SPECIALTY TRAINING CURRICULUM

FOR

GERIATRIC MEDICINE IN ICELAND

September, 2023

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Inngangur að marklýsingu fyrir sérnám í öldrunarlækningum

Marklýsing fyrir sérnám í öldrunarlækningum er nú sett fram í nýrri mynd. Markmiðið er að setja fagmennsku og gæði sérnáms í forgang. Þessi marklýsing gagnast sérnámslæknum, handleiðurum þeirra og yfirmönnum, sem og öðrum fagstéttum sem koma að mati og samvinnu við sérnámslækna. Forsenda fyrir sérnámi í öldrunarlækningum á Íslandi er annars vegar að læknir hafi lokið sérnámi í lyflækningum og þá er talað um undirsérgrein í öldrunarlækningum eða að læknir hafi lokið sérnámi í heimilislækningum og þá er talað um viðbótarsérgrein í öldrunarlækningum. Þessi útfærsla er í samræmi við ákvæði í reglugerð um menntun, réttindi og skyldur lækna og skilyrði til að hljóta lækningaleyfi og sérfræðileyfi nr. 856/2023.

Megináherslan er á sjúklinginn, samskipti og mikilvægt samstarf við fagaðila sem sinna umönnun og aðhlynningu sjúklinga. Sérstök áhersla er lögð á hruma aldraða með bráða eða langvinna færniskerðingu. Matsblöð sem meta samskiptafærni, kunnáttu, klíníska skráningu og faglega færni eru notuð. Matsblöðin eru lykilatriði í framþróun í sérnáminu.

Marklýsingin er unnin með hliðsjón af bresku marklýsingunni, “Curriculum for Geriatric Medicine Training, August 2022” og staðfærð með hliðsjón af íslenskum aðstæðum. „Training requirements for the speciality of Geriatric Medicine“ *frá European Union of medical specialists* (UEMs-GMs), var haft til hlíðsjónar (https://www.uems.eu/__data/assets/pdf_file/0020/123806/UEMS-2020.-30-European-Training-Requirements-in-Geriatric-Medicine.pdf), sjá lærdómsmarkmið með merkingu (EU). Marklýsingin er á ensku því ekki var talin ástæða til að þýða hana að svo stöddu. Hún gildir á öllum námsstöðum sérnámslækna á öldrunarlækningadeildum Landspítala og á Sjúkrahúsinu á Akureyri.
Yfirlestur og staðfærsla bresku marklýsingarinnar var gerð af kennsluráði í öldrunarlækningum. Hver og ein kennslustofnun getur að auki sett fram ítarlegri og sértækar leiðbeiningar og viðmið, ef talin er þörf á því. Marklýsingunni er ætlað að auka gæði og efla faglega færni sérnámslækna í öldrunarlækningum.

Nýja marklýsingin hefur eldri marklýsingu til grundvallar en frá árinu 2017 þurfa allar marklýsingar í Bretlandi að vera byggðar á staðfestingu á hæfni (higher level learning outcomes) og innihalda mat á almennum hæfniskröfum (generic professional capabilities, GPC), samkvæmt Generic professional capabilities framework. Helstu nýjungar eru að hæfniskröfur skv marklýsingu, sem samþykkt var árið 2020, eru orðnar að liðum í námsská en Capabilities in Practice (CiP) bættist við.

Abbreviations:

ES: Educational supervisor
JRCPTB: The Joint Royal Colleges of Physicians' Training Board
TPD: Training programme director
CMT: Core Medical Training
GPCs: generic professional capabilities
CGA: Comprehensive Geriatric Assessment
MDT: Multidisciplinary team
ADL: Activities of Daily Living
PDP: Personal Development Planning
LTF: Less than full time training
LSH: Landspítali/ Landspitali National University Hospital
SAK: Sjúkrahúsið á Akureyri / Akureyri Hospital
CiPs: Capabilities in practice
Workplace-based Assessments (WPBAs)

- Multi-Source Feedback (MSF)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Case-Based Discussion (CbD)
- Quality Improvement Project Assessment Tool (QIPAT)
- Audit Assessment (AA)
- Teaching Observation (TO)

1 Introduction

Geriatric medicine is concerned with the specialist medical care of older people, many of whom will be frail, and in the promotion of better health in old age. This document will enable the medical director, the training programme director (TPD) and educational supervisors (ES) to ensure that the required standards of clinical care are being met by having a structured training programme and objective assessment procedures.

2 Purpose

Purpose of the curriculum

The purpose of the Geriatric Medicine specialty training curriculum is to train doctors in the generic professional and specialty specific capabilities needed to take overall responsibility for management of patients presenting with geriatric syndromes: frailty, falls, dementia, delirium, declining mobility and functional impairment, polypharmacy and multiple co-morbidities. Such doctors will be qualified to practice as specialist consultant geriatricians, entrusted to deliver services for frail older people within hyper-acute, in-patient, out-patient and community settings. They will have the skills required to address the challenges of frailty, complex co-morbidity, different patterns of disease presentation, slower response to treatment, uncertain prognosis, end of life and requirements for rehabilitation or social support demanded by the demographic changes of population ageing.
At completion of training, they will be capable of independent unsupervised practice.

Rationale

Demographic change, resulting from population ageing, has significantly changed the case mix of acute hospitals. People living with frailty are increasing in number and constitute the majority of acute hospital in-patients. The 'Geriatric Giants' of instability, immobility, incontinence, intellectual impairment/memory and impaired independence, or the Geriatric 5 Ms: Mind, Mobility, Medications, Multi-complexity, and Matters most require skilled assessment and management. Comprehensive geriatric assessment increases patients' likelihood of being alive and in their own homes after an emergency admission to hospital. The UK report of the Future Hospital Commission recommends the need for "a cadre of doctors with the knowledge and expertise necessary to diagnose, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. This includes the expertise to manage older patients with frailty and dementia".

The resulting need for specialists in managing frail older people with long-term conditions requires a curriculum which equips doctors with the capabilities to manage older patients with acute illness, chronic conditions, rehabilitation, end of life and palliative care needs. Whilst it is clear that all future geriatricians will need to be able to provide these assessments and manage patients in a

hospital setting, there will also be a need for them to be able to undertake comprehensive assessments out of hospitals, in care homes and in the patient's own home. Stroke medicine is another area of significant patient and workforce need. Trainees in geriatric medicine will be able to apply for 4 months elective rotation of dedicated stroke/neurology training.

From May 2017, all postgraduate curricula in the UK should be based on higher level learning outcomes and must incorporate the generic professional capabilities (GPC). A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision-making. To this end, communication skills are emphasised throughout all of our capabilities in practice (CiPs – see below) and evidenced through all workplace-based assessments (particularly multi-source feedback – MSF).

Development

This curriculum was developed by the Planning Committee for Geriatric Medicine at Landspitali. For the first version of curriculum (2020), The Specialty Training Curriculum for Geriatric Medicine 2010 from the UK, as well as curricula from various countries, was reviewed and taken into consideration. The content of curriculum was discussed with trainees, the Icelandic Society for General medicine (Lyflæknafélag Íslands) and specialists in geriatric medicine through the Icelandic Geriatric Medicine Society (Félag íslenskra öldrunarlækna) as well as the Icelandic Society of Family Practitioners (Félag íslenskra heimilislækna). Consensus was achieved on the presented contents, including the aims, structure and evaluation methods proposed for the programme. Teaching/learning and assessment methods were chosen with guidance from the JRCPTB. Members of the Planning Committee for Geriatric Medicine at Landspitali at the time were: Anna Björg Jónsdóttir, FRCP L, Consultant Geriatrician; Ólafur Samúelsson, Consultant Geriatrician; Prof. Pálmi V Jónsson, FACP, FRCP L, Chief of Geriatrics; Steinunn Þórðardóttir, Consultant Geriatrician, Head of the Dementia Unit.

The current version of curriculum is based on a new updated curriculum by JRCPTB published in August 2022, which has been developed with input from trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the JRCPTB, the Geriatric Medicine Specialty Advisory Committee, the Stroke Medicine Subspecialty Advisory Committee and the British Geriatrics Society Education and Training Committee and Special Interest Groups (SIGs). The current version of curriculum was rewritten for use in Iceland by the Teaching Council in Geriatric Medicine (Kennsluráð öldrunarlækninga): Consultant Geriatrician and Training Programme Director Konstantín Shcherbak, Consultant Geriatrician and Chief of Geriatric Services Anna Björg Jónsdóttir, FRCP L, Consultant Geriatrician Ólafur Samúelsson, Consultant Geriatrician and Head of Dementia Unit Steinunn Þórðardóttir (until November 2023). Icelandic Geriatric Medicine Society (Félag íslenskra öldrunarlækna), Icelandic Society of Family Practitioners (Félag íslenskra heimilislækna), the Icelandic Society for General medicine (Lyflæknafélag Íslands) and office of Postgraduate Medical Education at Landspítali and SAk will all receive the current curriculum for review.

The programme can be completed in Iceland in the approved teaching facilities, which are currently Landspitali University Hospital (LSH), Reykjavik and Akureyri Hospital (SAk). Other institutions may apply for the approval.

Curriculum objectives

Geriatric Medicine higher specialty training will normally be a two-year programme that will begin after the trainee has obtained a specialist license in Family Medicine or Internal Medicine. This curriculum will ensure that the trainee develops the full range of generic professional capabilities and underlying knowledge and skills, specifically their application in the practice of Geriatric Medicine. It will also ensure that the trainee develops the full range of specialty-specific core capabilities, with the underlying professional knowledge and skills, together with an interest in one theme for service. Newly appointed consultants may be required to take on a role as a service lead and a dedicated focus on one of the specific service areas will facilitate this. Geriatric Medicine is constantly evolving as a specialty, and new themes for service may need to be added as additional

areas of practice (e.g. oncogeriatrics) upon decision of the Teaching Council in Geriatric Medicine at Landspitali.

The objectives of the curriculum are:

- to set out a range of specific professional capabilities that encompass all knowledge, skills and activities needed to practice Geriatric Medicine at consultant level;
- to set expected standards of knowledge and performance of various professional skills and activities at each stage;
- to suggest indicative training times and experiences needed to achieve the required standards.

Scope of Practice

The scope of practice of Geriatric Medicine requires diagnostic reasoning and the ability to manage uncertainty. Geriatric Medicine encompasses the clinical, preventative, remedial and social aspects of illness in older age. Geriatricians require specific medical skills to address the challenges of frailty, complex co-morbidity, different patterns of disease presentation, slower response to treatment, uncertain prognosis, end of life and requirements for rehabilitation or social support.

Patient-centred approaches, patient safety and team working are of vital importance. Geriatricians work both as hospital-based specialists, working closely with colleagues from other specialties, and community-based specialists, working closely with colleagues in primary care and community services. Geriatricians have a wide variety of opportunities for research, and the training is designed to facilitate opportunities for academic careers.

