

SPECIALTY TRAINING CURRICULUM

FOR

GERIATRIC MEDICINE

MAY 2007

Joint Royal Colleges of Physicians Training Board

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We wish to express our thanks to the many colleagues who helped with the production of this document. We are indebted to the Members of the Education and Training Committee of the British Geriatrics Society who supported its development.

Foreword

Consultants in geriatric medicine are responsible for managing the clinical, preventive, remedial and social aspects of illness in old age. Older people, particularly those with age-related frailty, have high morbidity rates, different patterns of disease presentation, slower response to treatment and often a requirement for social support. A primary objective of geriatric medicine is to restore an ill and disabled person to a level of maximum ability sufficient, when possible, for him or her to live independently in the community.

This new curriculum encompasses the knowledge, skills, attitudes and competencies needed by geriatricians to provide high quality care in hospital and in the community. The range of skills needed is broad, from the management of acute ill health in the first 24 hours to the rehabilitation of chronic disease in a community setting, while also including the need for the consultant to lead the development of new services, undertake research and audit, and perhaps concentrate in more depth on some of the sub-specialties of geriatric medicine.

With changing demography geriatric medicine has become the largest single specialty in terms of numbers of consultants and trainees in the United Kingdom. There are both opportunities and challenges at this time of rapid change in the organisation of hospital care as a result of major financial challenges and the emergence of acute medicine as a distinct specialty. The core curriculum and specialty training grids in this document provide both a firm base to equip consultants to meet the expectations of older people at times of crisis in their lives while at the same time allowing flexibility for individual trainees to develop their careers in geriatric medicine in a direction of their own choosing.

Professor Timothy J Hendra
Chair Specialist Advisory Committee for Geriatric Medicine

GLOSSARY

ADL	Activities of Daily Living
BGS	British Geriatrics Society
CBD	Case Based Discussion
CCT	Certificate of Completion of Training
CD	Compact Disc
CGA	Comprehensive Geriatric Assessment
CPN	Community Psychiatric Nurse
DGH	District General Hospital
DOPS	Directly Observed Procedural Skills
DVD	Digital Video Disc
EBM	Evidenced Based Medicine
HAS	Health Advisory Service
ITU	Intensive Therapy Unit
JRCPTB	Joint Royal Colleges Physicians Training Board
KBA	Knowledge Based Assessment
MD/DM	Doctorate of Medicine
Mini-CEX	Mini-clinical skills Examination
MRCP	Member of the Royal College of Physicians Diploma
MSc	Master of Science
MSF	Multi-Source Feedback
NHS	National Health Service
NICE	National Institute of Health and Clinical Excellence
PEG	Per-Endoscopic Gastrostomy
PhD	Doctorate of Philosophy
PMETB	Postgraduate Medical Education Training Board
PSQ	Patient Satisfaction Questionnaire
PYA	Penultimate Year Assessment
RITA	Record (Review) of Intraining Assessment
RCP	Royal College of Physicians
SAC	Speciality Advisory Committee
STC	Specialty Training Committee

1. RATIONALE

1.1 BACKGROUND AND INTRODUCTION

The primary purpose of this curriculum is to provide detailed guidance for trainees in obtaining the appropriate level of knowledge, clinical skills, and competence to be awarded a certificate of completion of training (CCT) which is a prerequisite to a career as a consultant geriatrician working in hospital and/or community settings. This document will also enable postgraduate deans, regional specialty training committees, and educational supervisors to ensure that the required standards of clinical care are being met by having structured training programmes and objective assessment procedures within each region. The curriculum has been produced using the standards specified by the Postgraduate Medical Education and Training Board (PMETB).

The content of the curriculum and the teaching/learning methods described were chosen by the specialist advisory committee (SAC) in geriatric medicine. Regular meetings were held by the SAC involving all relevant stakeholders (guidance was given by the Joint Committee on Higher Medical Training (JRCPTB) and officials from PMETB) with much work being done by a curriculum sub-committee. The curriculum was drawn up by the SAC and submitted for approval by PMETB. The majority of the members of the SAC are practitioners, teachers, trainers and trainees in the specialty.

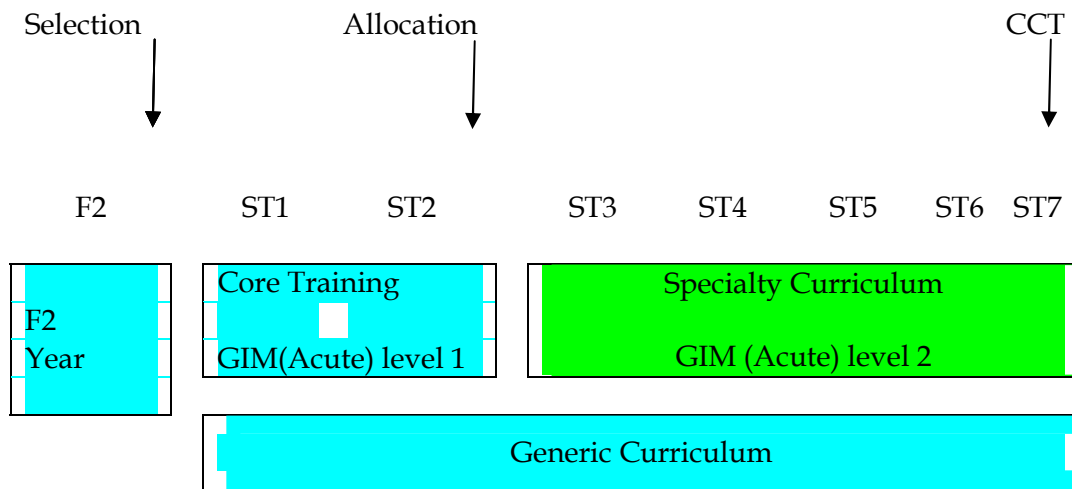
The competencies to be achieved as described within the curriculum build on the core medicine training including acute medicine level 1, achieved in specialty training years 1 and 2. Core medical training and acute medicine competencies build on foundation training. The curriculum describes the level of achievement expected from each of the years of training and how competency is attained and assessed. The specialty curricula identify competencies which are expressed as the knowledge, skills, attitudes and behaviours that trainees must achieve.

All trainees in geriatric medicine will undertake a programme of combined training using this curriculum, with the General Internal Medicine (Acute Medicine) curriculum for level 2. These curricula are to be used in conjunction with the Generic Curriculum for the Medical Specialties which includes the general professional competencies as specified in the domains of "Good Medical Practice" which are to be acquired by all specialist physicians and runs from the Core Medical Training to CCT (fig.1)

The curriculum will be achieved by completing the necessary specialty posts within training programmes. Until 2007 these posts will be at Senior House Officer (SHO) and Specialist Registrar (SpR) level. From August 2007 these will be described as Specialty Training (ST) year 1 through to Specialty Training year 7.

Fig.1

Diagrammatic representation of specialty, generic and GIM (Acute) curricula for acute speciality



General Internal Medicine (Acute) curriculum

The new curriculum for General Internal Medicine (Acute) is split into 3 parts.

Level one competencies will be achieved by all physicianly trainees during core training (core medical training – CMT or acute care common stem – ACCS) and must be achieved before progression to specialty training.

To participate in the acute medical take and to be responsible for the care of unselected acutely ill patients as a senior medical appointment a clinician requires a CCT in a medical speciality, such as geriatric medicine and diabetes mellitus, and a certificate in GIM (Acute). The Level 2 GIM (Acute) training programme ensures a trainee’s ability to provide acute medical care in the acute setting. Upon successful attainment of Level 2 competencies, the trainee will be certificated in GIM (Acute). The SAC in acute and general medicine has advised that it will generally be necessary for a trainee to spend a further two years in general and acute medicine from entry into ST3 in order to deliver the competencies required, for instance a dedicated period of acute medicine may deliver these competencies, or alternatively training in the speciality can continue in parallel with exposure to acute medicine.

Level 3 competencies will usually only be achieved by those wishing to CCT in GIM (acute) medicine and practice as an acute physician.

Dual Accreditation

Trainees who wish to achieve a CCT in GIM (Acute) must have applied for and successfully entered a training programme which was advertised openly as a dual training programme. This programme will need to achieve the competencies as described in both the geriatric medicine and

GIM (Acute) curricula and there must be agreed assessments (proposed by both SACs and approved by PMETB). These assessments will be those blueprinted to both curricula. It is expected that a number of assessments will be shared without a need for the trainee to repeat them separately for both curricula. Postgraduate deans wishing to advertise such programmes should ensure that they meet the requirements of both SACs.

1.2 RESPONSIBILITY FOR THE CURRICULUM

The medical director of the JRCPTB is responsible for the curriculum.

It was produced by the members of the SAC in geriatric medicine by consensus following work by a curriculum subcommittee. This includes trainers and trainees as well as professional advisers and lay members. Teaching and learning methods were chosen based on the teaching experience of the trainers and the suggestions of the JRCPTB.

The members of the SAC at the time of its production were:

Professor TJ Hendra MD FRCP (Current Chair of SAC), Dr CJ Turnbull FRCP (Secretary of SAC), Professor SC Allen MD FRCP (Chair of SAC from 1.7.06), Dr O J Corrado (Former Chair of British Geriatrics Society Education & Training Committee), Professor JRF Gladman DM FRCP (Academic representative), Dr K Kelleher FRCP (British Geriatrics Society Representative, Associate Dean London Deanery), Dr BJ Martin FRCP (Royal College of Physicians and Surgeons of Glasgow representative), Dr WR Primrose FRCP (Royal College of Physicians of Edinburgh representative), Dr PK Myint MRCP(UK) (trainee representative), Dr IR Hastie MD FRCP (Union of European Medical Societies representative, Deputy Dean London Deanery), Professor KM Cochran FRCP FRCP(Glas) FRCP (Edin) (Lead Dean for Geriatric Medicine), Dr DDP O'Shea MD FRCP (Royal College of Physicians of Ireland representative - Observer), Dr IC Steele FRCP (Northern Ireland PGMDE Observer), Dr RE Morse FRCP (Chair of British Geriatrics Society Education and Training Committee and Wales representative), Kirstin Barnett Specialty Co-ordinator, Joint Committee of Higher Medical Training Royal Colleges of Physicians).

