SPECIALTY TRAINING CURRICULUM
FOR
GERIATRIC MEDICINE IN ICELAND

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Öldrunarlækningadeild Landspítala

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 sérfræðireglugerð 467/2015.

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, klíniska skráningu og faglega færni, verða í notkun. Matsblöðin eru lykilatriði í framþróun í sérnáminu.

Marklýsingin er unnin með hliðsjón af bresku markmiðslýsingunni, ” Specialty Training Curriculum for Geriatric Medicine Curriculum August 2010” og staðfærð með hliðsjón af íslenskum aðstæðum. Marklýsingin er á ensku því ekki er 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 markmiðslýsingarinnar var gerð af kennslustjórn í öldrunarlækningum. Mats- og hæfisnefnd um starfs- og sérfræðinámið, skv. reglugerð nr. 467/2015, hefur samþykkt marklýsinguna og þannig hefur hún öðlast opinbert leiðbeiningargildi. Hver og ein kennslustofnun og sérgrein á stofnun 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.

Abbreviations:

ES: Educational supervisor
JRCPTB: The Joint Royal Colleges of Physicians' Training Board
TPD: Training programme director
CMT: Core Medical Training
CGA: Comprehensive Geriatric Assessment
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
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 the frail older person and the promotion of better health in old age. This curriculum is designed to cover all the areas of specialist medical care that an older person will experience from care at home or in a care home; in the outpatient clinic or day hospital or day care; in the accident and emergency and medical assessment unit; in the acute ward and specialist areas of acute care such as orthogeriatric care; in the rehabilitation ward or intermediate care or in long term care. Trainees will be expected to have learnt to manage the whole range of medical conditions at a generalist level for adults of all ages.

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 Rationale

2.1 Purpose of the Curriculum

The primary purpose of this curriculum is to provide detailed guidance for trainers and trainees in obtaining the appropriate level of knowledge, clinical skills, and competence to be awarded a certificate of completion of training in geriatric medicine which is a prerequisite to a career as a consultant geriatrician working in hospital and/or community settings, and being capable of working independently and effectively. It also specifies how the acquisition of the necessary knowledge, skills and behaviors are to be verified by various assessment methods.

The competencies required will follow on from those required for General Practice and for Internal Medicine. Thus the curriculum describes and gives guidance on a programme that is supplementary to mandatory prior completed training in either of these two specialties, as a subspecialty of internal medicine or added specialty to general practice (viðbótarsérnám, skv. reglugerð nr. 467/2015).
Patient-centered approaches, patient safety and team-work are of central importance. Training is structured to promote interest in order to facilitate learning. Trainees and trainers are required to have full knowledge of the curriculum.

2.2 Development

This curriculum was developed by the Planning Committee for Geriatric Medicine at Landspitali. The Specialty Training Curriculum for Geriatric Medicine Curriculum 2010 from the UK, as well as curricula from various countries, was reviewed and taken into consideration.

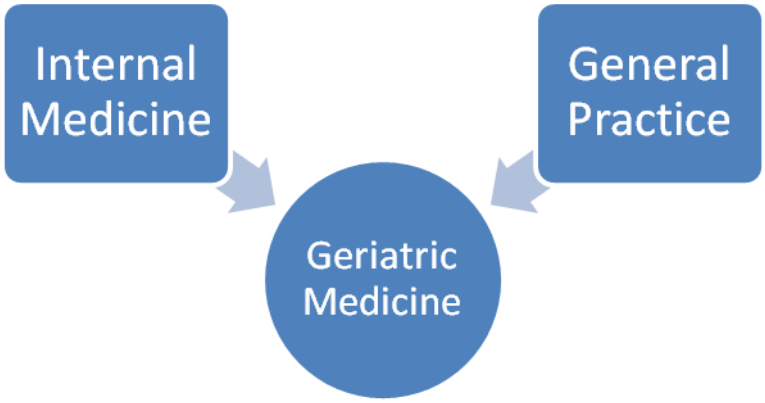
The content of the curriculum was discussed with trainees, the Icelandic Society for General medicine (Lyflæknafélag Íslands) and specialists in geriatric medicine through the Icelandic Geriatric Medicine Society (Félag íslenskra öldrunarlækna) as well as the Icelandic Society of Family Practitioners (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. The programme can be completed in Iceland in the approved teaching facilities (Landspitali University Hospital (LSH), Reykjavik and SAK, Akureyri).

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

2.3 Training Pathway and Entry Requirements

Specialty training in Geriatric Medicine consists of core and higher specialty training. Core training provides physicians with: the ability to investigate, treat and diagnose patients with acute and chronic medical symptoms; and with high quality review skills for managing inpatients and outpatients. Higher specialty training then builds on these core skills to develop the specific competencies required to practice independently as a consultant. In Iceland this can be acquired through two pathways, from Internal Medicine or from General Practice. To be able to enter specialty training in geriatric medicine the trainee has to have finished either the internal medicine or general practice training programmes and obtained specialist recognition in either of those specialties.

Fig 1: Training Pathway



There are common competencies that should be acquired by all physicians during their training period, starting at undergraduate level and developed through the postgraduate training. These include skills in communication, medical examination and history-taking skills. These are identified for Core Medical Training CMT and then developed further in the geriatric specialty training. This part of the curriculum supports a spiral nature of learning that underpins a trainee's continual development. It recognizes that for many of the competences outlined there is a maturation process whereby practitioners become more adept and skilled as their career and experience progresses. It is intended that doctors should recognize that the acquisition of basic competences is often followed by an increasing sophistication and complexity of that competence throughout their career. This is reflected by increasing expertise in their chosen career pathway.

