, who access to other forms of government-funded aged care support, have similar health issues involving multimorbidity associated with poor mobility and cognitive impairment.[7]

The ability of doctors to provide optimal care for RACF residents will depend on their understanding of the RACF context, which is often clinically resource poor,[1] and that RACFs provide residential and health care for people with complex comorbidities who are frequently frail and are also likely to have dementia.[8]

The current Australian general practitioner (GP) RACF workforce is aging, and there are concerns that specific training of the GP workforce to overcome future shortages of GPs willing to care for RACF residents is needed.[9] A medical student clerkship may start the process of addressing this workforce shortage by highlighting this area of work should the student train to be a GP.

CURRICULUM ISSUES

Here, the planned curriculum of learning outcomes, aspects of our enacted curriculum, delivered in three different clinical school contexts, including the IPP component, and evaluations of the experienced curriculum are described.[10] Our clinical schools train our medical students in the last 2 years of their 5-year medical degree and exist in a capital city, regional city and rural context.

The planned curriculum

As no curriculum for medical students providing care for residents in RACFs existed,[9] we designed ours de novo. The learning outcomes are noted in Box 1.

The medical student learning outcomes deliver a mix of those that are unique to the context of RACFs, such as the palliative care of people with profound dementia, and those that are common to other contexts, such as general palliative care and care of the frail elderly.

The programme is structured with enough time to consider ethical issues, such as those involved with healthy aging, the delivery of palliative care to residents, as they move from 'end of life' care towards death, and deprescribing, for the same reason.

Two of the clinical schools also include a pharmacist, as part of the teaching team for the RACF clerkship, who provides tutorials on optimising medication use in the elderly and safe deprescribing. Auditing activities have also been designed and supervised by pharmacist tutors, such as assessing the prevalence of the use of medication in managing resident behaviour, with findings leading to discussions encompassing the ethical and legal issues involved.

The enacted curriculum

Relationship building with partnering RACFs and the crucial role of nurse mentors

As is usual throughout Australia, GPs do not conduct their day-to-day practice in Tasmanian RACFs. Instead, they visit the facilities,

Box 1. Learning outcomes for the care of elderly frail people

These will be attained on placement in the residential aged care facility (RACF) programme but may also be attained elsewhere.

By the end of your RACF rotation, or by the end of your medical training, the minimum requirement is that you be able to achieve the following learning outcomes with intense, proactive, continuing, full supervision:

- Undertake comprehensive assessments of elderly frail people, producing a management plan that is sensitive to that person's goals of care, and that is contextualised to their care setting and to the services available
- Detail, initiate and monitor a management plan for a frail elderly person
- Communicate with a frail elderly person's family or other relevant carers with regard to the person's health issues and management goals
- Work with multidisciplinary teams to optimise the care of frail elderly people
- Working as a team member, design and undertake activities to assure and improve the quality of care and to minimise risk in order to improve health outcomes for the population cared for by the service

Assessment modalities: logbook and student end-of-week presentations; short-duration attachment form completed by one of the GP tutors after consulting with RACF staff; OSCE; summative long case.

often outside of business hours,[11] which poses a problem for the supervision of RACF-clerkship medical students.

Our solution relies on university-paid nurse mentors, GP tutors and (in some contexts) pharmacist tutors, who all provide clinical supervision at various times during the 5-day clerkship.

The nurse-mentor role has been developed by nursing academic colleagues with initial funding via the Teaching and Research Aged Care Services (TRACS) programme,[12] a national government programme limited to 2012–2015. Since TRACS funding ceased, our university has continued to pay for the role of RACF nurse mentors. The formula devised in the TRACS-related phase is of 40 hours per week when eight nursing students are present, plus 1 day for each placement group for preparation and 1 day post-placement for the completion of university documents. For medical students the formula is based on 1 day per semester for preparation, 2 days per week for each week that students are placed and 4 days per year for post-placement completion of documentation.