1.3 ENTRY REQUIREMENTS

Applicants for medical specialist training will have satisfactorily completed and obtained the competencies of the Foundation training programme, the evidence being full registration with the General Medical Council and a certificate of completion of Foundation training or equivalent.

Before entering Specialty training in geriatric medicine the trainee will have satisfactorily attained the competencies (or equivalent) of general internal (GIM) (Acute) to level one achieved during core medical or acute care core stem training in approved posts. Furthermore, it is desirable that they have undertaken a work placement of at least 4 months post-qualification in geriatric medicine and if possible some further experience in geriatric medicine beyond that achieved in the foundation programme as well as a range of experiences of other acute medical specialties. It is desirable that the trainee has experience of the unselected acute medical take of at least 12 months

during core training or other post foundation training by the time of entering Specialty training in geriatric medicine. 'Unselected take' is defined as acute medical intake encompassing the broad generality of medicine, i.e. not restricted to any single or small group of specialities. If any major component of acute medicine (e.g. patients with stroke or myocardial infarction) is excluded from the take, this experience must be obtained in other posts. In order to ensure an adequate breadth of experience to supervise more junior trainees, on average at least 40 acutely ill patients should have been seen during each month of involvement in the acute take. These competencies will be demonstrated by satisfactory completion including assessments of the Acute Medicine level 1 curriculum.

The trainee will be expected to demonstrate a commitment to geriatric medicine training.

1.3.1 Non-UK graduates

Non-UK graduates who apply for specialty training in geriatric medicine must provide alternative evidence of appropriate knowledge, training and experience, particularly in the care of acute medical conditions and success in an equivalent knowledge based examination and a minimum of 4 months post-qualification experience in geriatric medicine.

1.3.2 UK graduates who have not completed core medical or acute care core stem training

UK graduates who have not been through the core medical or acute care core stem training schemes will be expected to have a similar level of competence and experience of acute medicine, and a minimum of 4 months post-qualification experience in geriatric medicine.

1.3.3 Trainees entering geriatric medicine training after year 3

Rarely trainees may enter the programme after year 3 if it can be demonstrated that the trainee has already achieved the necessary outcomes of training suitable for advanced entry. They will be expected to have an appropriate level of competence and experience in the management of acute medical conditions and experience from at least a 4 month post in geriatric medicine. This will be at the recommendation of the programme director and regional specialty adviser but will require approval by the SAC who will base their decision on the qualifications, training and experience of the applicant and references from former senior supervisors and where appropriate information from the outcome of article 14 applications.

1.3.4 Communication, team and leadership skills

All entrants to subspecialty training in geriatric medicine should demonstrate good communication skills as evidenced by successful completion of competency assessments and desirably will have received above average scores in those assessments. Team working and leadership skills should be demonstrated as evidenced by Multi Source Feedback (MSF) at school, medical school and during postgraduate training.

1.4 AIMS OF TRAINING

The primary purpose of training in geriatric medicine is the development of a physician who has the appropriate level of knowledge, skills, attitudes and competence to work independently and effectively as a consultant in geriatric medicine. Patient-centred approaches and team working are of vital importance. Training should be enjoyable in order to facilitate the learning of the trainee.

1.5 DURATION AND ORGANISATION OF TRAINING

Although this curriculum is competency based, the duration of training must meet the European minimum of 4 (four) years for post registration in full time training adjusted accordingly for flexible training (EU directive 93/16/EEC requires that flexible training can be no less than 50% whole time equivalent). The SAC has advised that training from ST1 will usually be completed in 7 (seven) years in full time training (2 years core plus 5 years specialty training).

1.6 RESEARCH

Trainees who wish to acquire extensive research competencies, in addition to those specified in the generic element of the curriculum, may undertake a research project as an ideal way of obtaining those competencies, all options can be considered including taking time out of programme to complete a specified project or research degree. Time out of programme needs prospective approval from the SAC and the support of the Postgraduate Dean. Funding will need to be identified for the duration of the research period. A maximum period of 3 years out of programme is allowed.

1.7 TRANSITIONAL ARRANGEMENTS FOR TRAINEES AFTER IMPLEMENTATION OF THIS CURRICULUM

There are no fundamental changes between this version of the curriculum and its predecessor other than an increased flexibility for additional training. In case of any programme director, trainer or trainee having uncertainty about the implications of the new curriculum this should be brought to the attention of the SAC who will adjudicate on the arrangements for the training programme of the individual trainee. All trainees will be encouraged to undertake the new assessment methods. For existing trainees this will not be insisted on except where the new methods are needed to verify the competence of the trainee. All trainees appointed from August 2007 will be expected to follow this version of the curriculum and its assessment methods.

2 CONTENT OF LEARNING

This section lists the specific learning objectives, core knowledge areas, skills, attitudes and behaviours to be attained throughout training in Geriatric medicine.

2.1 PRIMARY LEARNING OBJECTIVES

The primary learning objectives represent a summary of what the trainee should be able to achieve at completion of specialty training. Each objective requires specific knowledge and skills that are provided in detail. Assessment will be based on the demonstration that a trainee has achieved competence in these objectives. The learning grid further on in this curriculum is designed to summarise the necessary level of performance required for each competency.

The following are the **primary** learning objectives which will provide the trainee with the expertise to practise as a specialist in geriatric medicine:

1. Perform a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient, day hospital or community setting
2. Diagnose and manage acute illness in old age in an in-patient setting and community setting where appropriate
3. Diagnose and manage those with chronic disease and disability in an in-patient, out-patient, day hospital and community setting
4. Provide rehabilitation with the multidisciplinary team to an older patient in an in-patient, out-patient, day hospital and community setting
5. Plan the transfer of care of frail older patients from hospital
6. Assess a patient's suitability for and provide appropriate care to those in long term (continuing care) in the NHS or community
7. Be able to apply the knowledge and skills of a competent geriatrician in an intermediate care and/or community setting.
8. Assess and manage older patients presenting with the common geriatric problems (syndromes) in an in- or out-patient setting (or where appropriate, in a community setting):
 - a. Falls with or without fracture
 - b. Delirium
 - c. Incontinence
 - d. Poor mobility

9. To demonstrate competence in the following sub-specialties:
 - a. Palliative care
 - b. Orthogeriatrics
 - c. Old Age Psychiatry
 - d. Specialist Stroke care

10. To be competent in basic research methodology, ethical principles of research, comprehensive scrutiny of medical literature and preferably to have personal experience of involvement in basic science or clinical (health services) research.

Overview:

Expertise in some areas will develop throughout training, while others may require specific full time or sessional attachments to achieve the appropriate level of knowledge and skills.

At the completion of training by a process of consolidation through the years of the training programme acquiring a variety of experience, the trainee should have acquired the following knowledge, skills and attitudes to function as a consultant geriatrician:

1. The ability to establish a diagnostic formulation for older patients presenting with specific and non-specific clinical features by appropriate use of history, clinical examination and investigation.
2. The knowledge, skills, and experience to develop management plans for each patient including treatment, rehabilitation, health promotion, disease prevention, and longer term management.
3. The appropriate attitudes and communication skills to deal effectively with patients and their families, and working colleagues.
4. To work effectively within a multidisciplinary team to promote the optimal recovery of patients and plan their safe transfer of care from all relevant settings.

2.2 CORE KNOWLEDGE AREAS

The following list is intended to underpin the primary learning objectives above. They should act as a guide for areas specific to geriatric medicine in which trainees should gain experience during the course of their training:

2.2.1 Basic Science and Gerontology

- Trainees should be able to explain:
 - The process of normal ageing in humans
 - The effect of ageing on the different organ systems and homeostasis
 - The effect of ageing on functional ability
 - Demographic trends in UK society
 - The basic elements of the psychology of ageing
 - Changes in pharmacokinetics and pharmacodynamics in older people

- Ageism and strategies to counteract this

2.2.2 Common Geriatric Problems (Syndromes)

Trainees should be able to describe the types of multiple pathology encountered particularly in older people and the effect this has on the presentation (e.g. specific or non-specific) and management of illness in old age. This is of particular importance in the following areas where non-specific presentation may occur:

- Falls and syncope assessment - including fractures and osteoporosis
- Immobility - including locomotor disorders and Parkinson's disease
- Incontinence - urinary and faecal
- Delirium and dementia

or where presentation may be more specific:

- Cerebrovascular disease - stroke and transient ischaemic attack (TIA)

2.2.3 Presentations of Other Illnesses in Older Persons

Older people can present with a wide array of symptoms. Trainees should be able to define the causes, pathophysiology, clinical features, laboratory findings, treatments, prognosis and preventative measures for the following common problems and presentations in old age. This list is a suggested, but by no means exhaustive range of presentations that trainees should encounter during their training, and be able to demonstrate competence in their management.