The trainee will be expected to demonstrate a commitment to Geriatric Medicine training.

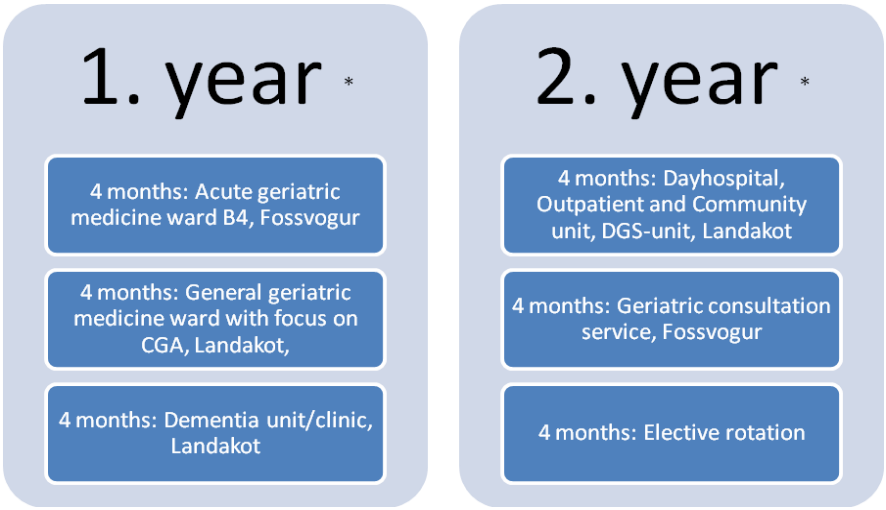
The curriculum will be achieved by completing the necessary specialty posts and evaluation processes within the training programme.

2.4 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 general practice 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, this requirement is fulfilled.

The supplementary specialty training (ísl. viðbótarsérnám) for General Practice specialists or subspecialty training for Internal Medicine specialists in geriatric medicine is organized as a two year programme.

Fig 2. Example of a plan for each year.



The training is in the first year is 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 Day hospital, outpatient and community unit, Landspitali-Landakot. There will be 4 months on a geriatric consultation service for Landspitali in Fossvogur and Hringbraut. Finally, there will be a 4 month elective rotation chosen by the trainee within the Department of Geriatrics at Landspitali or another service with high relevance to geriatrics, for example long term care facility.

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.

2.5 Less Than Full Time Training (LTFT)

Trainees who are unable to work full-time are entitled to opt for less than full-time training according to directive 467/2015 paragraph 9.

- LTFT shall meet the same requirements as full-time training, from which it will differ only in the length of time it takes to complete the training.
- The training program director and Program Training council for Geriatric Medicine shall ensure that the competencies achieved and the quality of part-time training is not less

than those of full-time trainees and meets the same internationally agreed standards as required by directive 467/2015.

Sick and Maternity/Paternity leave

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.

3 Content of Learning

This section lists the primary learning objectives, core knowledge areas, skills, attitudes and behaviors to be attained throughout training in Geriatric Medicine.

3.1 Principal Learning Objectives

The principle learning objectives represent a summary of what the trainee should be able to achieve at completion of specialty training. Each objective requires specific knowledge and skills. Assessment will be based on the demonstration that a trainee has achieved competence in these objectives.

The following are the **principal** learning objectives which will provide the trainee with the expertise to practice as a specialist in Geriatric Medicine:

1. Perform a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient or community setting, including day hospitals

2. Diagnose and manage acute illness in old age in an in-patient setting, out-patient setting and community setting where appropriate

3. Diagnose and manage those with chronic disease and disability in an in-patient, out-patient, day hospital and community setting

4. Provide rehabilitation with the multidisciplinary team to an older patient in an in-patient, out-patient, day hospital and community setting

5. Plan the transfer of care of frail older patients from hospital

6. Assess a patient's suitability for and provide appropriate care to those in long term care or community care

7. Be able to apply the knowledge and skills of a competent geriatrician in an intermediate care and/or community setting

8. Assess and manage older patients presenting with the common geriatric problems (syndromes) in an in- or out-patient setting (or where appropriate, in a community setting):

a. Falls with or without fracture
b. Delirium
c. Incontinence
d. Poor mobility
e. Sarcopenia and Frailty

9. To demonstrate competence in the following Special Topic areas:

a. Palliative care
b. Orthogeriatrics
c. Old Age Psychiatry
d. Specialist Stroke care
e. Geriatric pharmacology

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

Expertise in some areas will develop throughout training, while others may require specific full time or part time rotations to achieve the appropriate level of knowledge and skills.
At the completion of training by a process of consolidation through the years of the training programme acquiring a variety of experience, the trainee should have acquired the following knowledge, skills and attitudes to function as a consultant geriatrician:

1. The ability to establish a diagnostic formulation for older patients presenting with specific and non-specific clinical features by appropriate use of history, clinical examination and investigation.

2. The knowledge, skills, and experience to develop management plans for each patient, such as education of the patient and his/her carer, including treatment, rehabilitation, health promotion, disease prevention, and longer term management.

3. The appropriate attitudes and communication skills to effectively manage patients and their relatives/carers, and working colleagues of all relevant disciplines.

4. To work effectively within a multidisciplinary team to promote the optimal recovery of patients and plan the safe transfer of care between all relevant settings.