Nurse mentors have proven crucial to the success of the RACF-based programme for all health care students, including medical students. Nurse mentors welcome and orient students to the RACF on day 1 and are the organisers of contact with RACF residents, ensuring consent from residents or their family prior to student visits. Nurse mentors also organise IPP opportunities and offer general student support, for example when students deal with confronting clinical contexts such as locked wards used to care for mobile residents with advanced dementia. They are also able to engage with GP tutors who deliver aspects of the programme, with both professions modelling IPP for students.

If you do not have a school of nursing to lead the way for your medical school, it will still be necessary to closely engage with and pay RACF nursing staff to assist in delivering a medical student programme.

A highly structured programme assists with clinical supervision

To provide a proxy for close medical supervision we also use a timetabled 1-week experience that has students engage in RACF resident comprehensive medical assessments (CMAs), reviewing patients with increasing levels of cognitive impairment over the week. All students work in pairs of either medical students or with a student from another health profession to complete up to six assessments over a week. Table 1 gives a sample 1-week timetable for the medical student programme and Box 2 provides a guide for reporting the outcomes of a CMA, including changes in management recommendations.

Delivering a programme depending on the type of GP support available

Our three clinical schools have different contexts to bring to the clerkship: two of the schools have large general practices that look after one or more RACFs that are part of the programme; one school has a visiting GP tutor who is experienced in providing care to RACF residents but does not care for residents in the RACF programme.

Where RACF GP tutors have students reviewing residents that they care for, student recommendations can be considered at the time and possibly enacted by the appropriate RACF team member. Examples include recommendations to change, cease or reduce medication, the detection of unrecognised comorbidities, such as depression, or the assessment of an acute issue, such as newly recognised confusion. Illustrating the clerkship's emphasis on resident-centred care, students have also made suggestions designed to enhance a resident's lifestyle, such as the provision, for resident use, of raised garden beds or large-button telephones. In the context where the GP tutor is a visitor to an RACF, the writing of letters to the resident's usual GP about the findings and recommendations of students following their assessment of a resident has been instigated. This intervention is being evaluated to see whether changes are subsequently made in medical management, reminding us of the value of medical education research in our RACF programme.

Interprofessional practice

The placement provides IPP opportunities for medical, nursing, paramedicine and, more recently, pharmacy students.[13]

Our initial strategy of placing students from various health professions in the RACF together and hoping that IPP would happen failed. We then used the wisdom of the nurses and GPs, who work together within RACFs, to design legitimate activities that students could undertake together in caring for an RACF resident. In nursing and general practice, both undertake comprehensive assessments of residents. Noting the overlapping and 'unique to each profession' aspects of the assessments, students now meet before seeing a resident, and decide who will ask which questions and examine for what in a paired nursing–medical student team. Each pair observe, support and learn from each other as each undertakes their part. They then meet to discuss their findings and recommendations for improved care, and finally organise their presentation to the RACF team and GP tutor at the end of the week. Their presentation is formatively assessed by the meeting attendees, with some

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Table 1. Example timetable: residential aged care interprofessional learning/interprofessional practice programme