- **Cardiovascular** e.g. chest pain, arrhythmias, hypertension, heart failure
- **Respiratory** e.g. dyspnoea, haemoptysis, infection
- **Gastrointestinal** e.g. dysphagia, vomiting, altered bowel habit, jaundice
- **Endocrine** e.g. hyperglycaemia, thyroid dysfunction, hypothermia
- **Renal** e.g. fluid and electrolyte imbalance, renal failure, infection, lower urinary tract symptoms
- **Neurological** e.g. seizures, tremor, altered conscious level, movement disorders, speech disturbance
- **Sensory loss** e.g. impaired vision and hearing, neuropathy
- **Psychiatric** e.g. depression, delirium, anxiety, sleep disturbance
- **Dermatological** e.g. pruritus, rashes, leg ulcers and pressure sores
- **Musculoskeletal** e.g. joint pain and stiffness, degenerative joint disease
- **Non-specific** e.g. dizziness, fatigue, anaemia, weight loss, suspected abuse
- **Weight loss and Nutritional Disease**

2.2.4 Drug Therapy

Trainees should be able to explain the indications, effectiveness, potential adverse effects, potential drug interactions and alternatives for medications commonly used in older patients. A working knowledge of the basic principles of therapeutics including adverse drug reactions, drug interactions, and effects of disease states on drug pharmacokinetics is important. The following list provides examples of these but is not intended to be exhaustive:

Analgesics Lipid-lowering agents Antibiotics
 Drugs for urinary incontinence Anticoagulants Neuroleptics
 Antidepressants Peptic-ulcer healing drugs Steroids
 Anti-Parkinsonian drugs Cardiovascular drugs Vaccines

Drugs for thyroid disease Oestrogen replacement Diuretics
Vitamins/mineral supplements Bronchodilators Laxatives
Insulin/oral hypoglycaemic agents Drugs for dementia Antihypertensives
Antipsychotics Anxiolytics Tranquillizers

2.2.5 Rehabilitation in Older Persons

Trainees should be able to explain the:

- Principles of rehabilitation in older people and importance of comprehensive geriatric assessment (CGA)
- Different measures (assessment scales) used to assess functional status and outcome of rehabilitation and their limitations: to include objective evaluation of ADL ability and level of activity limitation and participation restriction, cognitive status, and mood
- Requirements, roles and expertise of the different members of a multidisciplinary team
- Knowledge of the range of interventions such as physical treatments, aids, appliances and adaptations, and a knowledge of specialist rehabilitation services available
- Specific requirements of stroke and orthopaedic rehabilitation
- An appreciation of the medical and social models of management of functional limitation due to ageing and disease
- Knowledge of the method of prevention and management of complications of acute illness such as pressure sores, contractures and aspiration pneumonia

2.2.6 Planning Transfers of Care and Ongoing Care Outside Hospital

Trainees should be able to explain the:

- Determinants of successful transfers of care outside hospital
- Suitability for different levels of care within the community
- Roles of the multidisciplinary team with regard to planning
- Liaison with primary care and social services to facilitate successful transfer of care from hospital
- Systems of provision of social care, day care, respite care and carer support
- Legislation surrounding long and intermediate term care

2.3 Ethical and Legal Issues

Trainees should be able to explain:

- Relevant medico-legal issues such as
 - Assessment of competence
 - Appointment of Power of Attorney
 - Appointment of Curator Bonis
 - Guardianship
 - Advance Directives
 - Procedure for sectioning under the Mental Health Act
 - The current legal framework for management of adults with mental incapacity in the country of training (Mental Capacity Act 2005 England & Wales, Adults with Incapacity Act 2000(Scotland))
- Relevant ethical issues such as
 - Decisions regarding life-prolonging treatments

- Resuscitation following cardio-respiratory arrest
- Consent procedures

2.3.1 Management

Trainees should be able to explain the:

- Structure of the NHS, its financing and organisation
- Roles of NICE and HAS (NHS QIS in Scotland)
- Clinical governance and its relevance in geriatric medicine
- Principles of the appraisal process
- Administrative duties relevant to a consultant geriatrician; including the workings of committees, service development and relevant employee law
- Methods of dealing with complaints

2.3.2 Health Promotion

Trainees should be able to explain the:

- Benefits of a healthy lifestyle in older age, including adequate nutrition, exercise and smoking cessation
- Specific techniques for disease prevention in older persons
- Techniques of risk reduction for relevant syndromes (e.g. stroke)

3 THE LEARNING PROCESS

Model of Learning

3.1 TEACHING AND LEARNING OPPORTUNITIES AND METHODS

The teaching methods and learning experiences and opportunities are described in detail in the curriculum learning grids. Trainees and trainers are expected to have full knowledge of the curriculum.

Most competencies are acquired over a sustained period of experience.

The majority of learning will be experiential on an inpatient, day patient, outpatient and at home basis. Trainees will learn from practice (work-based training) on ward rounds, in outpatients, day hospitals, care homes and patients' own homes. In these settings they will undertake activities both independently and directly supervised and observed by senior staff; trainees will have opportunities for concentrated practice in skills and practical procedures during their hospital placements; they will learn from peers and be supervised when not yet fully competent in skills by senior staff. This will be regularly backed up by feedback from senior staff including consultants and monitored by clinical, educational and research supervisors. Experience will be graded to the level of training and proportionate to the level of expertise. Supervision will always be given where the trainee has not yet acquired a sufficient level of competence.

Peer learning is also important with discussion amongst colleagues at all levels in the clinical placements and at regional meetings.

Approximately 4 hours per week of education in a lecture or seminar setting will be delivered for all hospital placements. A minimum of 4 hours each week of the timetable and preferably 6-8 hours will be allocated for continuing professional development, research and audit. In addition the equivalent of 4 hours per month for at least 10 months of the year should be delivered on a regional basis for delivery of taught components of the curriculum. It is expected that trainees will attend national and regional study days including at least one national meeting of the British Geriatrics Society each year.

Formal teaching is needed for topics such as teaching skills, research methodology, information technology skills, appraisal techniques and other clinical governance methodology. In addition trainees are expected to attend courses to cover such topics. The final part of any management course is usually undertaken in the last year of the training programme.

Personal study (self-directed learning) including the reading of relevant professional journals and textbooks and use of CDs, DVDs, searching the worldwide web (Appendix 1) and use of other library resources as detailed in the British Geriatrics Society reading list (Appendix 2) is also important.

Trainees are expected to complete evidence of reflective practice through case reports and other experiences in their training record as detailed in the curriculum grids. Other self-directed work

will be planning, data collection, analysis and presentation of audit and research work such that the training record will contain evidence of academic pursuits.

Trainees will take part and lead in bedside teaching and will teach undergraduates, postgraduates and non-medical staff in small groups and formal lectures making personal presentations using a variety of audiovisual methods. They will be expected to present at journal clubs, and make case presentations at grand rounds or similar settings. They will be expected to undertake personal audit and research and make presentations of their findings at clinical meetings.

Off-the job education and rotations to various work places will be arranged to enable delivery of the totality of the curriculum.

Trainees will rotate to different work places often on an annual basis.

The key will be regular work-based assessment by educational supervisors who will be able to assess, with the trainee, their on-going progress and whether parts of the curriculum are not being delivered within their present work place. The practice of educational supervisors is described below under supervision and feedback.

3.2 OVERALL CONTENT OF THE CURRICULUM

The curriculum is designed to cover all the areas of medical care that an older person will experience from care at home or in a care home; in the outpatient clinic or day hospital or day care; in the accident and emergency and medical assessment unit; in the acute ward and specialist areas of acute care such as coronary care, high dependency care, intensive care, acute stroke care etc; in the rehabilitation ward or intermediate care or in long term care.

3.3 LEARNING EXPERIENCES

The learning experiences are described in more detail in the curriculum grids below. The majority of learning is from clinical practice with opportunities created by trainees, programme directors and the specialty training committees for training in the main places of work but also practice outside the principal place of work. There will be learning with peers as described above both in everyday practice and as part of formal teaching. Teaching will be from clinical supervisors during clinical attachments, from peers in the same specialty and other specialties and as formal teaching in lectures and small groups.

3.4 Objectives by year of training

Trainees should achieve specific objectives each year relevant to the type of training programme being undertaken. Progress will be ascertained each year.

It is suggested that trainees should achieve specific objectives each year relevant to the type of training programme being undertaken. Progress will be ascertained each year by the regional specialty adviser working with the representatives of the postgraduate dean. This is done formally each year as part of the RITA which is organised by the deanery. At the RITA a panel including a representative of the postgraduate dean, the regional specialty adviser, academic representative

and other trainers meet with and question the trainee to review the trainee's reports and progress with assessments. Recommendations are made on future learning objectives and also whether targeted or repeat training is needed. These recommendations are communicated to the trainee and future educational and academic supervisors and mentors. Approximately 18 months prior to the estimated date of completion of training the RITA takes the form of a penultimate year assessment (PYA) at which an external representative of the SAC will also attend the panel which will make recommendations on objectives to be achieved during the rest of the training programme depending on progress in meeting the curriculum requirements.

Year 3 post foundation training will include a greater emphasis on acute medicine (level 2). Normally by the end of year 3 trainees should have successfully completed part 2 of the MRCP (UK) diploma. Completion of Part 2 of the MRCP (UK) diploma prior to the penultimate year assessment is essential. During years 3-5, trainees will be expected to achieve a level of competence which aims to satisfy the first five primary learning objectives. Years 6 and 7 will be spent consolidating this experience, but with greater emphasis on acquiring the skills and experience to achieve the remaining learning objectives which include subspecialty experience. There will be a geriatric medicine knowledge based assessment which can be taken after satisfactory completion of Part 2 MRCP (UK) normally in years 5 or 6. Trainees should have passed the subspecialty knowledge assessment by the time of the penultimate year assessment and it must be passed before completion of training and issue of a certificate of completion of training (CCT). One year of the programme usually during years 4-6 will be full time in geriatric medicine though trainees can be involved in the acute general take during this year. There should also be further training in acute medicine level 2 during years 6 and/or 7.

Academic and scholarly training should take place throughout the training programme.

3.5 Required sub-specialty experience

Experience in various sub-specialities is a mandatory requirement for completion of training in geriatric medicine and the following are designated as high priority subspecialty training areas: palliative care, orthogeriatrics, old age psychiatry, specialist stroke care, intermediate care and community practice. A minimum of a full-time attachment of 4 weeks or equivalent in each of the sub-specialities of palliative care, old age psychiatry and intermediate care with community practice and 12 weeks or equivalent in stroke and orthogeriatrics with falls over the seven years of training is recommended. Sessional experience over a longer period is also acceptable as long as training objectives are agreed and progress is reviewed accordingly.