It is anticipated that, when fully trained, the doctor will be:

- Safe and competent to practice as a specialist in Geriatric Medicine;
- Able to apply the knowledge and skills of a competent geriatrician, working within an MDT, in a hyper-acute (front door), in-patient, out-patient and community setting by:
    - Understanding the basic science and biology of ageing, and being able to give advice on, and promote, healthy ageing
    - Performing a comprehensive assessment of an older person and formulating multifactorial management plan
    - Diagnosing and managing older people with acute illness
    - Diagnosing and managing those with chronic disease, dementia, disability and frailty
    - Assessing and managing people presenting with the common syndromes of older age (falls, delirium, incontinence and poor mobility)
    - Demonstrating competence in the special topic areas of palliative care, continence, movement disorders, orthogeriatrics, stroke and psychiatry of old age
    - Understanding the basic principles of therapeutics, polypharmacy, de-prescribing, optimal prescribing, adverse medication effects and medication burden with specific reference to older people

    - Providing rehabilitation with the multi-disciplinary team to older people
- Able to plan the transfer of care of frail older patients from hospital;
- Able to assess and manage (in coordination with dedicated stroke physicians) patients presenting with acute stroke, including the selection of patients for cerebral reperfusion therapies;
- Able to communicate effectively with patients and carers to understand what 'matters most' to them, and thereby to promote shared clinical decision making;
- Able to discuss uncertainty and help patients plan and prepare for the end of their life;
- Able to understand and explain relevant medico-legal and ethical issues, such as assessment of capacity, involuntary admission, decisions regarding life-prolonging treatments and resuscitation following cardio-respiratory arrest;
- Able to work constructively with a wide range of other medical specialties, a wide range of different professions, and a wide range of other related organisations and agencies;
- Able to contribute effectively to service development, education and training and other management activities with particular emphasis on older people living with frailty

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

High level curriculum outcomes – capabilities in practice (CiPs)

The capabilities in practice (CiPs) describe the professional tasks or work within the scope of Geriatric Medicine. These are articulated in six generic CiPs and seven Geriatric Medicine specialty CiPs which have been mapped to the relevant GPC domains and subsections to reflect the professional generic capabilities required. Trainees in Geriatric Medicine must also select one additional theme for service CiP. It is integrated into Geriatric Medicine training, when trainees will undertake one module for a time period of 4 months.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. By the completion of training, the doctor must demonstrate that they are capable of unsupervised practice in all generic, clinical and specialty CiPs, along with one additional 'theme for service' CiP. All CiPs are to be assessed during the training in Geriatric Medicine and are not transferable from previous stages of training.

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within Icelandic organisational and management systems 2. Able to deal with ethical and legal issues related to clinical practice

3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focused on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor

Clinical CiPs (Internal Medicine) – þetta fer niður í sömu töflu með Geriatric CiPs

2. Managing the acute care of patients within a medical specialty service
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. [l e f t b l a n k p u r p o s e l y]
5. Managing medical problems in patients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills

Geriatric Medicine Specialty CiPs

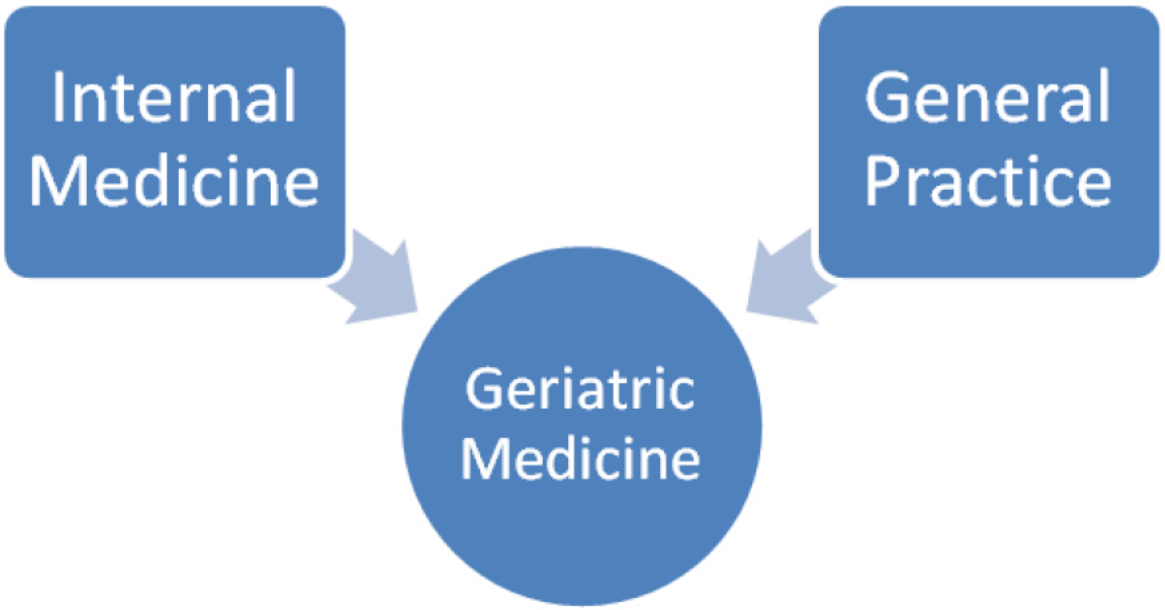
1. Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient and community setting
2. Managing complex common presentations in older people with or without frailty, including falls, delirium, dementia, movement disorders, incontinence, immobility and tissue viability in an in-patient setting
3. [l e f t b l a n k p u r p o s e l y]
4. Managing and leading rehabilitation services for older people, including stroke
5. M a n a g i n g p a t i e n t s i n o u t p a t i e n t s e t t i n g i n c l u d i n g managing community liaison and practice
6. Managing liaison with other specialties, such as surgery, orthopaedics, critical care, oncology and old age psychiatry
7. Evaluating performance and developing and leading services with special reference to older people

Geriatric Medicine CiPs (themed for service – 4 months elective rotation)
Trainees will complete <u>one</u> additional higher-level outcome from the list below according to service theme: 1. Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatrics and bone health service 2. Able to assess patients with urinary and faecal incontinence and is able to provide a continence service for a specific patient group in conjunction with specialist nursing, therapy and surgical colleagues 3. Able to manage ill or disabled older people in a hospital at home, intermediate care, nursing home, rural or community settings and is able to provide a comprehensive community geriatric medicine service 4. Able to manage patients with a wide range of movement disorders at any stage and is able to develop a specialist movement disorders service for older people 5. Able to assess patients presenting acutely with stroke and TIA including suitability for cerebral reperfusion treatments and their subsequent ongoing medical management within an organised stroke service (see Stroke Medicine CiP) 6. Able to assess and manage older patients in one of the following related specialties: Critical Care, Emergency Medicine, Geriatric Psychiatry, General Psychiatry, Neurology, Palliative Care, Sleep Medicine, or other specialties. Geriatric Medicine is constantly evolving as a specialty, and new themes for service may need to be added as additional areas of practice by the decision of Icelandic Teaching Council in Geriatric Medicine. Academic Geriatric Medicine is endorsed and encouraged in any capabilities in practice or the above service themes, linked to a formal academic appointment or completion of a higher research degree or postgraduate certificate of education. Icelandic Teaching Council in Geriatric Medicine can approve other academic work in the field of gerontology or geriatrics which leads to publication or practice change, as a part of the specialist training. Academic work can comprise up to 2 months of specialist training.

Training pathway

Trainees will normally enter higher specialty training having completed training in Family Medicine or Internal Medicine and obtained specialist recognition in either of those specialties.

Figure 1: Geriatric Medicine training pathway



The trainee will be expected to demonstrate a commitment to Geriatric Medicine training. The curriculum will be achieved by completing the necessary specialty posts and evaluation processes within the training programme.

Duration of training

Although this curriculum is competency-based, the duration of training must meet the European minimum of 5 years for full-time basic specialty training in Internal Medicine or Family Medicine and with added 2 years of supplementary training, adjusted for flexible training (EU directive 2005/36/EC). As trainees enter the program after 5 years of either Internal Medicine or General Practice/Family Medicine, this requirement is fulfilled.
The supplementary specialty training (ísl. viðbótarsérnám) for Family Medicine specialists or subspecialty training for Internal Medicine specialists in geriatric medicine is organized as a two-year full-time programme.

There will be options for those trainees with previous experience in Geriatric Medicine and/or related specialties who demonstrate exceptionally rapid development and acquisition of capabilities. It is recognized by JRCPTB and Icelandic Teaching Council in Geriatric Medicine that clinical experience is a fundamental aspect of development as a good physician. Hence, to complete training more rapidly than the current indicative time, the Icelandic Teaching Council in Geriatric Medicine can estimate educational value of previous work experience outside formal

training programs and recommend that some of previous work experience is recognized as a part of required 2 years of training. The general rule us that the previous work experience can constitute up to 50% of comparable rotation period.

There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training (The Gold Guide - Handbók um sérnám lækna: Almennar leiðbeiningar um framkvæmd sérnáms í læknisfræði á Íslandi).

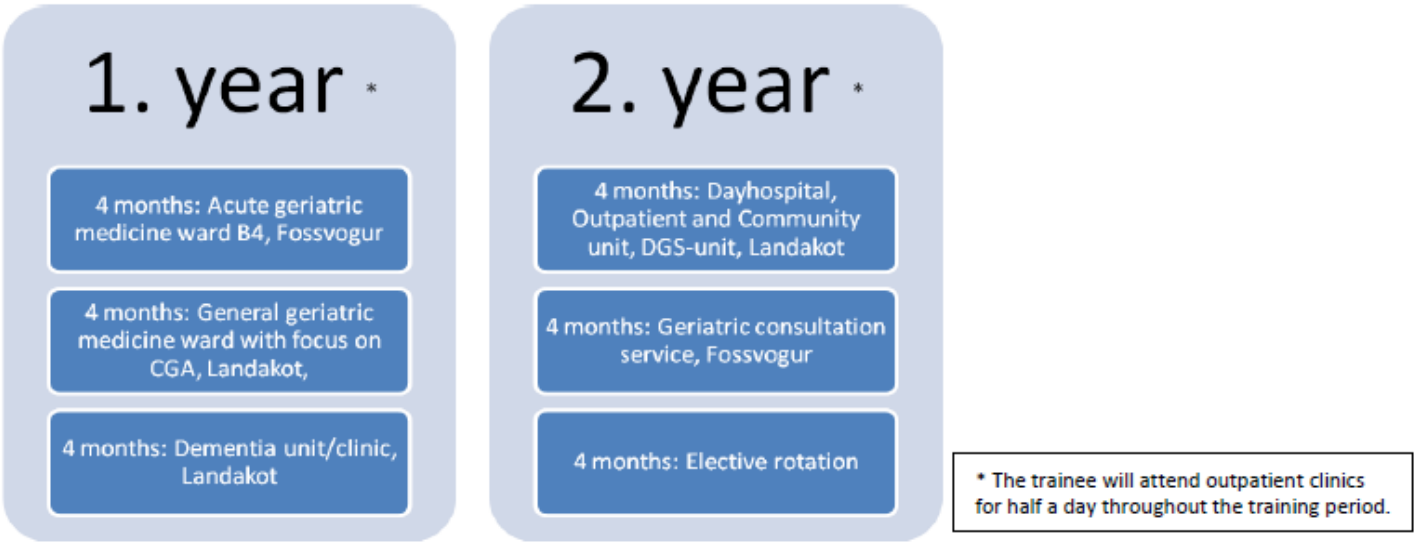
The training is in the first year is typically planned as three 4-month rotations: 4 months in an acute geriatric medicine ward at Landspitali-Fossvogur, 4 months in a memory clinic and a dementia ward at Landspitali-Landakot and 4 months on a ward focusing on comprehensive geriatric assessment, treatment and rehabilitation at Landspitali-Landakot.