Time	Monday	Tuesday	Wednesday	Thursday	Friday
08:00	Dr XX of XYZ Clinic (XYZ) – overarching supervisor of medical student for the week Introduction, consent and confidentiality, computer access at the XYZ practice	Med student **Tutorial** at XYZ. Student pairs do a 10-minute presentation of their RACF resident, focusing on one aspect of care. Attending: Dr XX, other XYZ doctors & students	07:00 Nursing medication round (one student per nurse round) Small group learning for XYZ clinic GPs at the XYZ clinic – visiting clinician. Students join too.	07:00 Nursing medication round (one student per nurse round) **IPL** with Dr XX at the RACF with med, nursing or other students **Tutorial topic:** dementia	07:00 Nursing medication round (one student per nurse round) Complete CMA 2/**IPP** – finalise presentation. If applicable, start draft letter to resident's usual GP.
09:00–13:00	Nurse mentor **Orientation:** To the RACF, what is **IPL/IPP**, need for confidentiality and student provides police check documentation. **Tutorial topic**: Care for people with dementia from nursing perspective.	RACF Round with Dr XX At the RACF **Tutorial topics**: 'RACF palliative approach' & 'patient-defined goals of care'	RACF rounds with Dr YY. **Case-based tutorial** – topics relate to the residents seen.	Continue CMA2/**IPP** Consider recommendations for changes in nursing and medical management plan. Closely review medications – what can be stopped?	09:00 RACF round with Dr ZZ At the RACF: **Case-based tutorial** 12:00 – at the RACF with palliative care nurse **IPL tutorial topic:** providing palliative care in an RACF
Lunch 13:00	Provision of lunch by the RACF or student brings their own. Lunching with other students may encourage IPL. RACF provided lunches paid for by the student may assist with understanding the food provided by the RACF. Lunching with residents may prove socially beneficial to residents and aid student understanding of the lives of residents.				At the RACF **IPP** presentations. Attended by Dr XX, RACF nursing staff, nurse mentor and pharmacist tutor
14:00–16:00	CMA 1 – review patient for Tuesday clinical case and topic presentation. Review Dr XX's patients for Tuesday RACF round. **IPP** activity planning with nursing or other students	CMA 2/**IPP** – continue patient CMA for Friday case presentation Physiotherapist delivered manual handling training – with nursing students (**IPL**) Review patients for Dr YY's Wednesday RACF round with DR YY	CMA 2/**IPP** – continue resident review. Pharmacist: **Tutorial topic**: 'Deprescribing' & 'evidence-based use of medications to manage dementia-related behaviour'	Dementia Unit working with staff and note 'sundowning related resident behaviour'. Review patients for DR ZZ's Friday RACF round with DR ZZ	**14:00 Wrap up** At the RACF with Dr XX Week review, aged care task list reviewed, CMA reviewed, and assessment forms completed
16:00	Case review at the RACF with Dr XX. Preparation for clinical presentation next day.				
Complete activities, prepare for the next day					

Notes: Clinic XYZ, general practice at which Drs XX,YY or ZZ work; CMA, comprehensive medical assessment; dementia unit, for residents who need higher levels of care and who may wander, often a locked ward; Dr XX, YY or ZZ, GPs involved as tutors; IPL, interprofessional learning; IPP, interprofessional practice; RACF, residential aged care facility.

Box 2. Comprehensive medical assessment (CMA) guide: written format/headings

Please use the following headings for the written documentation of your CMA. Use of ISOBAR (identify, situation, observations, background, assessment, recommendations) format for the verbal discussion is encouraged, with an emphasis on management plan recommendations.

Resident's name: _____

Resident's regular GP: _____

- **Active** medical issues:
- Summary of cognitive assessment:
- Summary of mood assessment:
- Falls risk assessment:
- **Active** social issues:
- Palliative care issues:
- Current medications & issues:
- **Status of advanced care directive: goals of care**
- **Include relevant power of attorney/guardianship 'medical decision maker' information**
- Important information from informants other than the patient:
- **Overarching recommendations to improve overall management of patient:**
- **Select one key issue identified by you (from the above list or outside this list) for an in-depth discussion during verbal presentation to GP tutor:**

Lead student name: _____ Student number _____

Second student name: _____ Student number _____

resident management suggestions adopted.

When different health professions are present, the same model applies but the student focuses on their role and scope in the assessment: for example, a pharmacy student may undertake a medication reconciliation or check inhaler technique with the resident.

Outcomes of the RACF programme

Some medical student learning outcomes were predicted, such as improved dementia knowledge, and some were unexpected, such as opportunities for students to contribute meaningfully to patient care.[14]

Student feedback has noted 'the luxury of time' to complete their assessments to ensure that they are resident-centred (residents can tire and need a break), and the students have time to plan, execute and digest their findings. As they undertake their CMAs and finalise their management recommendations, most students experience the chance to 'think for themselves', remarking that this is a rare event in other clerkships. They especially enjoy the chance to 'feel a bit valued', noting that it is 'nice to have your opinion considered and be able to apply stuff we have been learning whereas sometimes on … [another] rotation you don't get to use your brain at all'.

The majority of students also think that the experience is pitched at the right year of training, with one noting that 'I think the reason we have been helpful is that we know enough about the medications and the patient care'.

The highly structured nature of the programme is also appreciated by the students, who contrast it with the random nature of traditional ward clerkships, where they want to engage but may feel ignored by the supervising team all day.