3.6 Academic development

All trainees should be able to appraise research literature and use the evidence base to guide their practice. They should be able to demonstrate expertise in the assurance of the quality of health services. All trainees should be competent to teach and train others to a professional standard. Suitable indicators of achievement of these objectives includes the award of a higher degree (e.g. MSc), the completion of closed loop audits, participation in teacher training courses or the award of teaching diplomas / certificates, and the publication of one or more peer reviewed articles and the presentation of one or more abstracts to learned societies. Two half days per week should be

dedicated to this work including continuing professional development throughout the programme. It is likely that achievement of these objectives is likely to be possible only during the final years of the training programme. This underscores the importance of the academic mentor and also requires that the RITA process is used to monitor progress.

4 LEARNING OBJECTIVES

4.1 CURRICULUM LEARNING AND COMPETENCE GRIDS: GRIDS FOR PRIMARY LEARNING OBJECTIVES

1. COMPREHENSIVE GERIATRIC ASSESSMENT

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
To perform a comprehensive geriatric assessment	<p>Knowledge</p> <ul style="list-style-type: none"> • Factors influencing health status in older people • Measures employed in measuring health status and outcome • Understanding of the concept of frailty • Evidence base for CGA <p>Skills</p> <ul style="list-style-type: none"> • Diagnostic skills • Functional status evaluation including assessment of basic ADL and IADL, social support, mental health and cognitive status, mobility including gait and balance, and nutritional evaluation • Interpretation of results in the context of health planning, quality of life assessment, and appropriate use of available health-related and social-related resources <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • Collaborative working with other professionals and agencies (Health/ Social Care/Voluntary) • Championing the value of CGA amongst other professionals and service providers 	<ul style="list-style-type: none"> • Observation and discussion with senior medical and multidisciplinary staff in various settings • On the job training with feedback from senior staff • “Shadowing “ of other health and social care professionals during the assessment process • Personal study (textbooks, journals, internet, CDROM, self-assessment media) • Formal postgraduate courses

2. (a) DIAGNOSIS OF ACUTE ILLNESS

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To have the knowledge and skills to diagnose acute illness in old age</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Major Geriatric syndromes and illnesses • Acute geriatric medicine and basic gerontology • Changes in disease presentation in old age • Clinical pharmacology, therapeutics and pharmacy as related to older people <p>Skills</p> <ul style="list-style-type: none"> • • • Physical examination • Cognitive assessment • Diagnostic skills • Appropriate investigation and interpretation of results • Practical procedures <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • To strive to recognize and diagnose acute illness early • To work collaboratively with other health care professionals (eg Radiology, Other Medical Specialties, ITU) to achieve this • To appreciate the changes in acute illness presentation in old age and the deleterious effects of diagnostic delays 	<ul style="list-style-type: none"> • Observation of and discussion with senior staff • On-the-job training with feedback from senior staff • Post-take ward rounds (supervised and unsupervised) • Personal study • Formal postgraduate education course

2. (b) MANAGEMENT OF ACUTE ILLNESS

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To have the knowledge and skills to successfully manage acute illness in an older person</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Acute geriatric medicine and basic gerontology • Major geriatric syndromes and illnesses • Clinical Pharmacology, therapeutics and pharmacy as related to older people • Ethics • Risks of secondary complications of acute illness in older people and strategies to prevent them <p>Skills</p> <ul style="list-style-type: none"> • • Practical procedures • Drug and non-drug interventions • Appropriate referral to / collaboration with other specialists • Teamwork and rehabilitation skills <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • A meticulous approach to the treatment of acute illness in older people and to encourage others to work in a similar way • To work within an acceptable ethical & legal framework to help guide patients and their relatives through consent to medical investigations and treatments • To work collaboratively with other professions to minimize risks of secondary complications in older people with acute illness 	<ul style="list-style-type: none"> • Observation of and discussion with senior staff • On-the-job training with feedback from senior staff • Audit of one aspect of acute care (condition or process) • Personal study • Formal postgraduate education courses for acute medicine

3. DIAGNOSIS AND MANAGEMENT OF CHRONIC DISEASE AND DISABILITY

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To have the knowledge and skills to diagnose and manage those with chronic disease and disability in in-patient, out-patient, day hospital and community settings</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Major geriatric syndromes and illnesses • Basic gerontology • Clinical pharmacology, therapeutics and pharmacy for older people • Rehabilitation theory • Ethics • Health promotion theory • Services - health/social/voluntary - supporting patients (and carers) • Specific expert knowledge of common chronic conditions eg cardiac failure, COPD, musculoskeletal disorders, movement disorders, (see grids). • End of life planning <p>Skills</p> <ul style="list-style-type: none"> • Clinical examination • Cognitive and mood assessment • Gait assessment • Nutritional assessment and appropriate interventions • Organising appropriate investigations • Drug and non-drug interventions e.g. for painful long term conditions • Health promotion/disease prevention <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • A positive but realistic approach to management • A multiprofessional problem-solving approach appreciating the importance of regular review, continuity of care and fine tuning of treatments • Appreciating the importance of active rehabilitation maintaining function • Recognition of the terminal stages of illness adjusting management plans 	<ul style="list-style-type: none"> • Observation of and discussion with senior staff in a variety of clinical settings (hospital and community) • On-the-job training including participation in multi-disciplinary meetings, with feedback from senior staff • Attendance at clinics of other specialties eg rheumatology, cardiology, renal medicine • Involvement in services specifically designed for certain long term conditions eg COPD, heart failure, working alongside other Consultants/Specialist Nurses/Therapists • Involvement in primary care team meetings • Personal study to ensure sufficient knowledge base to manage the large variety of long term conditions encountered within geriatric medicine • Formal postgraduate education courses

4. REHABILITATION AND MULTIDISCIPLINARY TEAM WORKING

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To have the knowledge and skills to provide rehabilitation to an older patient in an in-patient, out-patient, day hospital and community-based settings and when to refer for further specialist advice</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Basic gerontology • Principles of rehabilitation and comprehensive assessment • Assessment scales • Roles and expertise of different members of interdisciplinary team • Specialist rehabilitation services • Evidence base for rehabilitation • Goal setting in rehabilitation • Physical therapies which improve muscle strength and function • Therapeutic techniques/training to improve balance and gait • Aids and appliances which reduce disability • Scope and nature of intermediate care approaches <p>Skills</p> <ul style="list-style-type: none"> • Selecting patients for rehabilitation <ul style="list-style-type: none"> • Continance Care – assessment and treatments • Goal setting according to expected disease prognosis/outcome • Expertise in the management of patients with multiple medical problems and disabilities <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • Recognition that older people take longer to recover from acute illness and frequently require rehabilitation • Promoting a rehabilitation ethos • Collaborative working to ensure that no individual should unnecessarily enter a system of domiciliary or institutionalized care • Appreciation that small changes in disability can avoid long term care 	<ul style="list-style-type: none"> • Observation of and discussion with senior staff in a variety of clinical settings (hospital and community) • Supervised chairing of team meetings, goal setting and communication with patients in all settings • Working with community based rehabilitation and reablement teams • Working in liaison with primary care – consider attachment to a GP/Primary Care Team • Assessing patients within other services regarding suitability for a period of hospital based or community based rehabilitation • Audit of one aspect of the rehabilitation process • Personal study • Formal postgraduate courses

5. PLANNING TRANSFERS OF CARE INCLUDING DISCHARGE

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To have the knowledge and skills to plan the successful transfer of care or discharge of frail older patients</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • The variety of resources available following discharge e.g. intermediate care, community care, domiciliary care, voluntary sector support, respite care, institution-based long-term care, health service funded long-term care • The current criteria (and processes) for health service-based continuing care • The financial support available to patients and their carers • The assessment methods/processes undertaken to access services (including the unified (single) assessment process) • Roles and rights of “informal” carers • Roles of the geriatrician and the multidisciplinary team in discharge planning <p>Skills</p> <ul style="list-style-type: none"> • Planning skills • Ability to test mental capacity <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • To view discharge planning as important which is timely and appropriate (from admission) • To view the discharge of a frail older person as a <i>transfer</i> of care • Recognition that the patient’s wishes are important • To ensure medical involvement in all hospital discharge planning • To strike the right balance between opinion-seeking, discussion and decisive management of patients 	<ul style="list-style-type: none"> • Observation and discussion with senior staff • Supervised chairing of team meetings, and communication with patients (and families where appropriate) • Observation of and time spent with social worker and discharge coordinator • Personal study and review of literature eg Dept Health guidance on discharge • Formal postgraduate courses eg team building and leadership • Undertake an audit of some aspect of the discharge process eg <ol style="list-style-type: none"> a) Return to home rates b) Readmission rates (early) with causes c) Delays in accessing social or health care involvement d) Continuing health care process e) Institutionalization rates

6. INTERMEDIATE CARE and COMMUNITY PRACTICE

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To understand intermediate care/community geriatrics. To have competence in managing elderly patients in an intermediate care/community geriatric setting in conjunction with a community based multi-disciplinary team and other agencies.</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Major geriatric syndromes and illnesses. • Basic gerontology • Clinical pharmacology, therapeutics and pharmacy for older people • Rehabilitation • Health promotion • Models of intermediate care/community geriatrics including evolving role of day hospital • Understanding of the various agencies involved in community care • Opportunities provided by assistive technologies eg Monitoring devices, technology assisted living • Current evidence base for intermediate and community care <p>Skills</p> <ul style="list-style-type: none"> • Good clinical skills • Appropriate use of facilities • Managing in a non-hospital setting • Good time management • Multidisciplinary team leadership • Effective liaison with GPs including joint management of cases <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • To develop an approach to care that crosses the traditional division between primary and secondary care • To recognize the importance of geriatrician involvement in intermediate care • To recognize the role of the geriatrician in education & management of community staff 	<ul style="list-style-type: none"> • ‘Seeing and learning’ with an intermediate care/community geriatrics team • ‘Seeing, learning and doing’ in an intermediate care/community geriatrics placement with a consultant • Day hospital placement with strong intermediate care/community geriatrics links and input • Personal study • Regional core programme • Formal postgraduate course • Attachment to a social services department to undertake a project that promotes joint working