During the second year there will be 4 months at the outpatient clinic , Landspitali-Landakot. There will be 4 months on a geriatric consultation service for Landspitali. Finally, there will be a 4 month elective rotation chosen by the trainee to achieve competence specified by 'theme for service' and approved by Training Programme Director. Locations outside of training sites of Landspítali and SAk or not covered by Geriatric Medicine CiPs (themed for service) must be approved by the Teaching Council. Elective rotation may be divided between several departments, provided that respective CiPs are still achieved before the end of training.

The trainee will gradually get more independent and get more responsibility from year 1 to year 2, hence the more specialized rotations during the latter part of the training time. Throughout the training period the trainee will attend his/her own outpatient clinic for a half a day per week.

In accordance to flexibility and accreditation of transferrable capabilities statements below some rotations can be shortened and some prolonged after review by Training Programme Director or Teaching Council. However, combined training programme and work experience outside the training programme recognized by the Teaching Council cannot be shorter than two years full time or part-time equivalent.

Fig 2. Example of a plan for each year.



Flexibility and accreditation of transferrable capabilities

In general, all CiPs needs to be assessed during the training in Geriatric Medicine and are never transferable from previous stages of training. However, the curriculum supports flexibility and transferability of outcomes across related specialties and disciplines, reflecting key interdependencies between this curriculum and other training programmes. The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty, in case the trainee decides to change the training programme. All transfers of outcomes and GPCs must be approved by the Training Programme Director or Teaching Council.

The Geriatric Medicine curriculum will allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities, and these skills will be transferable across other specialties. Academic Geriatric Medicine is endorsed and encouraged in any capabilities in practice or the above service themes, linked to a formal academic appointment or completion of a higher research degree or postgraduate certificate of education. Icelandic Teaching Council in Geriatric Medicine can approve other academic work in the field of gerontology or geriatrics which leads to publication or practice change, as a part of the specialist training. Academic work can comprise up to 2 months of specialist training.

Less than full time training

All aspects of the curriculum can be successfully achieved with less than full time training. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and

other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed and approved by the Teaching Council in Geriatric Medicine in accordance with the Gold Guide and should meet the same national standard by directive 856/2023 and internationally agreed standards as required by directive 467/2015. The minimum part-time occupation is 50% and the maximum duration of the training should be less than 4 years (including all forms of legitimate leave such as Maternity/Paternity leave, leave due to sickness, scientific activity, working for other organization and others), unless the trainee is explicitly exempted from this rule by the Teaching Council in Geriatric Medicine with approval of Post-graduate training board (Framhaldsmenntunarráð). Trainees who spend more than 4 years in the training programme will have their finishing date postponed such that any training time older that 4 years will be added to the total training time.

Sick, Maternity/Paternity leave and vacation

Trainees who have had more than 4 weeks sick or maternity/paternity leave in large blocks of time during their training programme will have their finishing date postponed such that any training time lost over 4 weeks is added to the total training time. Trainees may have rights to take vacation and leaves which accumulated during previous professional engagements according to the national legislation. However, only vacation that is earned during the training period counts as a part of training and normally will be 7 weeks a year (or pro rata share in less than full time training) as mandated by the agreement with the Labor Union.

Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practice within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of the GMC's Generic Professional Capabilities

Good medical practice (GMP) is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptors outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing training programme. These attributes are common, minimum and generic standards expected of all medical practitioners..

The nine domains and subsections of the GPC framework are directly identifiable in the Geriatric Medicine curriculum. They are mapped to each of the generic and clinical CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practice and to minimise the possibility that any deficit is identified during the final phases of training.

3 Content of learning

The practice of Geriatric Medicine requires the generic and specialty knowledge, skills, attitudes and behaviours to manage patients presenting with a wide range of medical symptoms and conditions. It involves diagnostic reasoning, managing uncertainty and dealing with co-morbidities. Geriatricians require specific medical skills to address the challenges of frailty, complex co-morbidity, different patterns of disease presentation, slower response to treatment, uncertain prognosis, end of life and requirements for rehabilitation or social support. Patient-centred approaches, patient safety and team working are of vital importance and demonstration of involvement with multidisciplinary and multi-professional working throughout training will be required.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education. Training will require participation in specialty-specific on call rotas.

The curriculum is spiral, and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from needing direct supervision to being able to be entrusted to act unsupervised.

Capabilities in practice (CiPs)

CiPs describe the professional tasks or work within the scope of the specialty and Internal Medicine. CiPs are based on the concept of entrustable professional activities which use the professional judgement of appropriately trained expert assessors as a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognize the knowledge, skills and attitudes which should be demonstrated. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.

In order to complete training, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP, only confirm that the capability is maintained (in line with standard professional conduct).

This section of the curriculum details the generic CiPs, specialty CiPs for Geriatric Medicine and the Geriatric Medicine Specialty CiPs themed for service.

The expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision are given for each CiP. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP there is a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

KEY

ACAT	Acute care assessment tool	QIPAT	Quality improvement project assessment tool
ALS	Advanced life support	TO	Teaching observation
CbD	Case-based discussion	MSF	Multi source feedback
GCP	Good Clinical Practice	MCR	Multiple consultant report
Mini-CEX	Mini-clinical evaluation exercise	PS	Patient survey
SCE	Specialty Certificate Examination	DOPS	Direct observation of procedural skills
Mini-IPX	Mini-Imaging Interpretation Exercise		

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within Icelandic organizational and management systems	
Descriptors	• Aware of, and adheres to, the professional requirements • Aware of public health issues including population health, social determinants of health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching • Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of, and processes for, operational structures within the Icelandic healthcare system • Aware of the need to use resources wisely
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures
	Management course End of placement reports
2. Able to deal with ethical and legal issues related to clinical practice	

Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements • Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX ALS certificate End of life care and capacity assessment End of placement reports
Category 2: Communication, teamworking and leadership	
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings • Communicates effectively with clinical and other professional colleagues • Identifies and manages barriers to communication (e.g. cognitive impairment, speech and hearing problems, capacity issues) • Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills • Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations • Shares decision making with children and young people • Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty
	• clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking

Evidence to inform decision	MCR MSF End of placement reports ES report
Category 3: Safety and quality	
4. Is focused on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: Wider professional practice	
5. Carrying out research and managing data appropriately	

Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act a clinical supervisor to doctors in earlier stages of training
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO
	Relevant training course End of placement reports

Clinical capabilities in practice:

Geriatric Medicine specialty capabilities in practice including relevant CiPs in Internal Medicine

The specialty CiPs describe the clinical tasks or activities which are essential to the practice of Geriatric Medicine. The CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

IM2	**Managing the acute care of patients within a medical specialty service**
Descriptors	• Able to manage patients who have been referred acutely to a specialised medical service (eg geriatric acute admissions) as opposed to the acute unselected take • Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Demonstrates appropriate continuing management of acute medical illness in a medical specialty setting • Refers patients appropriately to other specialties as required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge

	• professional requirements • national legislation Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD Logbook of cases Simulation training with assessment
IM3	**Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment**
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take • Recognises need to liaise with specialty services and refers where appropriate • Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions) Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement

	• patient safety quality improvement
Evidence to inform decision	MCR MSF Mini-CEX DOPS
IM5	**Managing medical problems in patients in other specialties and special cases**
Descriptors	• Demonstrates effective consultation skills (including when in challenging circumstances) • Demonstrates management of medical problems in inpatients under the care of other specialties Demonstrates appropriate and timely liaison with other medical specialty services when required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR CbD Mini-CEX
IM6	**Managing a multi-disciplinary team including effective discharge planning**
Descriptors	• Applies management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations • Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover • Effectively estimates length of stay • Delivers patient centred care including shared decision making • Identifies appropriate discharge plan Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control*

	and communicable disease) Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF Discharge summaries
IM7	**Managing the acutely deteriorating patient**
Descriptors	• Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious • Demonstrates the professional requirements and legal processes associated with consent for resuscitation • Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families Demonstrates competence in carrying out resuscitation
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR DOPS MSF ALS certificate (or equivalent) Logbook of cases Reflection Simulation training with assessment
IM8	**Managing end of life and applying palliative care skills**
Descriptors	• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life • Demonstrates safe and effective use of syringe pumps in the palliative care population • Able to manage non-complex symptom control including pain

	• Facilitates referrals to specialist palliative care across all settings • Demonstrates effective consultation skills in challenging circumstances • Demonstrates compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation
Evidence to inform decision	MCR CbD Mini-CEX MSF Regional teaching Reflection
GM1	**Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient setting**
Descriptors	• Performs a comprehensive assessment which includes physical, functional, social, environmental, psychological and spiritual concerns • Performs an assessment of cognition (including acute, chronic and rapidly deteriorating) and mental capacity • Performs an assessment of nutritional state • Demonstrates appropriate continuing management of acute medical illness and appropriately manages comorbidities • Performs a risk assessment of peri-operative morbidity • Performs a medication review and is able to optimise and manage medicines in patients living with multi-morbidity and frailty • Formulates an appropriate differential diagnosis and develops a problem list • Appropriately selects, manages and interprets investigations • Formulates an individualised management plan, taking into account patient preferences • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Recognises need to liaise with specialty services and refers where appropriate • Identifies patients with limited reversibility of their medical condition, is able to discuss end of life, undertake advance

	care planning conversations and determine palliative care needs
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF CbD Mini-CEX Reflection on clinical cases Letters generated in out-patient clinics / discharge summaries End of placement reports
GM2	**Managing complex common presentations in older people with or without frailty, including falls, delirium, dementia, movement disorders, incontinence, immobility and tissue viability in an in-patient setting**
Descriptors	• Assesses and manages older patients presenting with falls (with or without fracture) • Assesses and manages older patients presenting with syncope • Recognises, diagnoses and manages a state of delirium presenting both acutely or sub-acutely and identifies those who require follow up • Assesses, diagnoses and manages older people who present with dementia • Assesses and manages patients with dementia who present with other illnesses • Recognises and manages older people with common movement disorders • Assesses and manages older people with urinary and faecal

	incontinence • Assesses and manages older people who present with immobility and declining mobility • Assesses and manages common types of leg and pressure ulceration, surgical and other wounds in older patients • Demonstrates advanced diagnostic and communication skills, develops a problem list, appropriately selects, manages and interprets investigations (and knows when investigation is not appropriate) and formulates an individualised management plan, taking into account patient preferences • Identifies patients with limited reversibility of their medical condition, is able to discuss end of life, undertake advance care planning conversations and determine palliative care needs
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX Reflection on clinical cases Letters generated in out-patient clinics / discharge summaries End of placement reports Relevant training courses
GM4	**Managing and leading rehabilitation services for older people, including stroke**
Descriptors	• Demonstrates the ability to assess physical function, mood and

	cognition using appropriate scales in hospital, in the community and in other settings • Appropriately manages co-morbidities, including frailty and dementia • Identifies and manages barriers to communication (e.g. cognitive impairment, speech and hearing problems, capacity issues) and demonstrates effective consultation skills • Appropriately assesses patients for rehabilitation in medical, orthopaedic and surgical wards, and identifies those suitable for community rehabilitation • Applies management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations and promotes a rehabilitation ethos • Leads a multidisciplinary team meeting, facilitates discussion, builds rapport and resolves conflicts as they arise • Applies the principles of specialist rehabilitation services (including orthogeriatric and stroke) • Effectively estimates length of stay, identifies an appropriate discharge plan and ensures prompt and accurate information sharing with primary care team following hospital discharge • Identifies patients with limited reversibility of their medical condition • Able to discuss end of life and advance care planning to enable patients to make preferences known and ensure end of life care needs are appropriately identified and met.
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups

Evidence to inform decision	MCR MSF CbD Mini-CEX Reflection on clinical cases End of placement reports
GM5	**Managing patients in outpatient setting and providing community liaison**
Descriptors	• Performs a comprehensive assessment (which includes physical, functional, social, environmental, psychological and spiritual concerns) of older people in outpatient settings • Manages acute illness, comorbidities (including dementia) and other problems safely in outpatient settings, including in patient's homes • Able to discuss uncertainty and balance benefits/burdens of hospital versus home treatment • Manages rehabilitation in outpatient settings, collaborating with community services • Performs an assessment of mental capacity • Performs a medication review • Formulates an appropriate differential diagnosis, problem list, and individualised management plan taking into account patient preferences • Understands the various agencies involved in community care • Promotes multidisciplinary team working • Demonstrates a flexible approach to care which crosses the traditional division between primary and secondary care • Identifies patients with limited reversibility of their medical condition, is able to discuss end of life, undertake advance care planning conversations and determine palliative care needs
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention

	Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF CbD Mini-CEX Reflection on clinical cases Letters generated in out-patient clinics / discharge summaries End of placement reports
GM6	**Managing liaison with other specialties, such as surgery, orthopaedics, critical care, oncology, old age psychiatry**
Descriptors	• Contributes to peri-operative management of common co-morbid conditions • Demonstrates understanding of surgical and anaesthetic issues, postoperative care and complications (including pain control and tissue viability) • Demonstrates the ability to clinically assess hip fracture patients, including pre-operative assessment and management, acute post-operative care, post- surgical rehabilitation and discharge planning • Demonstrates the ability to contribute to older people's physiological management in multiple settings (including acute medicine, trauma, post surgical) • Contributes to the assessment and management of patients in critical care areas Including discussion of uncertain prognosis, limited reversibility and treatment escalation • Works collaboratively with orthopaedic surgeons, anaesthetists, cardiologists and other professionals including physiotherapy (PT), occupational therapy (OT), dietetics • Promotes multidisciplinary team working • Appropriately assesses bone health and manages osteoporosis • Demonstrates the ability to assess patients for rehabilitation in medical, orthopaedic and surgical wards • Appropriately assesses and manages older people with acute and chronic medical problems in psychiatry wards and other settings • Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using*

	medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge professional requirements • national legislation Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF CbD Mini-CEX Reflection on clinical cases End of placement reports
GM7	**Evaluating performance and developing and leading services with special reference to older people**
Descriptors	• Ensures patient safety is a priority in clinical practice and raises and escalates concerns where there is an issue with patient safety or quality of care especially pertaining to older people's services • Demonstrates commitment to learning from patient safety investigations and complaints, shares good practice appropriately and develops services accordingly • Contributes to, and delivers, quality improvement with a particular focus on services for older people and those living with frailty. Demonstrates a positive attitude to improvement and change • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Demonstrates ability to carry out critical appraisal of the literature and understands the role of evidence in clinical practice and its limitations in an older population under-represented in clinical trials • Understands public health epidemiology and global health patterns • Delivers effective teaching and training, with specific reference to older people, to medical students, junior doctors and other health care professionals • Demonstrates leadership and management skills, including working with others to effect change, the ability to articulate strategic ideas and provision of medical expertise • Acts as an advocate for older people and is able to challenge ageist practices • Understands management of services, including performance measures, and principles of commissioning where appropriate • Understands local and national health priorities and how they impact on services for older people living with frailty

	• Understands the principles of partnership working between health and social care
GPCs	Domain 1: Professional values and behaviours Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF QIPAT Reflection on clinical cases End of placement reports Training courses

3.2 Geriatric Medicine Specialty CiPs (themed for service)

Trainees will undertake one elective module for a time period of 4 months – designed to ensure the output of geriatricians with the appropriate skills to meet service needs.

Trainees will undertake one additional theme(s) for service CiP from a choice of six. Selection will be agreed with the Programme Director. Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and trainees will be expected to be entrusted to act unsupervised by the end of the training programme. More detail is provided in the programme of assessment section of the curriculum.

1.	**Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatric and bone health service**
Descriptors	• Demonstrates the ability to manage older people with fractures, including hip fractures, other fractures, polytrauma • Demonstrates the ability to manage the effects and risks of surgery and anaesthesia in older people, including the use of tools to risk assess for perioperative morbidity and mortality • Demonstrates the ability to clinically assess and manage older people with fractures and multi-morbidity peri-operatively, including e.g. anticoagulation, diabetes, COPD • Demonstrates awareness of different anaesthetic options for patients with complex co-morbidity • Demonstrates greater knowledge and ability to manage surgical complications, e.g. wound management (including options and timings for intervention), indications for repeat X-ray, non-union • Demonstrates ability to manage patients with osteoporosis treatment failure • Demonstrates greater ability to manage patients requiring parenteral

	osteoporosis therapy • Demonstrates an understanding of osteoporosis including special groups (e.g. men, younger adults, steroid treated, Down syndrome), and of patients presenting with metabolic bone disease • Demonstrates better understanding of the role for national audit to improve quality of care • Demonstrates an understanding of the knowledge and skills required to develop an orthogeriatric and bone health service for older people
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF QIPAT CbD Mini-CEX Reflective practice Relevant training courses End of placement reports
2.	**Able to assess patients with urinary and faecal incontinence and is able to provide a continence service for a specific patient group in conjunction with specialist nursing, therapy and surgical colleagues**
Descriptors	• Demonstrates the ability to perform a detailed assessment of patients presenting with urinary or faecal incontinence • Demonstrates the ability to perform bladder scans and understand urodynamic testing • Demonstrates the ability to interpret the results of investigations (including multichannel cystometry and anal ultrasound and manometry) • Selects treatment options for patients with bowel and bladder problems, including knowledge of behavioural treatments and when to refer for consideration of botox or surgery, taking into account patient preferences • Performs a detailed medication review • Demonstrates the ability to collaborate with specialist nursing, therapy and

	surgical colleagues • Possesses the knowledge and skills required to develop an integrated continence service for older people
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF QIPAT CbD Mini-CEX DOPS Reflective practice Relevant training courses End of placement reports
3.	**Able to manage ill or disabled older people in a hospital at home, intermediate care and community setting and is able to provide a comprehensive community geriatric medicine service**
Descriptors	• Demonstrates advanced skills in undertaking a comprehensive assessment (which includes physical, functional, social, environmental, psychological and spiritual concerns) of older people in community settings including the patient's own home and care homes. Performs an assessment of mental capacity, including in challenging circumstances • Manages acute illness, comorbidities (including dementia) and other problems safely in community settings. Appropriately selects, manages and interprets investigations with special regard to what matters most to the patient. Performs an extended medication review • Demonstrates excellent risk assessment and management skills in identifying the most appropriate place of care, recognising patient autonomy • Appropriately manages patients with pre-existing learning disability in a community setting • Leads rehabilitation in a community setting, and demonstrates advanced skills in managing and contributing to community MDT working • Understands the various agencies involved in community care, (including voluntary, social prescribing and third sector) • Delivers a flexible approach to care which crosses the traditional division between primary and secondary care

	• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Demonstrates advanced skills in care home medicine • Demonstrates skills in education and management of community staff • Possesses the knowledge and skills required to develop a community geriatric medicine service for older people
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF QIPAT CbD Mini-CEX Reflective practice Relevant training courses End of placement reports
4.	**Able to manage patients with a wide range of movement disorders at any stage and is able to develop a movement disorders service for older people**
Descriptors	• Demonstrates the ability to clinically assess, diagnose and manage patients presenting with a wide variety of movement disorders, including the role for further tests (e.g. Dopamine transporter (DaT) scan) • Demonstrates the ability to manage patients presenting with Parkinson's Disease (PD) at any stage (including motor and non-motor symptoms, complex and palliative phases and options for advanced therapies) • Recognises and appropriately manages patients with Dementia with Lewy Bodies, PD related dementia, impulse control disorders, dopamine dysregulation syndrome and Dopamine agonist withdrawal syndrome • Demonstrates the ability to work collaboratively with neurologists, old age psychiatrists and other professionals including physiotherapy (PT), occupational therapy (OT), speech and language therapy (SLT), dietetics • Performs an assessment of mental capacity, including in challenging circumstances

	• Demonstrates appropriate continuing management of acute medical illness and appropriately manages comorbidities • Performs a medication review including acute management of patients with impaired swallow or absorption • Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Possesses the knowledge and skills required to develop a comprehensive movement disorder service for older people
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF QIPAT CbD Mini-CEX Reflective practice Advanced movement disorders course or masterclass End of placement reports
5.	**Able to assess patients presenting acutely with stroke and TIA including suitability for cerebral reperfusion treatments and their subsequent ongoing medical management within an organised stroke service**
Descriptors	• Demonstrates knowledge of the different pathophysiological mechanisms, disease processes and causes that underlie the clinical syndrome of stroke (and its subtypes) • Able to conduct an urgent clinical evaluation and prioritise safely: initiating appropriate investigations in a timely manner, interpreting the results and communicating the management plan effectively (including face to face and virtually [e.g. telemedicine]) • Able to provide an accurate diagnosis and appropriate comprehensive management of patients with suspected TIA or stroke including identification of vascular risk factors and lifestyle modification • Able to identify conditions that mimic TIA and stroke and manage these

	effectively or make an appropriate referral • Able to manage comorbidities and risk factors relevant to TIA and stroke in an outpatient clinic (including tolerating uncertainty where investigation or intervention may not have high utility or benefit). • Awareness of up-to-date primary and secondary prevention treatment strategies for TIA and stroke (including knowledge and application of national guidance) • Able to prioritise referrals received through different mechanisms (e.g. electronic, telephone, in person) and by all healthcare professionals • Able to provide appropriate driving, vocational and social advice for patients with TIA or stroke working in partnership where necessary with the stroke multidisciplinary team • Able to apply principles of stroke team multi-professional assessment to understand the physical and psychological and social impact of stroke on patients and work collaboratively with the stroke unit multidisciplinary team to guide management strategies including positioning, hydration, nutrition, continence, risk factor modification and participation in rehabilitation
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (*history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease*) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	CbD Mini-CEX Mini-IPX Mini-Imaging Interpretation Exercise MSF QIPAT DOPS MCR End of placement reports
6	**Able to assess and manage older patients of one of the following related specialties**:
	Critical Care, Emergency Medicine, Geriatric Psychiatry, General Psychiatry, Neurology, Palliative Care, Sleep Medicine or other specialties. Geriatric Medicine is constantly evolving as a specialty, and new themes for service may

	need to be added as additional areas of practice by the decision of Icelandic Teaching Council in Geriatric Medicine.
Descriptors	Compiled individually for each rotation and approved by the Training Council
Evidence to inform decision	MCR MSF QIPAT CbD Mini-CEX Reflective practice Advanced movement disorders course or masterclass End of placement reports
Academic Geriatric Medicine is endorsed and encouraged in any capabilities in practice or the above service themes, linked to a formal academic appointment or completion of a higher research degree or postgraduate certificate of education. Icelandic Teaching Council in Geriatric Medicine can approve other academic work in the field of gerontology or geriatrics which leads to publication or practice change, as a part of the specialist training. Academic work can comprise up to 2 months of specialist training.	