Students who have not rated the clerkship highly find that it does not have enough of an acute-care focus at a stage of their training when they expect, the following year, to be working as an intern in a hospital environment.

Residents' and their families' positive experiences of participating in the programme were related to participation in meaningful encounters with the students.[15]

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RECOMMENDATIONS FOR DEVELOPING AND SUSTAINING A SIMILAR RACF CLERKSHIP IN YOUR MEDICAL PROGRAMME

Table 2 provides a checklist to be considered when developing a medical student RACF programme in your school.

Points to emphasise are that foundational support from your institution is vital because of the added financial costs and cultural change needed to support the programme. The cultural change is in the contrast of the focus for the programme, away from the acute-care clerkships that students usually undertake to a less medical-only focus, where whole-patient, end-of-life care is considered.

As it is a workable setting for students to participate in IPP, this may be a 'selling point' in

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Table 2. Aspects to consider when delivering a residential aged care facility (RACF) placement for senior medical students

What features of the curriculum optimise student learning and resident outcomes?	• Strong faculty member support for the RACF-based team, such as paying for the time of nurse mentors and supporting the RACF to engage in the programme • Preliminary workshops for students covering useful topics, such as how to assess someone with dementia or someone with impaired mobility • Ensuring resident safety is paramount in the curriculum design • Work-based learning that is structured, sequenced and scaffolded • Interprofessional learning (IPL) and practice (IPP) student activities based on usual resident-care practices, such as undertaking a comprehensive medical or nursing assessment • The potential for student contributions to resident care is optimised
What personnel and institutional aspects should be used to enact the curriculum?	• Strong GP tutor and RACF assistance to design, tweak and deliver the curriculum • Skilled GP tutors who care for the residents in the RACF, or who understand the skills needed to deliver this care • GP academic availability to formalise and champion the curriculum within the medical degree • Academics, RACF staff and GP tutors who champion interprofessional learning and practice (IPL/IPP) • If delivering a clinical audit within the programme or focusing on therapeutics, consider adding a pharmacist tutor to your team
How might the programme evolve over time?	• To sustain GP tutor enthusiasm, ensure younger GPs are mentored to co-tutor within the programme • An emphasis on IPL/IPP will be popular but challenging to deliver because of conflicting student timetables. Problem-solve this hurdle
What may be evaluated?	• Student attitudes towards, knowledge about, engagement with, and competence in completing placement tasks • Residents and families' perceptions of the programme • Whether student recommendations for care were enacted and whether this improved patient care
What may be the opportunity costs for students and others in delivering the curriculum?	• Removing students from acute-care placements may meet resistance, which may be overcome by noting the large number of patients that interns will care for who either reside in an RACF or will enter one after a hospital admission. Understanding the RACF context will assist junior doctors to better care for current or potential RACF residents • Financial resourcing of the programme may be seen as untenable if other programmes are perceived as competing for funds
What may be the emerging realisations or effects of the placement?	• GP tutors and RACF staff may seriously consider student resident assessment recommendations. Such professional engagement will enhance student satisfaction with the placement. Students may add value to resident care • Student appreciation of the complexity of issues managed in an RACF may improve • Students may better understand aspects of palliative care delivered in an RACF, especially that dementia is a palliative care issue • Student willingness to engage in the future care of RACF residents may improve • If a student specialises as a GP, they may be more inclined to care for RACF residents as part of their practice

having your institution adopt and continue to support the programme; however, the need to align timetables to achieve IPP can be the biggest challenge to delivering it, an issue not unique to an RACF programme. If you do develop an RACF programme, please describe and evaluate it for the benefit of others as we develop this important area of medical education.

CONCLUSION

Residential aged care facility (RACF) clerkships for senior medical students can provide valuable and student-valued learning outcomes that are unique to the context of caring for residents of RACFs and are general to the provision of high-quality medical education. The RACF context can also provide an opportunity for student IPP. Both aspects of the programme may lead to students contributing to enhanced resident care, an aspect of the programme that is highly valued by students.

[Students noted that it was] 'nice to have your opinion considered and be able to apply stuff we have been learning …'

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