3.2 Core Knowledge Objectives

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

3.2.1 Basic Science and Biology of Ageing

Trainees should be able to explain:

- The process of normal ageing in humans
- The effect of ageing on the different organ systems and homeostasis
- The effect of ageing on functional ability
- Demographic trends in the Icelandic society
- The basic elements of the psychology of ageing
- Changes in pharmacokinetics and pharmacodynamics in older people
- Ageism and strategies to counteract this

3.2.2 Comprehensive Geriatric Assessment (CGA)

Trainees should be able to describe and perform a comprehensive geriatric assessment (CGA) in an in- or out-patient setting (or where appropriate, in a community setting). They should understand the principles and importance of CGA in older people. Trainees will at completion of training be able to work in an interdisciplinary team while performing a CGA.

3.2.3 Common Geriatric Problems (Syndromes)

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

- Falls and syncope assessment - including fractures and osteoporosis
- Immobility - including locomotor disorders and Parkinson’s disease

- Incontinence - urinary and fecal
- Delirium and dementia

or where presentation may be more specific:

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

3.2.4 Presentations of Other Illnesses in Older Persons

Older people can present with a wide array of symptoms. Trainees should be able to identify and define the causes, pathophysiology, clinical features, laboratory and imaging findings, treatments, prognosis and preventative measures for common problems and presentations in old age. The trainees should be aware of the difference in presentation in old age vs. with younger people.

3.2.5 Drug Therapy

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

- Gastrointestinal: ulcer healing drugs and laxatives
- Cardiovascular: inotropes, diuretics, anti-arrhythmics, anti-hypertensive's, drugs for heart failure and angina, antiplatelet agents, lipid lowering agents, anticoagulants
- Respiratory: bronchodilators
- CNS: hypnotics and anxiolytics, antipsychotics, antidepressants, analgesics, antiepileptics, drugs for Parkinson's disease, drugs for dementia
- Infections: antibiotics
- Endocrine: insulin and oral hypoglycemics, drugs for thyroid disease, steroids, drugs for osteoporosis
- Urinary Tract: drugs for incontinence
- Nutrition: vitamins and mineral supplements
- Vaccines

3.2.6 Rehabilitation in Older Persons

Trainees should be able to explain the:

- Principles of rehabilitation in older people and importance of comprehensive geriatric assessment (CGA)
- Different measures (assessment scales) used to assess functional status and outcome of rehabilitation and their limitations: to include objective evaluation of Activities of Daily

Living ability and level of activity limitation and participation restriction, cognitive status, and mood

- Requirements, roles and expertise of the different members of a multidisciplinary team
- Knowledge of the range of interventions such as physical treatments, aids, appliances and adaptations, and a knowledge of specialist rehabilitation services available
- Specific requirements of stroke and orthopedic rehabilitation
- An appreciation of the medical and social models of management of functional limitation due to ageing and disease
- Knowledge of the method of prevention and management of complications of acute illness such as pressure sores, venous thromboembolism, contractures and aspiration pneumonia

3.2.7 Planning Transfers of Care and Ongoing Care Outside Hospital

Trainees should be able to explain the:

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

3.2.8 Ethical and Legal Issues

Trainees should be able to explain:

- Relevant medico-legal issues such as
    - Assessment of competence
    - Appointment of Power of Attorney
    - Guardianship
    - Advance Decisions
    - The current legal framework for management of adults with mental incapacity
    - Relevant Icelandic statutes and directives within the legal framework..

- Relevant ethical issues such as
    - Decisions regarding life-prolonging treatments
    - Resuscitation following cardio-respiratory arrest
    - Consent procedures

- Palliative, end-of life/terminal care treatment

3.2.9 Management

Trainees should be able to explain the:

- Structure of the Health Care System in Iceland, its financing and organization as relates to older individuals
- The framework and dynamics of inter-agency and partnership between different systems
- Clinical governance and its relevance in geriatric medicine
- Principles of the appraisal process
- Administrative duties relevant to a consultant geriatrician; including the workings of committees, service development and relevant employee law
- Methods of dealing with complaints

3.2.10 Health Promotion

Trainees should be able to explain the:

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

3.3 Syllabus

During the training period the trainee will be expected to acquire the knowledge various subjects. This can be done by reading one or more comprehensive textbook(s) in geriatric medicine, taking online or life courses, searching for evidence-based information and/or attending international conferences or courses.

3.3.1 Common Competencies

The principles of history taking, clinical examination and therapeutics and prescribing are competencies with which the trainee should be well acquainted from Foundation training (starfsnám/kandídatsár) and previous specialty training in internal medicine or general practice. It is vital that these competencies are practiced to a high level by all specialty trainees in their specialty training career.

This part of the generic competencies relate to direct clinical practice; the importance of patient needs at the centre of care and of promotion of patient safety, team working, and high

quality infection control. Furthermore, the prevalence of long term conditions in patient presentation to general internal medicine means that specific competencies have been defined that are mandated in the management of this group of patients.