Practical procedures

There are three procedures in which a trainee must become proficient unsupervised by completion of training. Trainees must be able to outline the indications for these procedures and recognize the importance of valid consent, minimisation of patient discomfort, and requesting for help when appropriate.

Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct).

Procedure	By the end of training
Bedside ultrasound bladder	Able to perform unsupervised
Dix-Hallpike test and Epley manoeuvre	Able to perform unsupervised
Spinal tap	Able to perform unsupervised

Core knowledge base

The following list is intended to underpin the clinical learning required to achieve the capabilities in practice. It is not an exhaustive list but should act as a guide for areas specific to Geriatric Medicine in which trainees will gain experience during the course of their training. Some of these areas will be assigned to the trainee as a topic of lectures and other presentations.

Basic science and biology of ageing

- the process of normal ageing in humans
- the effect of ageing on the different organ systems (including skin and digestive tract) and homeostasis
- the effect of ageing on functional ability
- pathophysiology of frailty and sarcopenia
- nutritional requirements of older adults
- demographic trends in society
- the basic elements of the psychology of ageing
- changes in pharmacokinetics and pharmacodynamics in older people
- clinical pharmacology and therapeutics for older people
- pathophysiology of pain
- ageism and strategies to counteract this
- health promotion and the benefits of a healthy lifestyle
- factors influencing health status in older people
- awareness of public health issues and how these relate to older people
- techniques of risk reduction (including both primary and secondary prevention)
- research in older adults and the application of this to individuals
- sleep in older age (EU)
- sexuality in older adults (EU)
- role of family and other care givers (EU)
- Gerotechnology and eHealth (EU)

Geriatric Medicine Syllabus

The scope of Geriatric Medicine is broad and cannot be encapsulated by a finite list of presentations and conditions. The table below details the key presentations and conditions of the specialty of Geriatric Medicine. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate CiPs and GPCs. In this spiral curriculum, trainees will expand and develop the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate advanced bedside skills, including:

- information gathering through history and physical examination
- information sharing with patients, families and colleagues
- communication with patients living with cognitive impairment and sensory impairment

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes an understanding of polypharmacy, de-prescribing, medicines optimisation and medicines management in patients living with multi-morbidity. It should include discussions and decisions as to whether treatment should be active or palliative, and also broader aspects of care, including involvement of other professionals or services.

In patients with multi-morbidity and frailty there will inevitably be a great deal of overlap between conditions and issues. However, for each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, pathophysiology, clinical features, investigation, management and prognosis. The table below should be considered as general guidance and not exhaustive detail, which would inevitably become out of date.

Key presentations and conditions for Geriatric Medicine (curriculum items)

Specialty area	Key components	Conditions/Issues (not exhaustive)	Map to CiPs
Comprehensive geriatric assessment A multi-dimensional, multi-disciplinary process which identifies medical, psychological, social and functional needs, and the	History taking (including from patients with special communication needs, in challenging circumstances and from multiple sources) Physical assessment	Physical and general frailty Multi-morbidity Cognitive impairment Polypharmacy Immobility Falls Functional decline Incontinence	GPC CiPs 2,3 IM CiPs 2-6,8 GM CiPs 1, 3-5
development of an integrated care plan to address those needs	(Including assessment of gait and balance, nutritional assessment, fitness for surgery) Functional, social and environmental assessment (including assessment of activities of daily living, functional status, formal and informal carer support) Continence assessment Psychological and spiritual assessment (including mood and cognition, capacity assessment) Medication review (including medicines optimisation) Development of a problem list and individualised management plan Collaborative working Effective communication (including with those with special communication needs) Discussion of dying, CPR, and preferences for future healthcare – advance care planning (ACP) Identification of opportunities for health promotion	Cardiovascular diseases Depression Dementia Social isolation Mental capacity Safeguarding issues/vulnerable adults Identification of lifestyle changes to positively improve health End of life care	

Diagnosis and management of acute illness in older patients To be able to diagnose and manage acute illness in older patients in a variety of settings	Recognition of non-specific acute presentations seen in older people Recognition of secondary complications of acute illness in older people and strategies to prevent them Assessment of acutely unwell older people in non-hospital settings (including judging when hospitalisation is necessary) Understanding and communicating prognosis to seriously ill older patients and their carers (including recognising uncertainty) Medication review (including medicines optimisation)	Acute medical presentations Exacerbations of known chronic conditions Delirium Pressure sores and skin ulceration Incontinence, urinary retention Constipation, diarrhoea, faecal impaction Immobility and functional decline Falls, fractures and other injuries Syncope, pre-syncope, dizziness Hypothermia / hyperthermia Physiological management of older people, including fluid balance, in multiple settings Infections and sepsis	GPC CiPs 2,3 IM CiPs 2 Ger Med CiPs 1-3,5,6
	Decisions about the appropriateness of resuscitation and other major interventions Application of legal and ethical principles to patients lacking mental capacity in an emergency situation	Acute surgical presentations Physical deconditioning and nutritional decline	
Diagnosis and management of chronic disease and disability in older patients To be able to diagnose and manage chronic disease and disability in older patients in both hospital and community settings	Recognition of the major chronic illnesses and disabling conditions seen in older people Assessment and interpretation of investigations (including recognising when investigation is not appropriate) Drug and non-drug management of chronic conditions, including use of aids and appliances and technology Assessment of multi-morbidity and polypharmacy (including principles of medicines reconciliation, de-prescribing and medicines optimisation) Assessment of physical function, mood and cognition using appropriate scales Principles of rehabilitation Nutritional assessment and support	Ischaemic heart disease, heart failure (including HFpEF), atrial fibrillation, valve disease, hypertension Chronic lung disease Chronic liver disease Chronic kidney disease, prostate disease Sensory impairment Neurological disorders (including peripheral neuropathy, movement disorders, stroke) Arthritis, polymyalgia rheumatica, osteoporosis Falls, dizziness, syncope Dementia, depression, anxiety Diabetes, thyroid disease Skin ulceration and chronic oedema Anaemia Weight loss, including	GPC CiP 3 IM CiPs 1-4 Ger Med CiPs 1-6

	Assessment of the impact of chronic illness on patients and carers Advance care planning (ACP) Health promotion and preventive medicine Principles of 'social prescribing' (including knowledge of volunteer and support groups)	sarcopenia Frailty Cancer	
Rehabilitation, multidisciplinary team working and discharge planning To have the knowledge and skills to provide rehabilitation to an older person in a variety of acute and community settings	Principles of rehabilitation (including goal setting, use of assessment scales) Physical therapies which improve muscle strength and function. Therapeutic techniques/training to improve balance and gait Aids and appliances which reduce disability	Stroke Low trauma fractures Functional decline post surgery or acute illness (including delirium) Immobility Sarcopenia Patients with multiple medical problems and disabilities	GPC CiP 3 IM CiP 3,6; Ger Med CiPs 4,5
	Leading a multidisciplinary team meeting, facilitating discussion, building rapport and resolving conflicts as they arise Assessment of patients for rehabilitation in medical, orthopaedic and surgical wards Promoting a rehabilitation ethos Leading case conferences for complex discharges (striking the right balance between opinion-seeking, discussion and decisive management of patients, but keeping the patient's wishes as the focus)	Specialist rehabilitation services (including orthogeriatric and stroke) Mental capacity Safeguarding issues /vulnerable adults The impact of cognitive impairment on rehabilitation Recognition that older people take longer to recover from acute illness Advance care planning (ACP)	
Medicines optimisation To have the knowledge and skills required to optimise and manage medicines in patients living with multi-morbidity and frailty	Performing a medication review (including knowledge of tools to aid medication reviews) Shared decision making Collaboration with primary care, pharmacists and with the patient and their carer	Polypharmacy Anticholinergic burden Numbers needed to treat (NNT) and numbers needed to harm (NNH) Compliance and concordance Medicines-related adverse events	GPC CiPs 3,4 IM CiPs 3-5 Ger Med CiP 1-6

Delirium To be able to recognise, diagnose and manage a state of delirium presenting both acutely or sub-acutely in patients in hospital, in the community and in other settings	Diagnostic criteria for delirium Standardised measures of assessing cognitive status in delirium (including use of assessment tools) Non-pharmacological management (including investigation of the underlying cause) Pharmacological management (including appropriate use of antipsychotics) Medication review Assessment of capacity Legal framework for practice Multidisciplinary working Recognition of patients who require follow up	Relationship of delirium with dementia syndromes Risk factors, causes and outcomes Complications of delirium Delirium as a medical emergency The impact of cognitive impairment on the assessment and management of other illnesses Legal aspects of capacity and consent Mental health legislation	GPC CiP 2 IM CiPs 1-3,5; Ger Med CiPs 2,3,5,6
Dementia To be able to assess and manage patients who	Diagnostic criteria (including in younger people and people with learning disabilities)	Alzheimer Dementia Vascular dementia Mixed dementia Dementia with Lewy Bodies	GPC CiPs 2,3 IM CiPs 3,4; Ger Med CiPs 1-6
present with dementia and also to assess and manage patients with dementia who present with other illnesses	Differential diagnosis of dementia Investigation and assessment (including assessment tools, imaging and neuropsychology assessment) Assessment of capacity Differentiation between dementia and other diagnoses (including depression and aphasia) Communication of diagnosis, prognosis and information about support and treatment options to people with dementia and carers Behavioural changes in dementia Pharmacological and non-pharmacological management Assessment of multi-morbidity, physical frailty and polypharmacy Collaborative working with old age psychiatry Personalised approach to care Legal framework for practice	Frontotemporal dementia Dementia associated with Parkinson's Disease and other parkinsonian syndromes Impact of dementia on the assessment and management of other illnesses, on nutrition, and on rehabilitation Effect of treatment of other illnesses on dementia Effect of drug treatments for dementia on other illnesses Behavioural and psychological symptoms associated with dementia Legal aspects of capacity and consent Safeguarding and protection of vulnerable adults Mental health legislation	