7. LONG TERM (CONTINUING) CARE

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To have the knowledge and skills to assess a patient's suitability to and provide appropriate care to those in long term care in the NHS or a community setting</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Basic gerontology • Major geriatric syndromes and illnesses • Clinical pharmacology, therapeutics and pharmacy for older people • Ethics and medico-legal issues • CPR Decisions • End of life care • Relevant national publications including guidelines re continuing health care • Understanding of care home structures, regulation and inspection <p>Skills</p> <ul style="list-style-type: none"> • Diagnostic skills • Drug and non drug interventions • Team and leadership skills • Palliative care skills • Nutritional assessment and approaches to feeding e.g. PEG • Skin and wound care – assessment and treatments • Continence Care – assessment and treatments • Ability to select appropriate patients for continuing health care <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • Appreciation that small changes in disability can improve quality of life • To work in an acceptable ethical framework helping patients and relatives accept or reject medical investigations and treatments • To discuss empathetically with patients and families prognosis • To recognize the value of a structured, active approach to care in care homes 	<ul style="list-style-type: none"> • Observation and discussion with senior staff • On-the-job training in long term care settings, with feedback from senior staff • Personal study • Formal postgraduate education courses • Attend Continuing Health Care Panel • Visits to care homes with GPs/specialist nurses/geriatricians

8 (a). FALLS

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To know how to assess and manage older patients presenting with falls (with or without fracture) in an in- or out-patient setting</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Basic gerontology • Causes of and risk factors for falls • Drug and neurovascular causes of falls and syncope • Interventions to prevent falls <p>Skills</p> <ul style="list-style-type: none"> • Gait assessment • Diagnostic skills • Drug and non-drug interventions • Team and leadership skills • Health promotion <p>Behaviour and attitudes</p> <ul style="list-style-type: none"> • Collaborative working with other professions and agencies, including orthopaedic services for fracture patients • Seeking remediable causes of falls • Positive but realistic approach to falls investigation and management • Aim to enable patients to the maximum 	<ul style="list-style-type: none"> • Observation and discussion with senior staff in various contexts (eg hospital wards, admitting wards, outpatient clinics, falls clinics, day hospitals, residential care homes and patients home) • On-the-job training including tilt testing, gait analysis, other specialist procedures, and multi-disciplinary team meetings, with feedback from senior staff • Personal study (textbooks, journals, internet, CD ROM, self-assessment media) • Formal postgraduate education courses (eg regional teaching programmes, conferences, in-house lectures at base hospitals, royal college and specialist society courses) • Small group teaching and discussion • Peer-supported learning methods, such as journal clubs • Participating in falls audits

8(b). DELIRIUM

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To recognize, diagnose and manage a state of delirium presenting both acutely or sub-acutely in patients in hospital, in the community and in other settings</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Diagnostic criteria for delirium • Relationship of delirium with dementia syndromes • Appropriate standardized measures of cognitive status • Severity indices in delirium • Risk factors and causes • Main outcomes observed <p>Skills</p> <ul style="list-style-type: none"> • To recognize the principal features of delirium in acute and sub-acute illness states • To be competent in the use of the standardized measures of assessing cognitive status in delirious states • To be competent in investigation and management of the delirious patient, including the underlying physical illness and the accompanying distressed mental state <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • To take a positive approach to the management of delirium and to seek and deal with remediable causes as quickly as possible • To work collaboratively with other professions to manage delirium effectively • To approach delirium as an acute or sub-acute medical emergency and to encourage all staff to work toward resolution of the delirious state 	<ul style="list-style-type: none"> • Observation of and discussion with senior medical staff in a range of settings including inpatient wards, admitting rooms, clinic, residential homes and patients' own home) • On the job training (involvement in the management of delirium) with feedback from senior staff • Personal study (textbooks, journals, internet, CD ROM, self-assessment media) • Formal postgraduate education course (lectures and seminars at regional training programme meetings, conferences, royal college and specialist society events) • Peer-supported learning , such as journal clubs • Participating in audit

8(c) INCONTINENCE

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To know how to successfully manage the basics of urinary and faecal incontinence, and to know how and when to refer for specialist advice</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Basic gerontology • Risk factors, epidemiology and causes of incontinence • Investigations available and how to use them appropriately • Management including the role of physiotherapy, drugs and surgery • Aids, appliances and equipment • The role of the continence nurse specialist <p>Skills</p> <ul style="list-style-type: none"> • Physical examination • Interpretation of investigations • Drug and non-drug interventions <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • To adopt a positive and realistic approach to the management of incontinence • To collaborate with other professions, medical and surgical specialities to manage incontinence optimally • To learn to work with primary care to reduce the burden of incontinence 	<ul style="list-style-type: none"> • Observation and discussion with senior staff • Taking part in the diagnosis and management of incontinence in inpatient, outpatient and community settings (wards, clinics etc) • Attendance at specialist clinics with continence nurse specialists, geriatricians with a special interest and surgical specialists (eg urologists, urogynaecologists) • Attendance at urodynamic sessions • Personal study (textbooks, journals, CD ROM, internet and self assessment media) • Formal postgraduate courses (lectures, seminars and workshops) at regional study sessions, royal college and specialist society events • Peer-supported learning, such as journal clubs • Taking part in audit

8(d) POOR MOBILITY

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To know how to assess the cause of immobility and declining mobility and aid its management (NB also see grids 1,4 and 5)</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Basic gerontology • Risk factors and causes of immobility • Principles of rehabilitation • Interventions to improve mobility <p>Skills</p> <ul style="list-style-type: none"> • Physical examination • Gait assessment • Team skills • Drug and non-drug interventions <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • Taking a positive and realistic approach to the investigation and management of immobility • Encouraging the use of available resources to prevent and reduce immobility in individual patients • Working collaboratively with other professions (eg therapists, nurses, podiatrists, orthotists and orthopaedic surgeons, primary care) to improve mobility 	<ul style="list-style-type: none"> • Observation and discussion with senior staff (medical, nursing, therapy) (seeing, learning and doing) in various settings, eg inpatient wards, clinics, day hospitals, residential homes and in patients' own homes • Supervised out-patient clinic assessments of immobility, either in general geriatric clinics or specialized immobility clinics • Attendance at specialist clinics (e.g. Parkinson's disease clinic), supervised by consultant or nurse specialist • Personal study (textbooks, internet, CD ROM, journals, self-assessment media) • Formal postgraduate courses (regional study days, in-house hospital teaching sessions, royal college and specialist society events, conferences) • Peer-supported learning such as journal clubs • Taking part in audit

GRIDS FOR SUBSPECIALTY EXPERIENCE

9(a). PALLIATIVE CARE

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To know how to and have the skills, and most appropriate attitudes to deliver palliative care to a dying patient</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Symptom profiles in the terminally ill and their management • Prescribing e.g. syringe drivers • Pathophysiology of pain and an understanding of specialist interventions such as nerve blocks, TENS, acupuncture • Management of emergencies in palliative care, e.g. acute pain, hypercalcaemia, haemorrhage, spinal cord compression • Issues around hydration and nutrition, e.g. legal, ethical & technical aspects • Modern bereavement care <p>Skills</p> <p>Assessment of prognosis (recognizing when a patient is dying)</p> <ul style="list-style-type: none"> • Ability to consider quality of life • Compassionate understanding of a dying person's wishes • Assessment of the problems and needs of palliative care patients • Ability to develop an appropriate management plan, which anticipates problems, the use of medications, special equipment, formal palliative instruments (such as the Liverpool Palliative Care Pathway), teamwork and various agencies. <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • Recognize and respect the wishes of a dying patient, family and carers. • Allowing for patient's personal, cultural and religious background • Working collaboratively with other professions and agencies to provide the best possible palliative care 	<ul style="list-style-type: none"> • Observation of and discussion with senior medical and nursing staff • On the job training (seeing, learning and doing) with feedback from senior medical and nursing staff • Flexible attachment at a local hospice or with a palliative care consultant (or geriatrician with a special interest in palliative care) depending upon local circumstances • Domiciliary visits with local palliative care team (consultants and nurse specialists) • Attendance at palliative pain clinics • Personal study (textbooks, internet, CD ROM, journals, self-assessment media) • Formal postgraduate education course (regional study days, departmental teaching in hospitals, royal college and specialist society events, conferences) • Peer-supported learning such as journal clubs • Taking part in audit

9 (b) ORTHOGERIATRICS

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To know how to assess acutely ill orthopaedic patients and how to manage including rehabilitate these patients (NB also see grids 2,5,6 and 9a)</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Basic gerontology, including responses to trauma in old age • Major geriatric syndromes and illnesses • Causes and management of osteoporosis and falls • Surgical and anaesthetic issues • Different models of orthogeriatric care • Particular aspects of rehabilitation in older patients with fractures <p>Skills</p> <ul style="list-style-type: none"> • Physical examination • Drug and non-drug interventions • Planning transfers of care <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • An approach to the management of elderly people with fracture that seeks to maximize function • Close collaboration with orthopaedic surgeons and other professionals to ensure best care 	<ul style="list-style-type: none"> • Observation and discussion with senior staff (consultants, nurses and therapists) • On-the-job training in surgical liaison and orthogeriatric rehabilitation with feedback from senior staff (seeing, learning and doing in inpatient and outpatient settings). Attachment to a geriatrician with an interest in orthogeriatrics (sessional or full-time) • Goal setting (orthogeriatric rehabilitation team) and communication with patients and carers in all settings, with feedback from a range of supervisors • Personal study (textbooks, internet, CD ROM, journals, self assessment media) • Formal postgraduate courses (regional study days, in house departmental teaching, royal college and specialist society events, conferences) • Peer-supported learning such as journal clubs • Taking part in audit