1. Decision Making and Clinical Reasoning
To progressively develop the ability to formulate a diagnostic and therapeutic plan for a patient according to the clinical information available **To progressively develop the ability to prioritize the diagnostic and therapeutic plan** **To be able to communicate the diagnostic and therapeutic plan appropriately** **All this should especially be considerate for the frail elderly**
2. Prioritization of Patient Safety in Clinical Practice
To understand that patient safety depends on the organization of care and health care staff working well together in a variety of different teams **To never compromise patient safety** **To understand the risks of treatments and to discuss these honestly and openly with patients so that patients are able to make decisions about risks** **To ensure that all staff are aware of risks and work together to minimize risk**
3. Relationships with Patients and Communication within a Consultation
To communicate effectively and sensitively with patients, relatives and staff **To be able to hold a effective meeting with the family** **To be able to recognize and accept the responsibilities and role of the doctor in relation to other healthcare professionals.** **Communicate succinctly and effectively with other professionals as appropriate**
Issues of communication both with patients and carers and within the healthcare team are often causes of complaint and inadequate communication can lead to poorer standards of patient care. Specific issues are highlighted within this section to promote better communication generally and within certain situations
4. Breaking Bad News
To recognize the fundamental importance of breaking bad news. To develop strategies for skilled delivery of bad news according to the needs of individual patients and their relatives /carers
Work based assessments Education Courses Part Reflection in log-book
5. Complaints and Medical Error
To know how to respond appropriately to complaints and medical errors
6. Health Promotion and Public Health

To progressively develop the ability to work with individuals and communities to reduce levels of ill health, remove inequalities in healthcare provision and improve the general health of a community
7. Principles of Medical Ethics and Confidentiality
To know, understand and apply appropriately the principles, guidance and laws regarding medical ethics and confidentiality **To ensure that research is undertaken using relevant ethical guidelines**
The legal and ethical framework associated with healthcare must be a vital part of the practitioner's competencies if safe practice is to be sustained. Within this the ethical aspects of research must be considered. The competencies associated with these areas of practice are defined in the following section.
8. Valid Consent
To obtain valid consent from the patient
9. Legal Framework for Practice
To understand the legal framework within which healthcare is provided in Iceland in order to ensure that personal clinical practice is always provided in line with this legal framework
10. Evidence and Guidelines
To progressively develop the ability to make the optimal use of current best evidence in making decisions about the care of patients **To progressively develop the ability to construct evidence based guidelines in relation to medical practice**
It is the responsibility of each practitioner to ensure that they are aware of relevant developments in clinical care and also ensure that their practice conforms to the highest standards of practice that may be possible. An awareness of the evidence base behind current practice and a need to audit one's own practice is vital for the physician training in general internal medicine.
11. Audit
To progressively develop the ability to perform an audit of clinical practice and to apply the findings appropriately
12. Management and Healthcare Structure
To understand the structure of the healthcare in Iceland and the management of local healthcare systems in order to be able to participate fully in managing healthcare provision
Working within the health service there is a need to understand and work within the organizational structures that are set. A significant knowledge of leadership principles and practiceis an important part of this competence.

Core Curriculum Grids for the Specialty of Geriatric Medicine
13. Comprehensive Geriatric Assessment
To be able to perform a comprehensive geriatric assessment (CGA)
To be able to perform a CGA in a variety of situation and use the appropriate tools and methods for each setting Take part and lead MDT meetings in a variety of settings Discussing and deciding on the outcome of CGA Plan further evaluation and follow up
14. Diagnosis and Management of Acute Illness
To be able to diagnose and manage acute illness in older patients in a variety of settings, both in hospital and community **Especially for the frail elderly patients**
Work based assessments Education Courses Part Reflection in log-book Participation in audit and research
15. Diagnosis and Management of Chronic Disease and Disability
To be able to diagnose and manage chronic disease and disability in older patients in both hospital and community settings **To understand the process in which health beliefs, socio-economic circumstances and culture impact on health, and vice-versa** **To understand that as doctors we have the opportunity and ability to address inequalities in healthcare**
Work based assessments Education Courses Part Reflection in log-book Participation in audit and research
16. Multidisciplinary Team Working
Take part and lead rehabilitation MDT meetings in a variety of settings
The individual practitioner has to have appropriate attitudes and behaviors that help deal with complex situations and to work effectively providing leadership and working as part of the healthcare team
17. Rehabilitation
To have the knowledge and skills to provide rehabilitation to an older patient in an in-patient, outpatient and community based setting including day hospital and when to refer for further specialist advice
Take part and lead rehabilitation MDT meetings in a variety of settings e.g. stroke,

orthogeriatric and general rehabilitation Assess patients for rehabilitation in medical, orthopedic and surgical wards
18. Planning Transfers of Care, Including Discharge
To have the knowledge and skills to plan the successful transfer of care or discharge of frail older patients
Take part and lead MDT discharge planning meetings Attend case conferences for complex discharges Follow discharge planning nurses in their function in discharge planning Needs to understand and be able to assess patients for Færni- og heilsumat (FHM)
19. Delirium
To be able to recognize, diagnose and manage a state of delirium presenting both acutely or sub-acutely in patients in hospital, in the community and in other settings
Work based assessments Education Courses Part Reflection in log-book Participation in audit and research
20. Dementia
To be able to assess and manage patients who present with dementia and also to assess and manage patients with dementia who present with other illnesses in acute and intermediate care **To be able to assess and manage patients who present acutely with cognitive impairment** **To be able to assess and manage patients who present non-acutely with cognitive impairment** **To be able to assess and manage patients who present with cognitive impairment incidental to other co-morbidities** **To be able to assess and manage patients who present with pre-existing intellectual disability presenting with cognitive decline**
Work based assessments Education Courses Part Reflection in log-book Participation in audit and research
21. Continence
To have the knowledge and skills required to assess and manage urinary and fecal incontinence across health care settings **To know how and when to refer for further specialist advice**
Work based assessments Education Courses