		Support for people with dementia and their carers End of life and palliative care	
Continence To have the knowledge and skills required to assess and manage urinary and faecal incontinence	Effects of ageing on the urogenital tract Assessment of patients with urinary and faecal incontinence (including history, physical examination, medication review, voiding chart, performing bladder scans, principles of urodynamics) Development of a management plan, including pharmacological and non-pharmacological interventions Multidisciplinary approach (continence nurse specialist, physiotherapist, urogynaecologist, proctologist)	Urinary incontinence Faecal incontinence Epidemiology, risk factors and causes Conservative management strategies (e.g. fluids, timing, environment) Pharmacological treatments Behavioural treatments Surgical treatments Catheters and devices Padding (including different types of pads, absorbency, local arrangements for use) and other equipment	GPC CiP 3 IM CiPs 2,3,4,6; Ger Med CiPs 1-5
Falls and syncope To know how to assess and manage older patients presenting with falls (with	Assessment of falls (including causes, risk factors, consequences, impact) Medication review	Falls Syncope Postural hypotension Cardiac arrhythmias Carotid sinus syndrome	GPC CiP 3 IM CiPs 1-4,6; Ger Med CiPs 1-5,7
or without fracture) and syncope in an acute or community setting	Assessment of gait, balance and vision Assessment and treatment of syncope (including cardiac monitors, event recorders, echocardiogram, BP evaluation, tilt testing and carotid sinus massage) Assessment and treatment of dizziness and vertigo (including Dix-Hallpike test and Epley manoeuvre) Assessment of bone health (including interpretation of bone densitometry scans) and treatment of osteoporosis and vitamin D deficiency Assessment of functional ability and need for rehabilitation Interventions to prevent falls and minimise consequences (including drug and non-drug interventions) Multidisciplinary approach (e.g. PT, OT, risk assessment, environment)	Vertigo (including benign paroxysmal positional vertigo (BPPV)) Dizziness Poor vision Drugs / polypharmacy Multifactorial Osteoporosis Consequences and impact of falls Fear of falling syndrome Fractures and other injury (including subdural haematoma) Awareness of compromises between patient's safety and improved mobility	

Poor Mobility To know how to assess the cause of immobility and declining mobility and aid its management	Assessment of patients presenting with immobility or declining mobility (including risk factors and causes) Gait assessment Interventions to improve mobility and prevent immobility Rehabilitation and multidisciplinary approach	Osteoarthrosis Inflammatory arthritis Crystal athropathies Polymyalgia rheumatica Myositis and myopathy Frailty and sarcopenia Movement disorders Stroke Cervical and lumbar myelopathy Peripheral neuropathy Poor vision Cardiac and respiratory disease	GPC CiP 3 IM CiPs 1-4,6; Ger Med CiPs 1-5
Nutrition To know how to assess the nutritional status of older people in different care settings and in conjunction with other relevant health professionals be able to devise an appropriate nutritional support strategy for patients	Assessment of nutritional state (including use of assessment tools) Investigation of weight loss Investigation of dysphagia and malabsorption Provision of strategies to enhance nutrition Nutritional support including indications, delivery routes (oral, nasogastric including "nasal bridles", gastrostomy, parenteral) and potential problems	Nutritional requirements of older adults Malabsorption states Stroke and other neurological causes of dysphagia Dementia and delirium Malignancy Refeeding syndrome Effect of nutrition on disease processes, tissue viability, recovery from illness and surgery	GPC CiP 2,3 IM CiPs 1-6,8; Ger Med CiPs 1-6
	Multidisciplinary team working (dietician, nutrition support team, gastroenterologist)	Withholding and withdrawing life sustaining treatments	
Tissue Viability To know how to assess, diagnose and monitor common types of leg and pressure ulceration, surgical and other wounds in older patients	Assessment and diagnosis of common causes of skin ulceration Risk scores and prevention of pressure ulceration Principles of wound care Management of ulceration and infection (including dressings, topical and systemic antibiotics, compression treatment) Multidisciplinary team working (including podiatry, vascular surgery, diabetes, tissue viability nurses)	Venous ulceration Pressure skin damage Diabetic foot ulceration Lipodermatosclerosis Malignant skin lesions Vasculitis Use of ankle brachial pressure index (ABPI) and Doppler scan Reasons for non-healing	GPC CiP 2,3 IM CiPs 1-5; Ger Med CiPs 1-6
Movement Disorders To be able to competently manage patients with common movement disorders	Assessment of symptoms and signs (including use of rating scales), investigation (including imaging) and diagnosis of common movement disorders	Idiopathic Parkinson's Disease (PD) Parkinsonism (including drug induced and vascular) Dementia with Lewy Bodies Essential tremor	GPC CiP 3 IM CiPs 3,4,6,8; Ger Med CiPs 1,4-6,7

	Evaluation of motor and non-motor impairments Pharmacological and non-pharmacological management of PD in initial, stable, complex and palliative phases Recognition of complications and problems in the complex phase Recognition of the palliative phase with disease progression Multidisciplinary team working (including PD nurse specialists, PT, OT, SLT)	Multisystem atrophy Progressive Supranuclear palsy Corticobasal degeneration Dopamine dysregulation syndrome Supervising an Apomorphine challenge test Indications for neurosurgery	
Community liaison and practice To have the knowledge and skills required to assess a patient's suitability for and deliver care to older people within intermediate care and community settings, working with multidisciplinary teams, primary care and local authority colleagues	Models of intermediate care/community geriatric medicine including evolving role of day hospitals and care home medicine Managing acute illness safely in community settings including hospital at home services Undertaking comprehensive assessment in a patient's own home or care home	Frailty Falls Immobility Dementia Heart failure and other cardiovascular diseases Polypharmacy and medication reviews Functional decline Incontinence Skin and wound care Multimorbidity	GPC CiP 2,3 IM CiPs 2,4,6,8; Ger Med CiPs 1,2,5,7

	Managing chronic conditions in community settings Community based assessment and rehabilitation services Pharmacological and non-pharmacological interventions Medication review (including medicines optimisation) Care home medicine (including management of acute illness, enhanced health in care homes, advance care planning) Delivery of domiciliary assessments (including CGA, urgent medical and rehabilitation assessments) Liaison with GPs and specialty community services (e.g. heart failure, COPD) Understanding of the various agencies involved in community care, (including voluntary and third sector) Assessment of patients requiring continuing health care	Interaction between health and social care and between primary and secondary care Role of assistive technology Carer stress Anticipatory care planning Palliative and end of life care Managing uncertainty in the community Benefits/burdens of hospital v. home treatments Practical challenges Decision making for patients you have not met	
Orthogeriatrics To know how to assess and manage acutely ill orthopaedic patients and how to manage rehabilitation	Medical optimisation prior to surgery (including working with anaesthetists and surgeons) Peri-operative management of common co-morbid conditions Surgical and anaesthetic issues and understanding of postoperative care and complications (including pain control and tissue viability) Models of orthogeriatric care (including acute trauma and orthogeriatric rehabilitation) Working collaboratively with orthopaedic surgeons, anaesthetists, cardiologists and other professionals including PT, OT, dietetics Assessment and management of falls Medication review (including medicines optimisation)	Falls Hip fracture and other fragility fractures Osteoporosis Fluid balance Heart failure Venous thromboembolism Delirium Pneumonia Acute kidney injury	GPC CiP 3 IM CiPs 5-8; Ger Med CiPs 1,3,6,7

	Assessment of bone health and treatment of osteoporosis (including fracture liaison services) National hip fracture audits		
Perioperative Medicine for Older People To know how to risk assess, optimise and manage the older elective and emergency surgical patient throughout the surgical pathway	Models and pathways of care for older surgical patients Clinical assessment with appropriate use of investigations and tools to risk assess for perioperative morbidity and mortality Knowledge of the natural history of common surgical disease to estimate likely prognosis with/without surgery Liaison with patients, anaesthetists and surgeons to ensure shared decision making Assessment of mental capacity Use of interventions to improve postoperative outcome (e.g. multimodal pre-habilitation) Timely medical optimisation of comorbidity and geriatric syndromes in both pre-operative and post-operative settings Decision making regards rehabilitation, and timely and effective discharge pertinent to the surgical patient	Risks of surgery in older people and how risk varies depending on patient factors (e.g. frailty and multi-morbidity) and surgical factors (e.g. type of surgery and anaesthesia) Post-operative issues and complications including: Delirium Failure to thrive Sepsis, wound infections Pain Arrhythmias Heart Failure Renal Injury Stoma management Amputation Post fracture care Traumatic Brain Injury	GPC CiP 3 IM CiP 5; Ger Med CiPs 1,6
Psychiatry of Old Age To know how to assess and manage older patients presenting with the common psychiatric conditions, and to know when to seek specialist advice	Psychiatric assessment methods and tools (including cognitive and mood assessment) Diagnosis of older people with psychiatric conditions Differentiating between cognitive impairment and other diagnoses Optimising management of people with cognitive impairment and other co-morbidities Pharmacological and non-pharmacological interventions Assessment of mental capacity Working collaboratively with other specialists, particularly old-age	Depression Delirium Dementia Anxiety Paranoid states Behavioural and psychological symptoms associated with dementia Legal aspects of capacity and consent Safeguarding and protection of vulnerable adults Mental health legislation	GPC CiPs 2,3 IM CiPs 2,3,4,6; Ger Med CiPs 1-6

	psychiatrists, and agencies to manage the older patient with mental ill health		
Palliative Care To have the knowledge and skills required to assess and manage patients with life-limiting diseases (malignant and non-malignant) across all health care settings, in conjunction with other health care professionals	Assessment of symptoms in terminally ill patients Medicines optimisation (including deprescribing) Pharmacological and non-pharmacological management of common symptoms Assessment and management of pain Management of palliative care emergencies (including acute pain, hypercalcaemia, haemorrhage, spinal cord compression, breathlessness) Management of hydration and nutrition (including ethical and legal aspects, withholding and withdrawing life prolonging treatments) Development of a holistic management plan (including multidisciplinary assessment) Effective communication with patients and carers, including 'breaking bad news' Discussing and recording ACP Working with specialist palliative care teams (acute and community)	Cancer Heart failure COPD Renal failure Stroke Dementia Parkinson's Disease Severe frailty Pain Nausea, vomiting, constipation Breathlessness, excess respiratory tract secretions Anxiety, agitation Polypharmacy Assessment of physical and mental state Assessment of prognosis (including recognising when a patient is not imminently dying but has limited physiological reserve and at risk of sudden acute deterioration) Recognition of the dying phase of terminal illness Prescribing in organ failure	GPC CiPs 2,3 IM CiPs 1-4,8; Ger Med CiPs 1,3,5
Care of Older People Living with Frailty To understand the science underpinning the pathophysiology of frailty and the evidence base for interventions to improve outcomes for older people living with frailty	Use of frailty scales to identify mild, moderate and severe frailty Assessment and management of clinical presentations in older people with moderate and severe frailty in both acute and community settings Assessment of multi-morbidity and polypharmacy (including principles of medicines reconciliation, de-prescribing and medicines optimisation) Assessment and management of secondary complications of acute illness in people living with frailty	Delirium Incontinence Immobility Functional decline Dementia Sarcopenia Advanced heart failure Non-specific acute presentations Adverse outcomes of frailty	GPC CiPs 2,3 IM CiPs 2-4; Ger Med CiPs 1-3,5,7