9(c) OLD AGE PSYCHIATRY

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<p>To know how to assess and manage older patients presenting with the common psychiatric conditions, and to know when to seek specialist advice</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • Major psychiatric conditions: depression, delirium, dementia, anxiety and paranoid states • Pharmacology • Medico-legal issues • Organisation of old age psychiatry services • Psychiatric assessment methods and tools <p>Skills</p> <ul style="list-style-type: none"> • Cognitive and mood assessment • Drug and non-drug interventions • Appropriate referral to other specialists <p>Assessment of mental capacity</p> <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> • To develop a positive approach to the investigation and management of psychiatric conditions in old age • To work collaboratively with other specialists, particularly old-age psychiatrists, and agencies to manage the older patient with mental ill health • To take account of a patient’s family, cultural and religious background to better enable the management of the individual patient 	<ul style="list-style-type: none"> • Sessional or full-time attachment with an Old Age Psychiatry team, to include experience in out-patients, domiciliary assessments, day hospital, CPN visits, in-patient ward rounds and medical liaison, under the educational supervision of an old age psychiatrist* • Observation and discussion with senior staff (doctors, nurses, social workers) • Personal study (textbooks, journals, internet, CD ROM, self-assessment media) • Formal postgraduate education course(regional study days, departmental teaching programmes, royal college and specialist society events, conferences) • Peer-supported learning, such as journal clubs

* It is envisaged that each region will set up an appropriate programme in collaboration with their Psychiatric colleagues

9(d) STROKE CARE

OBJECTIVE	SUBJECT MATTER	TEACHING METHODS LEARNING EXPERIENCES
<ul style="list-style-type: none"> To know how and to be able to provide a comprehensive service for patients with acute stroke and chronic stroke-related disability in hospital and the community 	<p>Knowledge</p> <ul style="list-style-type: none"> Epidemiology of stroke Evidence of primary and secondary prevention measures Acute stroke management Complications of stroke Different rehabilitation models in hospital and community Effects on carers Ethical and legal issues relating to patient with severe disability <p>Skills</p> <ul style="list-style-type: none"> Assessment of patients with acute stroke and chronic stroke-related disability Management of spasticity (including criteria for botulinum toxin administration) Management of feeding problems Organisation of rehabilitation and leadership of a multidisciplinary team <p>Behaviours and attitudes</p> <ul style="list-style-type: none"> To work collaboratively with specialists and other professions to provide a service for patients with stroke To take a positive and realistic approach to the management of patients with stroke, to restore function as much as is possible and appropriate 	<ul style="list-style-type: none"> Experience working on an acute stroke unit, a stroke rehabilitation unit, and a neurovascular investigation unit (supervised by clinicians with expertise in the field) Experience of community rehabilitation for stroke (supervised by community-based and/or outreach staff) Multidisciplinary working (in the inpatient setting, in day hospital and in the community, supervised by senior medical, nursing e.g. stroke-outreach and thrombolysis nurses and therapy staff) Assessment of patients with suspected TIA and non-disabling stroke (TIA clinic) Visit to a centre with a comprehensive stroke service Personal study including reading recent national guidelines for stroke management and intervention trials (textbooks, journals, CD ROM, internet, self-assessment media) Formal teaching (regional study days, departmental teaching programmes, royal college and specialist society events, conference) <p>NOTE: Some trainees will opt to undertake 1 year of formal additional training for the stroke sub-CCT</p>

ASSESSMENT STRATEGY

The domains of Good Medical Practice will be assessed using both workplace-based assessments and examination of knowledge and clinical skills, which will sample across the domains of the curriculum i.e. knowledge, skills and attitudes. The assessments will be supported by structured feedback for trainees within the training programme of Geriatric Medicine. Assessment tools will be both formative and summative and will be selected on the basis of their fitness for purpose.

It is likely that the workplace-based assessment tools will include miniCEX (clinical examination exercise), DOPS (direct observation of procedural skills) and MSF (multi-source feedback). The Federation of the Royal Colleges of Physicians has piloted these methods and has demonstrated their validity and reliability. It is proposed that the examination and assessment of knowledge will utilise elements of the MRCP(UK) examination relevant to training.

An assessment blueprint will be developed which will map the assessment methods on to the curriculum in a systematic way. The blueprint will ensure that there is appropriate sampling across the curriculum. It is expected the blueprinting exercise will have been completed by September 2006.

The SAC will be responsible for the blueprinting exercise.

5 TRAINEE SUPERVISION AND FEEDBACK

All training in post-graduate medicine should be conducted in institutions with appropriate standards of clinical governance and that meet the relevant Health and Safety standards for clinical areas. Training placements must also comply with the European Working Time Directive for trainee doctors.

Trainees must work with a level of clinical supervision commensurate with their clinical experience and level of competence. This is the responsibility of the relevant clinical supervisor after discussion with the trainee's Educational Supervisor and the designated clinical governance lead. In keeping with the principles of Good Medical Practice, trainees should know that they must limit their clinical practice to within their level of clinical competence and seek help and support without hesitation.

Supervision

The educational supervisor will meet regularly and formally 3 monthly with the trainee to discuss progress and to feed back on assessment. This will ensure the trainee understands what development is required. An important component of this will be the completion of work-based assessments. In addition there will be formal knowledge based assessment the format of which is yet to be determined. A yearly meeting will take place with each trainee with the regional specialty adviser, representative of the postgraduate dean and other consultants informed by reports from educational and research supervisors and others on the trainee's progress combined with feedback on the formal work based assessments. It is here that plans for the next year for training, revision of practice and knowledge combined with plans to further develop knowledge, skills and attitudes

will be made and agreed with the trainee. This information will be reported to the educational and other supervisors for the next year.

The role of the educational supervisor and the responsibilities of the trainee to ensure successful achievement of the curriculum are detailed below:

5.1 ROLE OF THE EDUCATIONAL SUPERVISOR

For each post throughout a training rotation, a trainee should have a named educational supervisor who has overall responsibility for the training in that post. The educational supervisor need not be the consultant trainer with whom the trainee works directly. Each educational supervisor's name should appear on the specialist register and should have been appointed by the deanery specialty training committee (STC).

The educational supervisor is responsible for the implementation and coordination of a structured training programme agreed with the other geriatricians and Trust management. S/he should also be in regular contact with the regional specialty adviser, programme director and STC.

An individual trainee is likely to have several educational supervisors throughout the course of a training programme. Trainees should also be mentored either by the programme director or other similar appointment made by the STC.

The educational supervisor should also have the following duties:

5.1.1 Overseeing an induction programme for the trainee

This includes introducing the duties and responsibilities of the post along with the educational opportunities of that post. Ideally there should be provision of a written description of a post prior to the commencement of a particular appointment.

5.1.2 Conducting an initial appraisal interview

This is an important opportunity to agree the trainee's individual learning objectives, and to explore potential training opportunities to improve any trainee shortcomings. This interview should lead to a written training agreement signed by the educational supervisor and the trainee.

5.1.3 Conducting in-training appraisal

This should take place at least every three months during the period of training. It can be based on progress in meeting the objectives of the learning agreement and should include formal appraisal of the trainee's knowledge, skills and attitudes relevant to their current practice. Appraisal should be non-threatening and can be done using various methods, including observation of the trainee conducting a ward round, chairing a team meeting or interviewing a relative. The educational supervisor should have suitable training in appraisal techniques.

5.1.4 Preparing the trainee for annual RITA

The educational supervisor is responsible for assessing the trainee's competence according to the standards laid out in this curriculum. They will be responsible for submitting a report that will form part of the trainee's annual RITA or PYA. They will also be responsible for validating sections of the training record completed by the trainee, and ensuring that the required training documentation is complete.

5.1.5 APPRAISING THE TRAINING PROGRAMME

The educational supervisor will also be responsible for ensuring that their post(s) meet the standards required for suitable training. They should ensure that there are sufficient facilities available for postgraduate education and opportunities for research and audit. They should use formal feedback from trainees to enhance the quality of future training.

5.2 ROLE OF THE ACADEMIC MENTOR

The academic mentor may be an academic geriatrician, or another academic. They may be NHS or University employed.

The mentor will encourage the trainees to develop an academic portfolio including research, quality assurance, teaching and training skills. The mentor will not in most cases directly teach any or all of these skills, but will facilitate the trainees in exploiting the locally available resources, and oversee their plans. Academic mentors should meet their trainees at least twice a year, more often if they are providing direct supervision of research or other training. The mentor should help prepare the trainees to report their academic progress to the RITA panel.

5.3 TRAINEES IN DIFFICULTY

The educational supervisor and programme director are responsible for identifying trainees in difficulty either because of lack of progress in training or because of personal issues such as illness, emotional strain etc. The programme director is responsible for establishing a system where each trainee's progress is monitored regularly and satisfactorily and that trainees know who to contact should they be having difficulty. If necessary the programme director will use the expertise within the deanery for managing such trainees.

5.4 RESPONSIBILITIES OF THE TRAINEE

The person ultimately responsible for an individual's training in geriatric medicine is the trainee him/herself. Although support and supervision will be available, the trainee should feel that they own their training programme. The trainee has an important responsibility to maintain a comprehensive training record as detailed below.

The responsibilities of the trainee include:

- Awareness of the requirements for training as detailed in this curriculum and use of learning opportunities available both within and outside their particular training rotation.
- Awareness of who their educational supervisor is for each post and their role as outlined above. Making arrangements to meet with their educational supervisor regularly and at least 3 monthly for appraisal and assessment and to complete an educational/learning plan.
- Awareness of who their academic mentor is and make arrangements to meet them at least twice yearly
- Attend deanery, Trust and unit induction programmes as arranged
- To maintain an up-to-date training record including a portfolio or reflective case reports and programmes of regional and national meetings attended, details of teaching, audit and research presentations, copies of abstracts and articles or details of book chapters they have written or contributed to, supervision reports and other certificates or documentation

pertaining to their training. The trainee should provide all the necessary documentation for the RITA which they should be prepared for and attend.

- To grasp the opportunities that are available to them in order to enhance their training.
- To attend local and regional training meetings, and at least one national or international geriatrics meeting each year.
- To join the British Geriatrics Society.
- To know whom to contact if problems arise: typically their educational supervisor followed by their regional speciality adviser, programme director or other mentor as arranged by the deanery.
- To be aware of their regional trainee representative.

