



Available online at  
**ScienceDirect**  
[www.sciencedirect.com](http://www.sciencedirect.com)

Elsevier Masson France  
**EM|consulte**  
[www.em-consulte.com/en](http://www.em-consulte.com/en)



Research paper

# The development of a European curriculum in Geriatric Emergency Medicine



S. Conroy<sup>a,\*</sup>, C.H. Nickel<sup>b</sup>, A.B. Jónsdóttir<sup>c</sup>, M. Fernandez<sup>d</sup>, J. Banerjee<sup>a</sup>, S. Mooijaart<sup>e</sup>,  
 F. Sjöstrand<sup>f</sup>, E. Devriendt<sup>g</sup>, O. Ganansia<sup>h</sup>, F.J. Martín Sánchez<sup>i</sup>, A. Bellou<sup>j,k</sup>

<sup>a</sup> University Hospitals of Leicester, Leicester, LE1 5WW, UK

<sup>b</sup> Emergency Department, University Hospital Basel, Petersgraben 2, 4031 Basel, Switzerland

<sup>c</sup> Consultant Geriatrician, Department of Geriatric Medicine, University Hospital of Iceland, Iceland

<sup>d</sup> Monte Naranco Hospital, Avda Dres Fernandez-Vega s/n, 33012 Oviedo, Spain

<sup>e</sup> Leiden University Medical Center, Albinusdreef 2, 2333 ZA Leiden, Netherlands

<sup>f</sup> Karolinska Institute, Stockholm, Sweden

<sup>g</sup> Leiden University, 35 blok d - bus 7001, 3000 Leuven, Belgium

<sup>h</sup> Groupe hospitalier Paris - Saint Joseph, 185, rue Raymond Losserand, 75014 Paris, France

<sup>i</sup> Emergency Department, Hospital Clínico San Carlos, Instituto de Investigación Sanitaria Hospital Clínico San Carlos (IdISSC), Universidad Complutense de Madrid, Madrid, Spain

<sup>j</sup> Therapeutics and Emergency Medicine, University of Rennes, Rennes, France

<sup>k</sup> Harvard Medical School, USA

## ARTICLE INFO

### Article history:

Received 15 February 2016

Accepted 25 March 2016

Available online 25 April 2016

### Keywords:

Geriatric medicine

Emergency medicine

Older people

Frailty

Curriculum development

Learning outcomes

## ABSTRACT

Older people represent a growing proportion of attendees in Emergency Departments across Europe. Traditionally Emergency Departments have not focused on care for older people, especially those with frailty. Similarly, geriatric services have not traditionally focused upon the care of older people in Emergency Departments. This work seeks to bring together the two disciplines of Geriatric and Emergency Medicine through a defined and validated curriculum on Geriatric Emergency Medicine. Domains and items for inclusion in the curriculum were derived through a combination of literature reviewing and a nominal group workshop. The domains and items underwent validation using a Delphi technique involving the European Societies of Geriatric and Emergency Medicine. In the development stage, 100 individual learning outcomes were identified, reflecting 16 domains; following the stage 2 validation process, 98 items remained. All items were approved by the relevant EU societies. In the final validation step, the curriculum was formally approved by the UEMS sections for Geriatric Medicine and Emergency Medicine (responsible for curriculae in the respective disciplines).

© 2016 Elsevier Masson SAS and European Union Geriatric Medicine Society. All rights reserved.

## 1. Background

The Emergency Department (ED) is a common entry point into urgent care systems for older patients. Older people use emergency services at a much higher rate than would be expected for their population subgroup [1]. With a substantive shift in the demographics of the ED patient population, it is imperative for the next generation of emergency physicians and geriatricians to develop a joint level of expertise in managing the older person in the ED.

However, ED teams have not historically had specific training nor guidelines for the care of older people especially aspects relating to frailty and geriatric syndromes, for which a broader, more holistic intervention is considered to be best practice [2–5]. Hence,

management of older patients with the primary problem being frailty has been regarded highly complex and time-consuming, as the ED environment has been organised according to single organ assessments and management.

Similarly, Geriatric Medicine (GM) has not traditionally focused on older people in the emergency care context. However, the competencies associated with geriatric medicine, such as delirium identification and management, falls management etc, are as important in the acute care context as they are in the more typical geriatric ward setting.

Emergency Medicine (EM) is a medical specialty based on the knowledge and skills required for the prevention, diagnosis and management of the acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders (EuSEM definition). The EM specialty includes pre-hospital and ED settings.

\* Corresponding author.

E-mail address: [spc3@le.ac.uk](mailto:spc3@le.ac.uk) (S. Conroy).

Time is critical because delays in urgent care correlate with adverse outcomes including mortality and morbidity. EM is one of the medical specialties where a collaborative approach improves health outcomes during the first hours following admission to hospital. Currently, only 17 of the 28 member states are recognised by UEMS as having a primary specialty of EM (5-year training program).

