had a meeting with my mentor to set a preliminary CESR program over 18 months, through which I can get experience in various subspecialties and get my JRCPTB geriatric training program competencies signed. I am following the specialist registrar training curriculum in Geriatric Medicine (which includes for example: specialist clinics, procedures, old age psychiatry, ortho-geriatrics, movement disorders, continence, tissue viability, stroke, community geriatrics and front door geriatrics). We have planned the training schedule using a Gantt chart and I meet my mentor monthly to chart progress.

Conclusion: CESR is an alternative route for inclusion on the specialist register for any specialty. It can be more realistic and a shorter route for physicians who have a lot of experience outside an approved training program to be on the specialist register. Gaining a CESR requires good planning and flexibility both for the candidate, colleagues and managers in order to accommodate training requirements within job plans, as well as a supportive working environment.

The challenge of patient safety in acute care geriatric unit

M. Al Tehewy

Patient safety is defined as “the absence of preventable harm to a patient during the process of health care. Harm to patient is not inevitable and can be avoided. To achieve this, clinicians and institutions must learn from past errors and learn how to prevent future errors. Medical Errors were estimated to be the eighth leading cause of death in USA and that 44,000 to 98,000 people die each year due to medical errors plus1 million injuries, (IOM, 2000). This leads to excess costs of $1 to 3 million in a mid-size hospital attributable to prolonged stays and complications. WHO estimated that 10% of all inpatient visits result in unintended harm in developed countries. This rate increased in elderly inpatients to reach up to 57% in some studies, (Szlijf, et al., 2012). However, 85% of the underlying causes of adverse events are due to system failure rather than individual errors. The problem of patient safety in Egypt and how to control system failure will be discussed in this presentation.

It’s recommended that medical adverse events should be monitored in elderly hospitalized patients because there is no risk profile for susceptible patients, and the consequences of adverse events are serious, sometimes leading to longer hospital stays or even death.

Geriatric considerations in Hospice care

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Hospice care can be viewed from different perspectives. From one angle Hospice would be a model of care while in another one, it would be seen as a care setting. In my humble opinion, hospice is a philosophy of care. Patients in the last days/hours of life often have unrelieved physical suffering, as well as significant emotional, spiritual, and social distress. Recognizing that a person is entering the imminently dying or terminal phase of their illness is critical to appropriate care planning, the most important at this phase is a shift to comfort care. Hospice is a health care delivery system under which support, and services are provided to a patient with a terminal illness when curative or life-prolonging therapy is no longer indicated, and the focus is on comfort rather than cure. Hospice care focuses on the management of pain and other symptoms while addressing other forms of distress. In a growing geriatric population Hospice care during the last days and hours of life, can help individuals have a “good death” and lead to higher family satisfaction with the quality of care the patient receives. The goal is to make the final days of life as comfortable as possible and Geriatricians are the best candidates to make this happen.

Geriatric services in Bahrain

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Bahrain is a small country, yet it has good integrated health services for elderly. The geriatric services in Bahrain covers primary, secondary and tertiary preventive levels through 4 domains of inpatient and outpatient acute, sub acute and long term care facilities, plus a developing home care system. In the presentation, the services will be highlighted and explained. The use of multidimensional assessment and multidisciplinary team management at all levels will be explained. And the coordination among the 4 domains will be also discussed as an example of how to conduct an integrated geriatric health care on a small nation level that can be implemented anywhere on larger and smaller scales.

GMAP: geriatric multidisciplinary approach for pressure ulcer management

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Background: Pressure ulcers are one of the most common complications of ICU prolonged stay. Patients who develop pressure ulcers experience a wide range of morbidities as well as an increased risk of mortality. The occurrence of pressure ulcers is considered an indicator of health care quality and safety. Incidence in intensive care units ranges from 3% to 50% according to published data. In November 2017, Incidence of hospital acquired pressure ulcers in geriatric ICU in Ain Shams University hospitals was 31%.

Objective: To study the effect of Geriatric Multidisciplinary Approach in pressure ulcer management, in the period between end of December 2017 till end of February 2018, in Geriatric ICU in Ain Shams University Hospitals.

Methods: A multidisciplinary team including Geriatric ICU Residents, Nursing staff, Dietician and a General surgeon was organized and supervised by: an ICU management team member, a senior resident physician and a head nurse. The multidisciplinary team performed pressure ulcer risk assessment tool (Braden Scale) on admission, nutritional status assessment, and assessment tool for effective nursing care for all patients admitted to the ICU in this period, as well as education for medical and nursing staff. The supervising committee performed daily surveillance to ensure effective system implementation, to detect incidence of new ulcers and ensure their adequate management. The incidence rate, site and grade of new emerging pressure ulcers, as well as Braden scale and list of comorbidities is collected by the supervising committee.