5.5 SUPERVISION OF PRACTICE AND SAFETY OF PATIENT AND DOCTOR

The educational supervisor having met with the trainee to establish previous experience and current competence will set learning objectives. Following assessment of the current level of competence of the trainee and taking into account the learning objectives the supervisor will decide what activities it is appropriate for the trainee to undertake unsupervised or with graded levels of supervision. Progress will be observed and assessed by all supervisors (educational, clinical and academic) such that appropriate decisions can be made to allow practice to be less formally supervised.

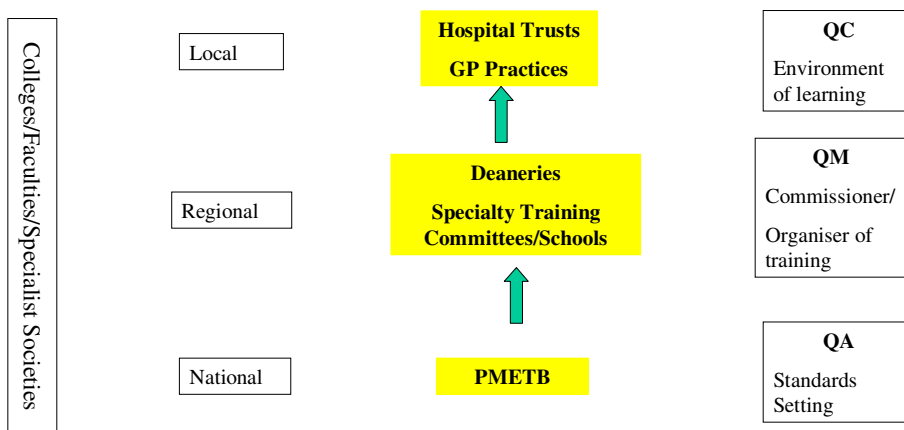
Each deanery, Trust and department will provide induction including the provision of appropriate written or electronic information so that trainees are aware of the policy within the work place, safety issues and support systems. Programme directors and mentors of trainees will check with trainees whether they have been exposed to situations of unsafe clinical practice.

The educational supervisor will discuss with the trainee issues of clinical governance, risk management and the report of any untoward clinical incidents involving the trainee. If the clinical director of the service within which the trainee is working has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these will be discussed with the educational supervisor. This does not detract from the statutory duty of the employing Trust to deliver effective clinical governance through its management systems.

6 CURRICULUM IMPLEMENTATION

Deaneries are responsible for quality management, PMETB will quality assure the deaneries and educational providers are responsible for local quality control, to be managed by the deaneries. The role of the Colleges in quality management remains important and will be delivered in partnership with the deaneries. The College role is one of quality review of deanery processes and this will take place within the SACs on a regular basis.

The Organisation and Quality Assurance of PG Training



6.2 Intended use of Curriculum by trainers and Trainees

This curriculum, the General Internal Medicine (Acute Medicine) curriculum and the Generic Curriculum for the Medical Specialties are web-based documents which are available from the JRCPTB (soon to be known as JRCPTB, the Joint Royal Colleges of Physicians Training Board) website.

Each trainee will be given copies of the curricula and portfolio upon enrolling as a specialist trainee with the JRCPTB.

Each trainee will engage with the curriculum by maintaining a portfolio. The trainee will use the curriculum to develop learning objectives, self-assess accomplishment in disparate areas of the curriculum, and reflect on learning experiences.

6.3 - Ensuring Curriculum Coverage

The details of how the curriculum is covered in any individual training programme and training unit is the responsibility of the local faculty of education in consultation with the Federation of

Royal Colleges of Physicians. The need to show how trainees are progressing in their attainment of competencies will be a strong driver in ensuring that all the curriculum objectives are met.

6.4 – Responsibilities of Trainees

This curriculum puts the emphasis on learning rather than teaching. Trainees are responsible for their own learning and the utilisation of opportunities for learning throughout their training. The work-based assessment process is also trainee led.

6.5 - Curriculum management

Local management of the curriculum is the responsibility of the local faculty of education.

Coordination of the Curriculum at national and regional level is the joint responsibility of the Deaneries and the Federation of Royal Colleges of Physicians, with robust arrangements for quality assurance of training.

7 CURRICULUM REVIEW

Curriculum review will be informed by a number of different processes. For instance the SAC will be able to use information gathered from specialty heads, specialty deans and the National Health Service. It will have available to it results of the trainee survey, which will include questions pertaining to their specialty. Interaction with the NHS will be particularly important to understand the performance of specialists within the NHS and feedback will be required as to the continuing need for that specialty as defined by the curriculum. It is likely that the NHS will have a view as to the balance between generalist and specialist skills, the development of generic competencies and, looking to the future, the need for additional specialist competencies and curricula. The curriculum is a living document which will be amended by the SAC as necessary. Every 3 years a full review of the curriculum will be carried out by the SAC. Major changes will require approval from PMETB

8 EQUALITY AND DIVERSITY

In the exercise of these powers and responsibilities, the Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of relevant legislation, such as the:

- Race Relations (Amendment) Act 2000;
- Disability Discrimination Act 1995 and Special Educational Needs and Disabilities Act 2001;
- The Disability Discrimination Act 1995 (amendment) (further and higher education) regulations 2006
- Age Discrimination Act in October 2006

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers, as advisers from the medical profession, as members of the Colleges' professional bodies or as doctors in training and examination candidates. Accordingly, it warmly welcomes contributors and applicants from as diverse a population as

possible, and actively seeks to recruit people to all its activities regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation.

STATUTORY RESPONSIBILITIES

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of legislation, such as the:

- Human Rights Act 1998
- Freedom of Information Act 2001
- Data Protection Acts 1984 and 1998

APPENDIX 1 - USEFUL WEBSITES

(adapted from a list provided by the education and training committee of the British Geriatrics Society)

Useful Internet addresses relevant to geriatric medicine

<http://www.pmetb.org.uk> PMETB

<http://www.mmc.nhs.uk> MMC

<http://www.JRCPTB.org.uk/> JRCPTB

<http://www.bgs.org.uk/> BGS

<http://www.bgs.org.uk/links.htm> BGS links site

<http://www.gmc-uk.org/> GMC

<http://www.bma.org.uk/> BMA

http://www.bgs.org.uk/Publications/Compendium/compend_index.htm BGS compendium

<http://ageing.oupjournals.org/> Age and Ageing

<http://www.ace.org.uk/> Age Concern

<http://www.merck.com/mrkshared/mmg/home.jsp> Merck manual

http://www.kcl.ac.uk/kis/schools/life_sciences/health/gerontology/ Age Concern Gerontology

<http://www.soc.surrey.ac.uk/bsg/welcome.html> British Society of Gerontology

<http://www.americangeriatrics.org/> AGS

<http://www.asgm.org.au/> AUSGS

<http://www.blackwell-synergy.com/loi/jgs/> JAGS

<http://www.cochrane.co.uk/> Cochrane database

<http://www.nejm.org> New England Journal

<http://www.thelancet.com> Lancet

APPENDIX 2 – RECOMMENDED READING LIST

(Based on a list provided by the education and training committee of the British Geriatrics Society – to check for updates to this list trainees and trainers can check the BGS website- www.bgs.org.uk)

Recommended Reading List

This list of reference books, journals and other forms of educational material is not meant to be exhaustive and all inclusive but merely a guide to some of the publications relevant to Geriatric Medicine which consultants, GPs, Subspecialty Trainees and other Trainees might find useful.

1. Journals

Age and Ageing

Age and Society

Gerontology

International Journal of Geriatric Psychiatry

Journal of American Geriatrics Society

Journal of Geriatric Psychiatry and Neurology

Journal of Gerontology

Reviews in Clinical Gerontology

CME Journal – Geriatric Medicine

2. Textbooks

General Introduction

Physiological basis of Ageing and Geriatrics. Timiras 3rd ed 2002 ISBN 0849309484

General Textbooks

Brocklehurst's Textbook of Geriatric Medicine and Gerontology. Tallis, Fillit, Brocklehurst 6th ed 2002 ISBN 0443053707

Oxford Textbook of Geriatric Medicine. Evans, Williams, Beattie, Michel, Wilcock 2nd ed 2000 ISBN 01926228305

Principles and Practice of Geriatric Medicine. Pathy 3rd ed 1998 ISBN 0471963488 (New edition due 2006)

Principles of Geriatric Medicine and Gerontology. Hazzard et al 6th ed 2003 ISBN 0071402160

Merck Manual of Geriatrics. Abrams 3rd ed 2000 ISBN 0911910833

Acute Emergencies and Critical Care of the Geriatric Patient. Yoshikawa and Norman Marcel Dekker 2002 ISBN 0824703456

Elderly Medicine: A Training Guide. Mulley and Rai 2001 ISBN 9058232344

The Specialist Registrar Handbook. Gattrell and White 2nd ed 2001 ISBN 1857754646

Caring for the Fourth Age- A Practical Guide to Medical Problems in Old Age. Oram 1997 ISBN 0953107000

Older People at Home Practical Issues. Mulley, Penn, Burns 1998 ISBN 0727912585

Books in Specialist Areas

Medical Ethics and Law

Ethical Patient Care: A Casebook for Geriatric Health Teams. Mezey MD, Cassel CK, Hyer K, Howe JL, Fulmer TT 2002 ISBN 0801867703

Medical Ethics and the Elderly a Practical Guide. Rai 2nd ed 2004 ISBN 9057024039

Medical Ethics Today. The BMA's handbook of Ethics and Law. 2nd ed 2004 ISBN 0727917447

Assessment of Mental Capacity Guidance for Doctors and Lawyers. BMA 2nd ed 2004 ISBN 072796718

Withholding and Withdrawing Life-prolonging Medical Treatment. Guidance for decision making. BMA books 2nd ed 2001 ISBN 0727916157