GM is a specialty of medicine concerned with the physical, mental, functional and social conditions occurring in the acute care, chronic disease, rehabilitation, prevention, social and end of life situations in older patients. This group of patients is considered to have a high degree of frailty and active multiple pathologies, requiring a holistic approach. Diseases may present differently in old age, are often difficult to diagnose, the response to treatment is often delayed and there is frequently a need for social support. GM therefore exceeds organ-orientated medicine offering additional therapy in a multidisciplinary team setting, the main aim of which is to optimise the functional status of the older person and improve the quality of life and autonomy. GM is not specifically age-defined but will deal with the typical morbidity found in older patients. Most patients will be over 65 years of age but the problems best dealt with by the specialty of GM become much more common in the 80+ age group. It is recognised that for historic and structural reasons the organisation of GM may vary between European Member Countries (UEMS definition).

Both GM and EM have existing curriculae, aspects of which relate to the general care of older people.

## 2. Geriatric Emergency Medicine

Despite a growing awareness of the importance of geriatric competencies in Europe, there is no specific European Geriatric Emergency Medicine (GEM) curriculum [6]. The purpose of the GEM curriculum is to highlight the competencies that might be expected of ED and geriatric services focusing on the care of predominantly frail older people in the EM setting. It is the intention that the curriculum will also be useful to all key team members, such as nurses and therapists.

In an attempt to align the two paradigms of EM and GM, the respective European Societies (EuSEM and EUGMS) created a joint Geriatric Emergency Medicine Special Interest Group (GEMSIG) in 2013. A specific activity of this group was to create the European Taskforce on Geriatric Emergency Medicine (ETFGEM), to develop the GEM curriculum.

### 2.1. Funding

Funding was provided by both societies to cover travel costs and accommodation for the ETFGEM meeting.

## 3. Methods

As there is no existing European GEM curriculum, a consensus process was used to develop the curriculum. In the first instance a modified Nominal Group Technique (NGT) was used to generate domains and items based on the published literature, which were then broadened and validated using a modified Delphi process.

### 3.1. Review of the literature

Potentially relevant papers were identified from MEDLINE 1996+ using the following search terms: older patients OR geriatric AND emergency medicine. The search was supplemented from the grey literature, personal collections and by hand-searching the references of selected papers. Papers were selected on the basis of their relevance to developing competencies in GEM by agreement between a geriatrician and an emergency physician. A range of

articles including North American initiatives to develop a GEM curriculum and recent reviews and key articles in the field were identified and used to inform the development of the domains and items [7–17]. The development focused upon the additional competencies over and above that which would be expected from training in either GM or EM—so this was not simply a reproduction of how to practice EM in older people, but an attempt to develop higher-level competencies that will add value to existing curriculae [7].

### 3.2. Curriculum development—nominal group method

The membership of the joint Geriatric Emergency Medicine Special Interest Group was derived from e-mail and web invitations to members of the European societies of Emergency and GM, as well as through awareness raising at respective European conferences. Volunteers to participate in the ‘Taskforce’ to work on the curriculum were invited from the 140 or so members of the Special Interest Group. Eleven volunteers eventually formed the Taskforce (six EUGMS, four EUSEM and one GEM nurse), and participated in a curriculum development weekend in London, United Kingdom in December 2014.

Based on the literature review findings, the panel generated a list of domains and a range of items for potential inclusion in the GEM curriculum. These were discussed openly and modified following the principle of consensus. Following the meeting the draft competencies were e-mailed to the broader Taskforce for initial validation.

### 3.3. Second stage curriculum validation - Delphi process

The domains and individual items were entered into a spreadsheet and sent out to the boards and Councils of both EUSEM and EUGMS. Participants were asked to respond to each of the domains and items of the pre-Delphi curriculum by stating whether they fully agreed with the learning outcome or not (two choices only). If they did not agree, they were asked to specify why not and what changes they would suggest, if any, that would make the learning outcome acceptable to them. Additionally, responders were asked to give general comments for improvement of the suggested curriculum. An important instruction posed was: ‘Please take into account that the curriculum contains a list of **minimal requirements** a geriatrician/emergency physician should be able to demonstrate at the end of their specialty training in emergency medicine/geriatric medicine respectively’.

Responses were counted, tabulated and copied in full length to the members of the Nominal Group for evaluation. Where there was any ambiguity, the individual Delphi respondent was contacted for clarification. Based on this information, the leads of the Nominal Group revised the curriculum, according to the following principles:

- requests for improving the clarity or wording were checked;
- requests for adding a new aspect, or for increasing the difficulty level of an existing objective were only taken into account, if this was most likely an unintentional omission, and would most likely be accepted by all experts from all countries;
- requests for deleting an aspect, or for lowering the difficulty level of an existing objective, were evaluated, and if required, personally discussed (by phone or individual email) with the panel member, with the intention of better understanding the request and finding consensus on an acceptable modification;
- The Nominal Group leads ensured that any modification did not result in the omission of an objective that was considered relevant by the majority of the Delphi panel or the Nominal Group.

Download English Version:

<https://daneshyari.com/en/article/5662543>

Download Persian Version:

<https://daneshyari.com/article/5662543>

[Daneshyari.com](https://daneshyari.com)