Part Reflection in log-book Participation in audit and research
22. Falls
To know how to assess and manage older patients presenting with falls (with or without fracture) in an in- or out-patient setting
Involvement with management of patients admitted with falls in emergency admission wards, general medical wards, rehabilitation wards and day hospitals Attendance at specialist clinics – Falls, Syncope, Tilt, Osteoporosis Discussions with multidisciplinary team members eg. physiotherapists, occupational therapists, nurses, social workers Work based assessments Education Courses Part Reflection in log-book Participation in audit and research
23. Poor Mobility
To know how to assess the cause of immobility and declining mobility and aid its management
Supervised in-patient and out-patient assessments of immobility e.g. geriatric clinics, specialized Attendance at specialist clinics (e.g. Parkinson's disease clinic), supervised by consultant or nurse specialist Work based assessments Education Courses Part Reflection in log-book Participation in audit and research
24. 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
Knowledge of basic systematic assessments of nutritional intake consulting with nutrisians Work based assessments Education Courses
25. Tissue Viability
To know how to assess, diagnose and monitor common types of leg and pressure ulceration, surgical and other wounds in older patients. Also how to prevent this from happening.
Work based assessments

Education Courses Part Reflection in log-book
26. Movement Disorders
To be able to competently manage patients with movement disorders (MDs) of any stage including knowing when to ask for help
Work based assessments Education Courses Part Reflection in log-book
27. Community Practice Including Continuing, Respite and Intermediate Care
To have the knowledge and skills required to deliver care to older people within intermediate care and community settings, working with multidisciplinary teams, primary care and local authority colleagues **To be able to confidently diagnose and manage ill or disabled older people in intermediate care or community settings for those with a special responsibility for this type of care**
Attachment to Intermediate Care and Community Schemes Visits to Care Homes and Continuing Care Hospitals Visits to Community Services Visit to daycare centers Attendance at a Continuing Care Assessment Panel Sessional or full-time attachment with intermediate care services at home or in institutional settings at nursing levels Attachment a consultant geriatrician with a special responsibility for community and/or intermediate care Attachment to a public health service or commissioners organizing and funding care for older people including that in community settings
28. Orthogeriatrics
To know how to assess acutely ill orthopedic patients and how to manage these patients including rehabilitation
Work in orthopedic or geriatric wards with hip fracture patients Work in orthogeriatric rehabilitation facilities. Attend osteoporosis clinics and falls clinics Educational courses Reflection in log-book
29. 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 **To be able to assess and manage patients who present acutely with cognitive**

impairment
Assess new and follow-up patients and discuss with educational supervisor Work based assessments Education Courses Reflection in log-book
30. Palliative and End of Life 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
Assess new and follow-up patients and discuss with educational supervisor Acquire knowledge of a variety of settings e.g. hospice, specialist palliative care unit, day hospice, general hospital, outpatients A weeks(or more) visit at specialist palliative care unit attending MDT meetings or Small group sessions with other trainees (Geriatrics and/or Palliative Care) Education Courses –Palliative Care, Communication Reflection in log-book Participation in audit and research
31. Perioperative Medicine for Older People
To know how to risk assess, optimize and manage the older elective and emergency surgical patient throughout the surgical pathway
Attend clinics where comprehensive geriatric assessment methodology is used to improve outcomes Participate in routine pre-assessment and high risk pre-assessment of older surgical patients Liaison work on surgical wards
32. Stroke Care
To be able contribute to a comprehensive service for patients with acute stroke and chronic stroke-related disability in hospital and the community
Working with a multidisciplinary team in a stroke rehabilitation ward with exposure t nursing and Allied Health Profession services including physiotherapy, occupational t dietetics, speech and language and social work services Work based assessments Education Courses Reflection in log-book
33. Falls and Syncope
To provide the trainee with advanced knowledge and skills to assess and manage older patients presenting with falls (with or without injury) or syncope in any healthcare

setting
Knowledge of multidisciplinary falls prevention programs Experience of performing tilt testing and carotid sinus massage Keeping up to date with guidelines such as NICE, British Geriatrics Society/American Geriatrics Society Attending national/international conferences or training courses on falls/syncope Work based assessments Education Courses Reflection in log-book
34. Orthogeriatrics and Bone Health
To have advanced knowledge and skills in order to assess and manage older patients presenting with fracture, particularly hip fracture, from presentation to discharge **To have advanced knowledge and skills to assess and manage fracture risk**
Experience of working in a variety of orthopedic and or geriatric settings including preoperative assessment and management, acute postoperative care, post-surgical rehabilitation and discharge planning. Keeping up to date with evidence base for interventions and national/international guidelines. Attending national / international conferences or study courses on post-hip fracture care, osteoporosis and metabolic bone diseases and falls. Work based assessments Education Courses Reflection in log-book
35. Continence
To have the knowledge and skills required to assess patients with urinary and fecal incontinence **To have the knowledge, skills and behaviors required to develop a continence service for a specific patient group, in conjunction with specialist nursing, therapy and surgical colleagues**
Knowledge of urinary incontinence workup and care Knowledge of fecal incontinence workup and care Knowledge of assisting devices, clothing, toilet adaptations and bathing aids Work based assessments Education Courses Reflection in log-book
36. Geriatric pharmacotherapy

To be able to confidently review and give consultation on pharmacological treatment of older people
Knowledge of Physiological changes of aging affecting pharmacodynamics and pharmacokinetics Knowledge of ways to systematically review polypharmacy and detecting Potentially Inappropriate Prescriptions (PIMs) Knowledge of clinical tools and criteria to assist in such review (i.e. STOPP/START, BEER´s, FORTA) Being able to effectively reduce inappropriate polypharmacy with emphasis on goals of care in a broad sense, with emphasis on situations like severe functional impairment, advance directives, end stage cognitive impairment and nearing end of life.