Biomedical Ethics. Glannon. 2004 ISBN 0195144317

Lecture notes on Medical Law and Ethics. Howard P, Bogle J. 2004 ISBN 1405118687

Law and Medical Ethics. Mason et al 6th ed 2002 ISBN 0406949956

Introduction to Medical Law. Marquand 2001 ISBN 0750642394

Healthcare Law. Montgomery 2nd ed 2003 ISBN 0198765746

Falls and Syncope

Falls in Older people-Prevention and management. Tideiksaar 3rd ed 2002 ISBN 1878812440

Falls in Older People. Lord, Sherrington. 2001 ISBN 0521589649

Reducing Falls in an Acute General Hospital. Barnett 2002 In Shaw T and Sanders K eds
Foundation of Nursing Studies Dissemination Series Vol 1 No 1

Syncope: Mechanisms and Management. Grubb BP 2nd ed 2005 ISBN 1405122072

The Evaluation and Treatment of Syncope; A handbook of clinical practice
Benditt, Blanc, Brignole, Sutton 2003 ISBN 1405103744

Syncope and falls in the Older Patient. Kenny, Lippincott, Williams and Wilkins 1996 ISBN
0412568101 (New edition due 2006)

Orthogeriatrics

Geriatric Orthopaedics: Rehabilitative Management of Common Problems Goldstein 2nd ed 1999
ISBN 0834210762

Psychiatry of Old Age

Principles and Practice of Geriatric Psychiatry. Copeland, Abou-Saleh, Blazer DG 2002 ISBN
0471981974

Psychiatry in the Elderly. Jacoby, Oppenheimer ed 2002 ISBN 0198515634

Everything You need to Know about Old Age Psychiatry. Howard 1999 ISBN 1871816386

Diagnosis and Management of Dementia. Wilcock, Bucks, Rockwood 1999. ISBN 0192628224

Neurology

Neurology of the Elderly. Godwin-Austen, Bendall 1990 ISBN 3540195939

Parkinson's Disease in the Older Patient. Playfer, Hindle 2001 ISBN 0340759143

Parkinson's Disease and Parkinsonism in the Elderly. Meara, Koller 2000 ISBN 139780521628846

Queen Square Neurological Rehabilitation Series: Neurological rehabilitation of Parkinson's
Disease. Playford 2003 ISBN 1841842974

Stroke

Stroke. A Practical Guide to Management. Warlow et al 2nd ed 2001 ISBN 0632054182

Stroke Syndromes. Bogousslavsky, Caplan 2nd ed 2001 ISBN 0521771420

Stroke Pathophysiology, Diagnosis and Management Barnett, Mohr, Stein, Yatsu, 3rd ed 1998 ISBN 0443075514

National Clinical Guidelines for Stroke. RCP 2004

Stroke Care. A Practical Manual. Harwood, Huwez, Good 2005

Elder Abuse

Elder abuse: concepts, theories and interventions. Bennett and Kingston 1993 ISBN 0412453104

Elder Abuse in Perspective. Biggs, Phillipson and Kingston 1995. ISBN 0335191460

Crime, Abuse and the Elderly. Brogden and Nihar 2000 ISBN 1903240026

The Mistreatment of Elderly People. Decalmer and Glendenning (eds) 2nd ed 1997. ISBN 0761952624

Elder Abuse: critical issues in policy and practice. Slater and Eastman (eds) 1999 ISBN 0862422485

Dermatology

Skin Diseases in Old Age. Marks 2nd ed 1999 ISBN 1853172278

Cardiology

Cardiovascular Disease in the Elderly. Gerstenblith 2005 1588292827

Respiratory

Respiratory Diseases in the Elderly Patient. Connolly 1996 ISBN 0412568306

Diabetes and Endocrinology

Diabetes in the Elderly. Sinclair 2nd ed 2000 ISBN 0471490105

Endocrinology of Ageing. Morley, van den Berg 2000 ISBN 0896037568

Gastroenterology

Geriatric Nutrition. The Health Professional's Handbook. Chernoff 2000 ISBN 0834210827

Bowel Care in Older People. Research and Practice. Potter, Norton, Cottenden 2002 ISBN 1860161677

Infection

Infectious Disease and Ageing. A Clinical Handbook. Yoshikawa, Norman 2001 ISBN 0896037444

Infections in Elderly People. MacLennan 1994 ISBN 0340559330

Continence

Incontinence. Lucas, Emery and Beynon 1999 ISBN 0632050039

Urinary Incontinence (Part of Fast Facts Series) Shah and Leah 2nd ed 1998 ISBN 1899541640

Nursing for Continence. Norton 2nd ed 1996 ISBN 0906584426

Cancer and Palliative Care

Cancer in the Elderly. Hunter, Johnson, Muss 2000 ISBN 0824702786

Symptom Management in Advanced Cancer. Twycross, Wilcock 3rd ed 2001 ISBN 1857755103

Comprehensive Geriatric Oncology. Balducci, Ershler, Layman 2003 ISBN 1841842966

Radiology

Textbook on Diagnostic Imaging in the Elderly. Impallomeni et al 2000 ISBN 1899066888

Surgery and Anaesthesia

Principles and Practice of Geriatric Surgery. Rosenthal, Zenilman, Katlic 2001 ISBN 0387983937

Surgical Care for the Elderly. Adkins, Scott 2nd ed 1998 ISBN 0781714508

Pharmacology

Drug Therapy in Old Age. George, Woodhouse, Denham, McLennan 1998 ISBN 0471941492

Rehabilitation

Rehabilitation of the Older Person – A Handbook for the Interdisciplinary Team.
Squires, Hastings 3rd ed 2002 ISBN 0748754709

Intermediate Care, Community Geriatric Medicine and Day Hospital

Integrating Care for Older People. New care for old –a systems approach. Foote and Stanners 2002
ISBN 184310010X

Geriatric Day Hospital: their role and guidelines for good practice. BGS/RCPU 1994 ISBN
1873240783

Continuing Care

Care of the Long Stay Elderly Patient. Denham 3rd ed 1996 ISBN 0412606704

Research, Audit and Statistics

Principles of Best practice in Clinical Audit. National Institute for Clinical Effectiveness (NICE)
2002 ISBN 1857759761

Clinical Governance a Guide to Implementation for Healthcare Professionals. McSherry and Pearce
2001 ISBN 0632058013

How to Read a Paper – The basis of evidence based medicine. Greenhalgh 2004
ISBN 072795789

Evidence Based Practice- a critical appraisal. Trinder and Reynolds 2000 ISBN 0632050586

Statistics at Square One. Campbell and Swinscow 10th ed 2002 ISBN 0727915525

3. E Learning and CD Roms

Depression and Dementia in Older People. CD Rom Interactive Training Programme. Kiss of Life
Multimedia Ltd.

Falls and Bone Health. CD Rom Interactive Training Programme.
Kiss of Life Multimedia Ltd

Bladder problems in Adults. CD Rom Interactive Training Programme.
Kiss of Life Multimedia Ltd

“Off His Legs” CD Rom Interactive Training Programme.
Kiss of Life Multimedia Ltd

Doctors.Net at www.doctors.net.uk has an E Learning CME section with over 100 learning topics (all subjects and specialties) and is free to register.

The Merck Manual online at www.merck.com has information on older people and ageing which may be useful.

The National Institute of Clinical Excellence www.nice.org.uk has produced a number of useful guidelines applicable to older people.

The Modernising Medical Careers website www.mmc.nhs.uk has information on the rapidly changing situation of medical career pathways.

The Scottish Intercollegiate Guidelines Network (SIGN) www.sign.ac.uk is a valuable source of guidelines and information in a number of clinical areas.

4. Reports in Specialist Areas

Department of Health. National Service Framework for Older People. London. DOH,2001
www.doh.gov.uk/nsf/oldrerpeople.htm

Topic Working Group. Report to the NHS R&D Strategic Review. Ageing and age-associated disease and disability. London. NHS Executive,1999
www.doh.gov.uk/research/documents/rd3/ageing_final_report.pdf

Department of Health. Shaping the Future NHS: Long Term Planning for Hospitals and Related Services. Consultation on the Findings of the National Beds Enquiry. 2000
www.doh.gov.uk/nationalbeds.htm/

Royal Commission on the funding of long term care with respect to old age: long term care – rights and responsibilities. London: Stationery Office, 1999

Joint Working Party. The health care of older people in care homes. Royal College of Physicians, Royal College of Nursing and British Geriatrics Society. 2000 ISBN 1860161375

Royal College of Physicians. National Clinical Guidelines for Stroke. Clinical Effectiveness and Evaluation Unit. 2nd ed 2004 ISBN 186016120

Royal College of Physicians. Management of the older medical patient. The interface between general (internal) medicine and geriatric medicine. 2000 ISBN 1860161308

Effective practice in rehabilitation: the evidence of systematic reviews. Sinclair, Dickinson London: Kings Fund Publishing 1998.

Audit commission. The coming of age: improving care services for older people. London: Audit Commission 1997.

Clinical Standards Advisory Group. Community health care for older people. A committee report. J Clark ed. London: Stationery Office 1998.

Federation of the Royal Colleges of Physicians. Medical Aspects of Intermediate Care: Report of a Working Party. 2002

Principles of Pain Control in Palliative Care for Adults. A Working Party Report. Royal College of Physicians 2000

Specialist Equipment Services for Disabled People- The need for change. Royal College of Physicians and Institute of Physics and Engineering in Medicine. 2004

Osteoporosis: Clinical guidelines update. Working party Report. Royal College of Physicians and Bone and Tooth Society of Great Britain. 2004

The Health and Well-being of Older People in Scotland – insights from national data. NHS Scotland, Information and Statistics Division 2001 ISBN 1841340006

Adding Life to Years – Report of the Expert Group on Healthcare of Older People. NHS Scotland 2003 ISBN 0755908236

Adding Life to Years – Annual Report 2002-3. NHS Scotland 2003 ISBN 0755908236

Revised April 2006