	Interventions to improve outcomes for frail older people in a variety of settings (including acute services, care homes, day hospitals, community) Advance care planning (ACP) Models of care and frailty pathways, including early intervention		
Stroke Medicine	Assessment and management of patients presenting with acute stroke (including various cerebral reperfusion strategies and referral for neurosurgical intervention) Assessment and management of patients presenting with TIA and/or mimic (including selection of appropriate investigations, treatments and advice) Assessment and management of common complications of stroke (including dysphagia) Assessment and management of hydration and nutrition after stroke Primary and secondary prevention of stroke and TIA Stroke rehabilitation across the patient pathway as part of an MDT (both early and late inpatient)	Stroke (including cerebral infarction and intracerebral haemorrhage) Broad range of mechanisms for stroke (e.g. athero-thromboembolism, arterial dissection) Small vessel disease Cerebral Amyloid Angiopathy (CAA) Transient Ischaemic Attack Transient Focal Neurological Episodes (including relating to CAA) Common Stroke and TIA mimics (including focal seizure, migraine, functional neurological presentations) Complications of stroke (medical and due to immobility) Atrial fibrillation Hypertension Nutrition Impact of cognitive impairment on rehabilitation Palliative care relevant to stroke Medical guidelines on 'fitness to drive'	GPC CiPs 2,3 IM CiPs 1-4, 6,8; Ger Med CiPs 2,4,7
Evaluating performance and developing and leading services with special reference to older people To develop the skills to evaluate your own	Public health epidemiology and global health patterns Principles of quality improvement Knowledge of research principles and concepts and the translation of research into practice	Prioritisation of patient safety in clinical practice Service development specifically to older people (e.g. falls services, models of orthogeriatric care, surgical liaison and peri-operative	GPC CiPs 1,4-6 Ger Med CiP 7

performance and the service in which you work, contribute to service development and develop leadership skills to improve services for older people	Leadership and Management skills for clinical settings (including demonstrating positive behaviours and leadership styles) Working with others to effect change Understanding management of services, including performance measures, and principles of commissioning where appropriate Improving services, including developing a business plan and option appraisal Setting direction for services using best practice and evidence/guidelines Teaching and training with specific reference to older people Advocating for older people	care of older people, frailty teams, hospital at home teams, community geriatric medicine, geriatric oncology) Quality improvement methodology Critical appraisal of literature Evidence based medicine and clinical trials Partnership working between health and social care	
Transitional care (EU) Plan discharge from hospital and the continuity of care of frail older patients	This contains the coordination of the different services for the care of multimorbid older patients in community settings Assess a patient's eligibility for admission to long term care and assess the care needed for those in long term care (continuing care) Take part and lead MDT discharge planning meetings Attend case conferences for complex discharges Follow discharge planning nurses in their function in discharge planning Assess patients for nursing home placement	Managing uncertainty in the community Benefits/burdens of hospital v. home treatments Practical challenges Assessment of physical and mental state Assessment of prognosis (including recognising when a patient is not imminently dying but has limited physiological reserve and at risk of sudden acute deterioration) Managing chronic conditions outside the hospital setting Community based assessment and rehabilitation services Care home medicine (including management of acute illness, enhanced health in care homes, advance care planning) Liaison with GPs and specialty community services (e.g. heart failure,	

		COPD) Understanding of the various agencies involved in outside outside hospital setting Assessment of patients requiring continuing health care	

Each curriculum item must be tagged in the respective PDP and a consultant geriatrician and/or other supervisor must confirm trainee's knowledge in the subject for the ARCP. It is advised that 50% of curriculum items are signed off before the ARCP, between the first and the second year.

4 Learning and Teaching

The training programme

A training programme director (TPD) will be responsible for coordinating the specialty training programme. Progression through the programme will be determined by the ARCP process and the training requirements for each indicative year of training are summarised in the Geriatric Medicine ARCP decision aid (available on Landspítali website).

Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person.

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site should be defined to ensure that, during the programme, the curriculum requirements are met and also that unnecessary duplication and educationally unrewarding experiences are avoided.

Mandatory training

All training should be conducted in institutions which are approved for specialist training in Iceland. However, elective rotation can be carried out in institutions that meet relevant criteria and standards for training and education upon the decision of Training Council in Geriatric Medicine. This section provides guidance on the learning experiences required. When training in Geriatric Medicine, all trainees will have an appropriate clinical and educational supervisor who must be actively involved in practicing Geriatric Medicine.

Acute medical take

Trainees should be involved in the acute selected medical take and should be actively involved in the care of patients presenting with acute medical problems. Trainees will need to demonstrate they have the required capabilities to manage the acute selected take at completion of training.

Inpatients

Trainees in Geriatric Medicine will require to rotate through units which provide continuing ward care of patients admitted with acute medical problems (4 months) , provide experience in the management of people living with frailty, comprehensive assessment of acutely ill older people, rehabilitation of older people (including stroke), orthogeriatrics, and movement disorders.

Outpatients

Trainees should attend a wide variety of clinics in order to gain sufficient competence in the following areas:

- Falls and syncope
- Osteoporosis and bone health
- Memory clinic or other clinic with a focus on dementia
- Outpatient comprehensive geriatric assessment including nutrition, psychological problems, physical function decline, multimorbidity

Trainees might also attend a wide variety of clinics outside of Geriatric services in order to gain experience in the following areas:

- Tissue viability (including leg ulceration, vascular surgery, diabetes podiatry}
- Continence (including urodynamics, urogynaecology, physiotherapy)
- Movement disorders
- Stroke and TIA
- Heart failure and other cardiovascular diseases

The choice of clinic / experience should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor, with the educational objectives as set out in the teaching and learning methods section.

Trainees in Geriatric Medicine might be required to coordinate outpatient work with community settings and co-develop care plans in patients' own homes, care homes and in rehabilitation settings. They will be required to gain experience in coordinating with community multidisciplinary teams and primary care teams to provide coordinated integrated case management.

Liaison experience

Trainees in Geriatric Medicine will be expected to gain experience and training in liaison work with other specialties, particularly psychiatry, surgery, orthopaedics, critical care, oncology, and palliative medicine. This may most commonly be achieved through rotation to Geriatric consultation service and should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor, with the educational objectives as set out in the teaching and learning methods section.

Research and quality improvement

Academic Geriatric Medicine is crucial to maintaining clinical excellence in an ageing population, and older people remain under-represented in the evidence base for clinical practice.

Trainees will be expected to be competent in basic research methodology, ethical principles of research, performing a literature search, and critical appraisal of medical literature (see Generic CiP 5). Trainees in Geriatric Medicine must be able to demonstrate application of the above principles with regard to older people living with frailty. Trainees are encouraged to have completed a research methodology course and a Good Clinical Practice course.

Trainees will be expected to be competent in principles of audit and quality improvement methodology (see Generic CiP 4), to have personal experience of involvement in quality improvement, and to have completed a quality improvement project during the second year of training. Trainees should have completed a formal study course on Quality Improvement.

Academic Geriatric Medicine is endorsed and encouraged in any capabilities in practice or the above service themes, linked to a formal academic appointment or completion of a higher research degree or postgraduate certificate of education. Icelandic Teaching Council in Geriatric Medicine can approve other academic work in the field of gerontology or geriatrics which leads to publication or practice change, as a part of the specialist training. Academic work can comprise up to 2 months of specialist training.

Medical education

Trainees will be expected to demonstrate that they are competent in teaching and training, and in providing effective feedback (see Generic CiP 6). Trainees in Geriatric Medicine will be expected to demonstrate competence in teaching or mentoring a wide variety of healthcare professionals who form part of the multi-disciplinary team. Trainees are encouraged to have completed an appropriate teaching skills course.

Leadership and management

Trainees will be expected to demonstrate competence in understanding of management and clinical governance structures (see Generic CiP 1). In addition, trainees in Geriatric Medicine will be expected to demonstrate competence in leadership and management specifically relating to older people (see Specialty CiP 7). Trainees are encouraged to have completed a Leadership and Management course.

Additional theme for service

Trainees must complete at least one additional theme for service as elective rotation. Additional 'themes for service' capabilities will be integrated into the final year of Geriatric Medicine training and should consist of 4-month whole time equivalent dedicated experience in the chosen fields.

Recommended training

Working in the manner of a consultant

At the completion of training programme doctors need to be able to function as independent consultant practitioners. It will be a marker of good practice for trainees to be given experience 'acting up' (with appropriate supervision) as a consultant in Geriatric Medicine.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities described in the syllabus through a variety of learning methods in a variety of settings. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. Training will require participation in specialty specific on call rotas

as well as involvement in the specialty specific medical take.

Work-based experiential learning

The majority of learning will be work-based experiential learning on an in-patient, day patient, out-patient, community and at home basis. Trainees can learn from practice (work-based training) on acute, rehabilitation and post-take ward rounds, multidisciplinary meetings, in out-patient clinics, day hospitals, care homes and patients' own homes. In all training environments, after initial induction, trainees will review patients under appropriate supervision. The degree of responsibility taken by the trainee will increase as competency increases. Trainees should see a range of new and follow-up patients and present their findings to their clinical supervisor. Learning is maximized by active participation and timely, constructive feedback.

Medical clinics including specialty clinics

- These may be held in a variety of settings including hospitals, ambulatory care facilities and the community.
- The educational objectives of attending clinics are:
    - To understand the management of chronic diseases
    - To be able to assess a patient in a defined timeframe
    - To interpret and act on the referral letter to clinic
    - To propose an investigation and management plan
    - To review and amend existing investigation plans
    - To write an acceptable letter back to the referrer
    - To communicate with the patient and, where necessary, relatives and other health care professionals.
- Trainees should see a range of new and follow-up patients and present their findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.
- The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be a minimum of two hours.
- Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

Specialty specific takes

Trainees will be involved in the acute selected take on a regular basis throughout the training programme. It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WBA such as mini-CEX or CBD).

- Teaching ward rounds (including post-take) should be led by a more senior doctor and include feedback on clinical and decision-making skills.

- As training progresses, trainees should be given opportunities to lead ward rounds under direct consultant supervision.

Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments

Trainees have supervised responsibility for the care of in-patients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to, and liaison with, clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

Every patient seen, on the ward, in the community or in out-patients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

Multi-disciplinary team meetings

Multi-disciplinary team meetings are a core component of many elements of the practice of Geriatric Medicine, including goal-setting meetings and discharge planning meetings, team educational and development meetings. Clinical problems are discussed with clinicians in other disciplines, including a wide variety of therapy and nursing disciplines. These provide excellent opportunities for observation of clinical reasoning, and developing skills in clinical leadership, facilitating discussion and conflict resolution. Trainees will learn about the knowledge and skills of each team member, and how to support team members in their own training and development.