4 Learning and Teaching

4.1 The Training Programme

The organization and delivery of postgraduate training is the statutory responsibility of the Chief Medical Officer at LSH as laid out in the Reference Guide for Medical Training in Iceland.

The sequence of training should ensure appropriate progression in experience and responsibility. The training is to be provided to ensure that, during the programme, the entire curriculum is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. Ideally, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest.

Objectives by Year of Training

Trainees should achieve specific objectives each year relevant to the type of training programme being undertaken. Progress will be ascertained each year. See fig 2 for an example on how the plan will be. 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.

Progression through the programme will be determined by using the decision aid (see section 5.5 ARCP Decision Aid Iceland). The final award of a certificate in Geriatric Medicine will be dependent on achieving competencies as evidenced by successful completion as evidenced by the type and number of assessments set out in the curriculum.

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

4.2 Teaching and Learning Methods

The majority of learning is from clinical practice with opportunities created by trainees, program director and the Training program Council for Geriatric Medicine for training in the main places of work but also practice outside the principal place of work. There will be learning with peers both in everyday practice and as part of formal teaching. Teaching will be from clinical supervisors during clinical attachments, from peers in the same specialty and other specialties and as formal teaching in lectures and small groups.
Learning will also take place by undertaking audit, research, teaching, presenting and writing and observing management and taking part in clinical governance activities e.g. risk management, handling complaints, writing guidelines and pathways. In particular all trainees should take part in clinical audit or a quality improvement project and will need to complete a full cycle for at least one topic.
Most competencies will be acquired over a sustained period of experience.
Trainees will rotate to different work stations, as explained before.

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

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

Work-based Experiential Learning
The majority of learning will be work-based experiential on an inpatient, day patient, outpatient and at home basis. Trainees will learn from practice (work-based training) on acute, rehabilitation and post-take ward rounds, multidisciplinary meetings, in outpatients, day hospitals, care homes and patients' own homes. Where appropriate they will take day-to-day responsibility for patients completing appropriate medical notes. In these settings they will undertake activities both independently and directly supervised and observed by senior staff; trainees will have opportunities for concentrated practice in skills and practical procedures during their hospital placements; they will learn from peers and be supervised when not yet fully competent in skills by senior staff. This will be regularly backed up by feedback from senior staff including consultants and monitored by clinical, educational and research supervisors. Experience will be graded to the level of training and proportionate to the level of expertise. Supervision will always be given where the trainee has not yet acquired a sufficient level of competence. See chapters 5 and 6 about assessment and supervision.

Learning with Peers

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

Formal Learning

Approximately 4 hours per week of education in a lecture or seminar setting will be delivered for all. A minimum of 4 hours each week of the timetable and preferably 6-8 hours will be allocated for continuing professional development, research, quality improvement project and audit. Activities could include case presentations, grand rounds, journal clubs, presentation of audit, quality improvement project and research, lectures and small group teaching.
It is expected that trainees will attend national meetings such as the yearly Icelandic Medical Associations Conference.
The trainee will also attend important international conferences as selected by the Training Program Council in Geriatric Medicine one week per training year.

Personal Self-Directed Study

Personal study (self-directed learning) including the reading of relevant professional journals and textbooks and use of CDs, DVDs, searching the worldwide web is also important.
Trainees are expected to complete evidence of reflective practice through case reports and other experiences in their logbook, see next paragraph. Other self-directed work will be planning, data collection, analysis and presentation of audit and research work such that the training record will contain evidence of academic pursuits.
Trainees will take part in and lead bedside teaching and will teach undergraduates, postgraduates and non-medical staff in small groups and formal lectures making personal presentations using a variety of audiovisual methods. They will be expected to present at journal clubs, and make case presentations at grand rounds or similar settings. They will be expected to undertake personal audit and make presentations of their findings at clinical meetings.

Logbook

Each trainee must keep an authorized logbook that meets the standards of the EUMS logbook for documentation of professional experience. It will contain report from the trainer giving an account of the trainee´s active participation in the work of the unit, his/her publications, scientific and research works, including quality improvement project. The trainee will have to demonstrate that he/she has managed a wide range of cases. Logbook entries will be monitored by regular inspection and signed off by the educational supervisor; assessment forms for each training period completed and signed by trainers for that period should also be included.
Moreover, the trainee will be encouraged to keep a Training Portfolio, which should include an up-to date curriculum vitae (EUROPASS style) incorporating:

- Details of previous training posts, dates, duration and trainers
- Details of examinations passed
- List of publications with copies
- List of research presentation at local, national and international meetings
- List of courses attended

4.3 Quality improvement project and audit

A quality improvement project or an audit is mandatory during the training period so that the trainee will be competent in basic quality improvement work.

4.4 Research

Trainees, who wish to acquire research competencies, in addition to those specified in their specialty curriculum, may undertake a research project as an ideal way of obtaining those competencies. For those in specialty training, one option to be considered is that of taking time out of program to complete a specified project or research degree.