Palliative and end of life care

Trainees should have significant experience of palliative care with the objective of:

- Enhancing skills in recognising the patient with limited reversibility of their medical condition and the dying patient.
- Enhancing ability to recognise the range of interventions that can be delivered in hospital and other settings (e.g. community, hospice or care home).
- Increasing confidence in managing physical symptoms in patients and psychosocial distress in patients and families.
- Increasing confidence in developing appropriate advance care plans, including DNA/CPR decisions.

Formal postgraduate education

It is suggested that trainees spend at least 4 hours a week on learning activities (including formal training courses). Trainees will use this time in a variety of ways depending upon their stage of

learning. There are many opportunities throughout the year for formal teaching in local postgraduate teaching sessions and at regional, national and international meetings.

Suggested activities include:

- Attendance at training programmes organised on an international or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.
- A programme of formal regular teaching sessions to cohorts of trainees (e.g. a weekly training hour for specialty trainees within a training site).
- Case presentations.
- Presentation of research, audit and quality improvement projects.
- Lectures and small group teaching.
- Grand Rounds.
- Critical appraisal and evidence-based medicine and journal clubs.
- Teaching of medical students.

Learning with peers

There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions.

Independent self-directed learning and professional development

Approximately 4 hours each week of the timetable should be allocated for non-clinical tasks, continuing professional development, research, quality improvement project and audit. Suggested activities include:

- Reading, including journals and web-based material.
- Maintenance of personal portfolio (self-assessment, reflective learning, personal development plan).
- Planning, data collection, analysis and presentation of audit and research work.
- Leading bedside teaching sessions.
- Preparation for teaching undergraduates, postgraduates and non-medical staff.

Formal study courses

Trainees are encouraged to attend national and international courses and conferences, using their study days mandated by Labor Union Agreement. Trainees may benefit from consolidating knowledge in core topic areas such as communication, continence, movement disorders, palliative medicine by attending a recognised course. Trainees are expected to attend some formal courses:

- ALS
- Quality improvement methodology

Academic training and Research

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. Time out of programme for research (OOPR) requires discussion between the trainee and the TPD that the proposed period and scope of study is sensible. All applications for out of programme research must be prospectively approved by the Icelandic Teaching Council in Geriatric Medicine.

Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the Teaching Council in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

5 Programme of Assessment

Purpose of assessment

The purpose of the programme of assessment is to:

- Assess trainees' actual performance in the workplace.
- Enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development.
- Drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience.
- Demonstrate trainees have acquired the GPCs and meet the requirements of GMP.
- Ensure that trainees possess the essential underlying knowledge required for their specialty.
- Provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme.
- Inform Teaching Council, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme.
- Identify trainees who should be advised to consider changes of career direction.

Programme of Assessment

Our programme of assessment refers to the integrated framework of assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose

of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the curriculum

A range of different types of assessment is used to generate the evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, can be linked to the relevant curricular learning outcomes.

The programme of assessment emphasises the importance and centrality of professional judgement by trainers in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees continually to gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all SLEs and WBPAs and should take place regularly throughout each year of the training programme. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace-based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment anchor statements

- ➢ Below expectations for this year of training; may not meet the requirements for critical progression point
- ➢ Meeting expectations for this year of training; expected to progress to next stage of training
- ➢ Above expectations for this year of training; expected to progress to next stage of training

The educational supervisor (ES) will review the evidence in the portfolio including workplace- based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in the ES report, with commentary.

For **generic CiPs**, the ES will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For **clinical and specialty CiPs**, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Level descriptors for clinical and specialty CiPs

Level	**Descriptor**
Level 1	**Entrusted to observe only** – no provision of clinical care
Level 2	**Entrusted to act with direct supervision:**
	The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3	**Entrusted to act with indirect supervision**: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4	**Entrusted to act unsupervised**

The Annual Review of Competency Progression (ARCP) will be informed by the ES report and the evidence presented in the portfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision

for each CiP. The ARCP panel, consisting of TPD in Geriatric Medicine, the Head of Geriatric department, the Head of teaching faculty in Geriatrics of the University of Iceland or their representatives, and an external reviewer which is usually TPD of other specialty will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

Critical progression points

There will be a key progression point on completion of specialty training. Trainees will be required to be entrusted at level 4 in all clinical and specialty CiPs in order to achieve an ARCP outcome 6 and be recommended for graduation from programme.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training

The outline grids below set out the expected level of supervision and entrustment for the IM clinical CiPs and the specialty CiPs and include the critical progression points across the whole training programme.

Table 1: Outline grid of levels expected for Internal Medicine clinical capabilities in practice (CiPs)

Level descriptors

Level 1: Entrusted to observe only – no clinical care; Level 2: Entrusted to act with direct supervision; Level 3: Entrusted to act with indirect supervision; Level 4: Entrusted to act unsupervised

IM Clinical CiP	Year 1	Year 2	CRITICAL PROGRESSION POINT
2. Managing the acute care of patients within a medical specialty service	4*	4*	
3. Providing continuity of care to medical inpatients	3	4	
5. Managing medical problems in patients in other specialties and special cases	3**	4**	
6. Managing an MDT including discharge planning	3	4	
7. Managing the deteriorating patient	4	4	
8. Managing end of life and applying palliative care skills	3	4	

Comments:
*- Required only once during two-year period: the year that the trainee rotates to Acute Geriatric Unit. Thereafter only confirmation is needed that the CiP is maintained.
**- Outcome 4 is required only once during two-year period: the year that the trainee rotates to Geriatric Consultation Service. Thereafter only confirmation is needed that the CiP is maintained.

Table 2: Minimum entrustment levels to be achieved by the end of each training year for Geriatric Medicine specialty (CiPs)

Level descriptors

Level 1: Entrusted to observe only – no clinical care; Level 2: Entrusted to act with direct supervision; Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

Geriatric Medicine Specialty CiP	Year 1	Year 2	CRITICAL PROGRESSION
1. Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient and community setting	4	4	
2. Managing complex common presentations in older people, including falls, delirium, dementia, movement disorders, incontinence, immobility and tissue viability in an in-patient and out-patient setting	3	4	
4. Managing and leading rehabilitation services for older people, including stroke	3	4	
5. Managing patients in outpatient setting and providing community liaison	3	4	
6. Managing liaison with other specialties, such as surgery, orthopaedics, critical care, oncology, cardiology, old age psychiatry	3**	4**	
7. Evaluating performance and developing and leading services with special reference to older people	3	4	
8. Specialty theme for service (ONE ONLY) a) Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatrics and bone health service b) Able to assess patients with urinary and faecal incontinence and is able to provide a continence service for a specific patient group in conjunction with specialist nursing, therapy and surgical colleagues c) Able to manage ill or disabled older people in a hospital at home, intermediate care and community setting and is able to provide a comprehensive community geriatric medicine service d) Able to manage patients with a wide range of movement disorders at any stage and is able to develop a specialist movement disorders service for older people e) Able to assess patients presenting acutely with stroke and TIA including suitability for cerebral reperfusion treatments and their subsequent ongoing medical management within an organised stroke service f) Other competences achieved during elective rotation (specify):	4***	4***	

Comments: **- Required only once during two-year period: the year that the trainee rotates to Geriatric Consultation Service. Thereafter only confirmation is needed that the CiP is maintained. ***- Required only once during two-year period: the year that the trainee have elective rotation. Thereafter only confirmation is needed that the CiP is maintained.			

Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid found in Appendix A.

Summative assessment

Examinations and certificates

- Advanced Life Support Certificate (ALS)

Workplace-based assessment (WPBA)

Formative assessment

Supervised Learning Events (SLEs)

- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)

WPBA

- Multi-Source Feedback (MSF)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below.

Assessment should be recorded in the trainee's portfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Case-based Discussion (CbD)

The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, and discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient clinic, rehabilitation or community setting.

mini-Clinical Evaluation Exercise (mini-CEX)

This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

Direct Observation of Procedural Skills (DOPS)

A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative).

Multi-source feedback (MSF)

This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors (at least 3 consultants), administrative staff, and other allied professionals. Trainees in Geriatric Medicine will be expected to include a range of people encompassing all the different professions the trainee works with. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the same quality improvement project by more than one assessor.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

Multiple Consultant Report (MCR)

The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisor's report (ESR)

The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR will include the ES's summative judgement of the trainee's performance and the entrustment decisions given for the learning outcomes (CiPs). The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors (MCRs) and formative assessments demonstrating progress over time.

Decisions on progress (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global

decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum.

The evidence to be reviewed by ARCP panels should be collected in the trainee's portfolio. ARCP panel will usually consist of TPD in Geriatric Medicine, the Chief of Geriatric department, the Head of teaching faculty in Geriatrics of the University of Iceland or their representatives, and an external reviewer which is usually TPD of other specialty.

As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal portfolio review either with their educational supervisor or arranged by TPD. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

There should be review of the trainee's progress to identify any outstanding targets that the trainee will need to complete to meet all the learning outcomes for completion training.
Poor performance should be managed in line with the Gold Guide.

Assessment blueprint

Appendix A contains a blueprint for documenting ARCP.

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning.

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training

Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.

Clinical supervisor

Consultants responsible for patients that a trainee looks after provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide an MCR for the trainee to inform the Educational Supervisor's report.

The educational and (if relevant) clinical supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors (as well as the trainee). These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Educational and clinical supervisors need to receive formal training by RCP or Office of Postgraduate Education of Landspítali. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

Trainees

Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competences without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate

supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the portfolio.

Induction Appraisal
The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the portfolio at this time, recording their commitment to the training process.

Mid-point Review
This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns, or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal
Trainees should review the PDP and curriculum progress with their clinical supervisor using evidence from the portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed. Supervisors should also identify areas where a trainee has performed above the level expected and highlight successes

7 Quality Management

The organisation of training programs is the responsibility of the TPD and Training Council at Landspitali:

- oversee recruitment and induction of trainees into the specialty
- allocate trainees into particular rotations appropriate to their training needs
- oversee the quality of training posts provided locally
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes

- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training.

Educational programmes to train educational supervisors and assessors in workplace-based assessment are delivered by the Office of Postgraduate Training.

Development, implementation, monitoring and review of the curriculum are the responsibility of the TPD and Training Council.

8 Intended use of curriculum by trainers and trainees

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an portfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences

Recording progress in the portfolio

The portfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainee's main responsibilities are to ensure the portfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use the portfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.
All appraisal meetings, personal development plans and workplace-based assessments (including results of MSF) should be recorded in the portfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the portfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other portfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice

- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

9 Equality and diversity

The Training Council in Geriatric Medicine believes that equality of opportunity is fundamental to the training programme. Compliance with anti-discriminatory practice will be assured through:

- Standardization of recruitment processes.
- Providing resources to trainees needing support.
- Ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature.

  Ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage the trainee All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.