5 Assessments

5.1 The Assessment System

The purpose of the assessment system is to:

- enhance learning by providing formative assessment
- enabling trainees to receive immediate feedback
- measure 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
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme
- assess trainees' actual performance in the workplace
- ensure that trainees possess the essential underlying knowledge required for their specialty
- inform the Annual Review of Competence Progression (ARCP)
- 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.

The integrated assessment system comprises workplace-based assessments and knowledge – base assessments. Individual assessment methods are described in more detail below. Workplace-based assessments will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide trainees with formative feedback. They are not individually summative but overall outcomes from a number of such assessments provide evidence for summative decision making. 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.
The assessments recommended have been chosen because of the wide experience of use of these methods, their relevance to the nature of the clinical work involved in the specialty and the relevant generic competencies that need to be acquired.

5.2 Assessment Methods

The following assessment methods are used in the integrated assessment system:

Workplace-based Assessments (WPBAs)

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

These methods are described briefly below. More information about these methods including guidance for trainees and assessors is available on the JRCPTB website www.jrcptb.org.uk. Workplace-based assessments should be recorded in the trainee's log-book. The workplace-based assessment methods include feedback opportunities as an integral part of the assessment process; this is explained in the guidance notes provided for the techniques.

Multisource 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 objective 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, administration staff, and other allied professionals. The trainee will not see the individual responses by raters, feedback is given to the trainee by the Educational Supervisor.

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.

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 include discussion about 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 department.

Audit Assessment (AA)
The Audit Assessment Tool is designed to assess a trainee´s competence in completing an audit. The Audit Assessment can be based on review of audit documentation OR on a presentation of the audit at a meeting. If possible the trainee should be assessed on the same audit by more than one assessor.

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 Teaching Observation form is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation can be based on any instance of formalized teaching by the trainee who has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).
There will be immediate feedback by the assessors to the trainees at the time of the above assessments. This will relate to the specific knowledge, skills and behaviors tested by the assessment. General progress judged by the summation of all the assessments will be given back to the trainee at regular reviews with their educational supervisor and through the supervisors

report and other assessments following the ARCP in training organized by the programme director.

Other Evidence

Supervisors' Reports

Some aspects of behavior and attitudes can only be assessed by supervisors who repeatedly observe the trainee in their clinical practice and are not amenable to a workplace-based assessment or a knowledge based assessment. These reports though not one of the formal assessments listed in our grids provide a summation of the experience of the educational supervisor of the work of the trainee taking into account all the evidence from work-place based and other formal assessments. These reports are acquired annually as part of the ARCP process (see below) the information being used alongside the Logbook to evaluate trainee progress.

5.3 Decisions on Progress (ARCP)

The Annual Review of Competence Progression (ARCP) is the formal method by which a trainee's progression through her/his training programme is monitored and recorded. ARCP is not an assessment – it is the review of evidence of training and assessment. The ARCP process is described in the Reference Guide for Medical Training in Iceland. The evidence to be reviewed by ARCP panels should be collected in the trainee's log-book.

The Geriatric Medicine ARCP Decision Aid for Iceland is in attachment.

5.4 Complaints and Appeals

Appeals against decisions concerning in-year assessments will be handled as laid out in the Reference Guide for Medical Training in Iceland.

All WPBA method outcomes must be used to provide feedback to the trainee on the effectiveness of the education and training where consent from all interested parties has been given. If a trainee has a complaint about the outcome from a specific assessment this is their first opportunity to raise it.

6 Supervision and Feedback

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

Trainees will be supervised throughout their training by appropriately trained clinical and Educational Supervisors. Educational and Clinical Supervisors must meet their specified trainee formally at the beginning, mid-point and end of each placement and in addition provide informal feedback on trainee's performance during each placement. At the initial meeting a learning agreement should be signed by supervisor and trainee to indicate what training and supervision will be provided and what training or experience the trainee will be expected to achieve.
It is extremely important that trainees' progress is mapped against the curriculum to ensure that trainees' experience and training reflect curriculum content and objectives. It is the responsibility of educational and clinical supervisors in conjunction with the trainee to ensure that training is structured in such a way that these curriculum objectives are met.
At or soon after appointment the trainee should be assigned an appropriately qualified Educational Supervisor. Ideally the Educational Supervisor (ES) should be the first consultant the trainee works for or alternatively another consultant from within that department. The trainee and Educational Supervisor must be informed of this arrangement ideally in writing (either by letter or email) and both parties must be clear of their roles and responsibilities and also those of trainee clinical supervisors (CS) and methods of communication between ESs, CSs and trainee.

6.1 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 personally discuss all cases if required. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.
The role of the educational supervisor and the responsibilities of the trainee to ensure successful achievement of the curriculum are described below.

Educational Supervision

Trainees must have a designated educational supervisor during all of their training programme. The educational supervisor need not be the consultant trainer with whom the trainee works directly.

The educational supervisor is responsible for the implementation and coordination of a structured training programme agreed with the other geriatricians and the programme director.

The educational supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The educational supervisor should be part of the clinical specialty team. Thus if the clinical directorate (clinical director) have any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the educational supervisor.

Requirements to be an Educational Supervisor

All educational supervisors must satisfy the following minimum standards and requirements to undertake this role:

- Educational Supervisors will normally have completed specialist training in Geriatric Medicine.
- Educational supervisors must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and time to supervise trainees.

Trainees in Difficulty

The educational supervisor and programme director are responsible for identifying trainees in difficulty either through of lack of progress in training or because of personal issues such as illness, emotional strain etc. The programme director is responsible for establishing a system whereby each trainee's progress is monitored regularly and satisfactorily and that trainees know who to contact should they experience difficulty. The programme director will use the expertise within the hospital for managing these trainees and ensuring they have appropriate support.

Trainee's Responsibilities

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

The responsibilities of the trainee include:

- Awareness of the requirements for training as detailed in this curriculum and use of learning opportunities available within and outside their particular training rotation.
- Awareness of who their educational supervisor for their training and their role as outlined above. Making arrangements to meet with their educational supervisor regularly and at least 3 monthly for appraisal and assessment and to complete an educational/learning plan.
- Attend hospital and unit induction programmes as arranged
- To maintain an up-to-date training record including a portfolio or reflective case reports and programmes of national meetings attended, details of teaching, audit and research presentations, copies of abstracts and articles or details of book chapters they have written or contributed to, supervision reports and other certificates or documentation pertaining to their training. The trainee should provide all the necessary documentation for their annual ARCP which they may need to attend.
- To take advantage of the opportunities available to them in order to enhance their training.
- To attend local training meetings, and at least one national or international geriatrics meeting each year.
- To join the Icelandic Geriatrics Society.
- To know whom to contact if problems arise: typically their educational supervisor followed by their programme director or other mentor as arranged by the hospital.

Supervision and Practice and Safety of Patient and Doctor

Patient safety is of paramount importance and it is essential to ensure that a trainee does not undertake duties which are inappropriate to their degree of expertise and competence or without the relevant degree of supervision from a more senior clinician.

- Trainees must make the needs of patients their primary concern
- Trainees must be appropriately supervised according to their experience and competence
- Those supervising the clinical care provided by trainees must be:
    - clearly identified
    - competent to do so
    - accessible and approachable by day and by night: with time for these responsibilities identified in their job plan
- Trainees must be expected to obtain consent only for procedures which they are competent to perform

- Shift and on-call patterns must be designed to minimize the effects of sleep deprivation
- Trainees must have well-organized handover arrangements which ensure continuity of patient care between shifts.

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

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.

6.2 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during the 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 trainee's Portfolio.

Induction Appraisal
The trainee and educational supervisor should have an appraisal meeting at the beginning of each training year to review the trainee's progress to date, agree learning objectives for the year ahead and identify the learning opportunities presented by their next year's placement(s). 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 mandatory, 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 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 both their educational and clinical supervisors (if the same individuals are not undertaking these roles) 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.

7 Equality and Diversity

All training posts are fully compatible with Icelandic and European employment laws. Data on Equality and diversity is available specifically for Landspítali at: Mannauðsstefna Landspítala. Icelandic laws include: Lög um Mannréttindasáttmála Evrópu 62/1994, Lög um jafna stöðu og jafnan rétt kvenna og karla 10/2008, Lög um heilbrigðisstarfsmenn 34/2012, 43/2014.

8 Structures and Organization

8.1 The program structure

A trainer is registered as a specialist in geriatric medicine and he/she will have satisfied the requirements as regards accreditation/appraisal/training to be a trainer

A trainer will be:

- Familiar with all aspects of the overall geriatric medicine curriculum
- Experienced in teaching and in supporting learners.
- Skilled in identifying the learning needs of the trainees and in guiding the trainees to achieve their educational and clinical goals.
- Able to recognize trainees whose professional behaviors are unsatisfactory and initiate supportive measures as needed.
- Trained in the principles and practice of medical education and follows regular updating in educational and team leader skills.

A Training Program Director would be someone who has been accredited and who has considerable knowledge and experience in training doctors. The program director is in active clinical practice and sits on the Postgraduate Medical Council at Landspitali, on behalf of the Specialty Training Program in Geriatric Medicine

There is also a Program Training Council (ísl. kennsluráð) within the Department of Geriatric Medicine which function is to support the Training Program Director regarding the curriculum and its delivery. On it sit three members, who all are trainers in the program and one trainee.

8.2 Organization

The geriatric medicine department in Landspitali is a big and important part of the hospital, partly because the geriatric department is in charge of about one third of all the beds. Also the consultation service provided by specialists in geriatric medicine is one of the largest, surpassed only by cardiology.

The different elements of the organization are:

- B-4 - The acute geriatric medicine unit
- The consultation service
- L4 - a ward with focus on people with dementia and behavioral problems
- L3 - a ward with focus on comprehensive geriatric assessment, treatment and rehabilitation
- L2 - a ward with focus on comprehensive geriatric assessment, treatment and rehabilitation
- K1 - a ward with focus on comprehensive geriatric assessment, treatment and rehabilitation
- K2 - a ward with focus on comprehensive geriatric assessment, treatment and rehabilitation
- DGS - Day Hospital, Outpatient and community unit, which focuses on comprehensive geriatric assessment, treatment and rehabilitation. This unit is divided into several specialized clinics, i.e. . Memory clinic, Fall clinic and Fracture clinic
- Vífilsstaðir - An intermediary for those people that are waiting for long term care. This is a very fragile and sick group as evidenced in that about one fifth dies before moving to a long term care facility.
- Consultation service for a Day Hospitals specialized for people with dementia

There is a continuous improvement and innovation work being done in the department of geriatric medicine. For example did we participate in a project called ACE, which was a collaboration aimed at improving the service for older adults in the Emergency department. Plans for an orthogeriatric unit are ready and waiting approval. And a Gero-psychiatry unit is planned as our next imitative.