Geriatric Emergency Medicine

Train the Trainer

Faculty Guide

Version 1.1 October 2024

Authors

Áine Mitchell, Consultant in Emergency Medicine (EM), Sligo University Hospital, IE
Jacinta Lucke, Consultant in EM, Spaarne Gasthuis, NL
James van Oppen, Clinical Research Fellow in EM, University Hospitals of Leicester, GB
Rosa McNamara, Consultant in EM, St Vincent's University Hospital, IE
Arjun Thaur, Consultant in EM, Guy's and St Thomas', GB
Pieter Heeren, Geriatric nurse and nurse researcher, University Hospitals Leuven; KU Leuven, BE

Contributors

The European Task Force for Geriatric Emergency Medicine (geriEM) is a collaboration between the European Society for Emergency Medicine (EUSEM) and the European Geriatric Medicine Society (EuGMS). As part of this taskforce, the below contributed to the development of the Geriatric Emergency Medicine course training resources:

Bas de Groot, Consultant in EM, Leiden University Medical Centre (LUMC), NL
Simon Mooijaart, Consultant Geriatrician, LUMC, NL
Simon Conroy, Consultant Geriatrician, University College London, GB
Christian Nickel, Consultant in EM, University Hospital Basel, CH
Ruth Sneep, Consultant in EM, Royal London Hospital, GB
Laura Blomaard, Department of Internal Medicine: Geriatric Section, LUMC, NL
Deirdre Breslin, Consultant in EM, Mater Misericordiae University Hospital, IE
Michel van der Geest, Physician Assistant EM, LUMC, NL
Don Melady, Academic Emergency Physician, Schwartz-Reisman Emergency Centre, CA
Sarah Turpin, Consultant Geriatrician, Borders General Hospital, GB
James Wallace, Consultant in EM, Warrington and Halton Teaching Hospitals, GB

The TTT Model delivered on the GEM TTT course and the advice for workshop facilitation in this manual have been informed by the National Open Disclosure Train the Trainer Programme, HSE (Health Service Executive), IE

Copyright

Disclaimer

The European Task Force for Geriatric Emergency Medicine (geriEM) recognises that patients, their situations, Emergency Departments and staff all vary. This guide cannot cover all clinical scenarios. The ultimate responsibility for the interpretation and application of this guide, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Contents

Section 1: Before the Course:

Section 2: During the course

Section 3: After the course

Section 4: Appendixes

Geriatric Emergency Medicine #geriEM

What is #geriEM

Geriatric emergency medicine is an emerging sub specialty across the globe, pertaining to the care of older people that may be patients within the range of Emergency Healthcare settings. As the world's population ages there naturally follows an increase in the use of healthcare by those people, which is not without risk. Our current healthcare systems are not designed to care for the increasing numbers of older patients with increasingly complex needs, and the risk of iatrogenic injury from accessing these emergency healthcare settings is still a very real threat.

Age cut offs are unhelpful in defining the population with geriatric emergency care needs. Traditionally the WHO definition of an older person is 60, with the sociological age of retirement defining that limit in several countries. An international consortium on healthcare outcomes has defined older people as being in the last ten years of life, based upon the life expectancy of that country and region. People with geriatric emergency care needs are probably better identified by the presence and severity of frailty, as described in next section.

Whichever definition is used, older people will attend emergency care settings in increasing numbers with crises in their physical, social and mental healthcare needs. Solving the problems pertaining to health, access to health care and even research in the emergency care of older people are crucial in the development of robust future proof healthcare systems.

Who are we?

The mission of the European Task Force on Geriatric Emergency Medicine (ETGEM) is to develop #geriEM with collaboration between emergency physicians and geriatricians involved in the respective sections of two different societies, European Society for Emergency Medicine (EUSEM) and European Union of Geriatric Emergency Medicine Society (EUGMS). These both have a common objective to improve the quality of older patients' emergency care. One of the originalities of this approach compared to other EUSEM sections is the creation of a unique group including emergency physicians and geriatricians, leaders and members of EUSEM and EUGMS that will dedicate its effort on the development of #geriEM.

The objective is to concentrate concepts and goals avoiding overlap and repetition. Merging the two groups' expertise will give more potential and will help to achieve missions at the European Union and Global level. This group will focus on three domains, Organisation, Education and Research. The following will develop the status of this section.

In April 2016 the European Task Force on Geriatric Emergency Medicine (#geriEM) produced a European curriculum for Geriatric Emergency Medicine, which is available for download at https://eusem.org/wp-content/uploads/2017/04/The-European-Curriculum-of-Geriatric-Emergency-Medicine.pdf

Since 2017 the same European Task Force on #geriEM has initiated an initiative to compile a European Research Agenda on #geriEM. A prioritised set of research questions will help to increase impact of #geriEM research throughout Europe and the world.

The European research agenda on Geriatric Emergency Medicine was published and can be found here: https://pubmed.ncbi.nlm.nih.gov/33219983/

The taskforce has produced educational material on eight key topics: https://posters.geriemeurope.eu/

EUSEM Pre-congress teach-the-teacher course on #geriEM

This teach-the-teacher course is a hands-on pre-course that has the goal to improve the knowledge and skills regarding Geriatric Emergency Medicine for the participants and involves an international faculty of Emergency Physicians and Geriatricians from EUSEM and EUGMS.

As a participant, you will be provided with practical tips and learning points which you can start working with when you return to your own hospital. Furthermore, we will give you the lesson plans of the precourse, so you can start teaching in your own hospital.

We will cover several themes which were identified by expert consensus as being crucial to working with older patients in Emergency Departments:

- Frailty
- Trauma in older people
- Sepsis
- Pain management
- Syncope
- Polypharmacy
- Cognitive impairment/delirium
- End of life care

In the next few pages we will give you a brief introduction to some of these topics, which you will have the opportunity to explore in table top exercises, scenarios and simulations throughout the course.

The faculty of the #geriEM course thank you for your interest in this crucial subject, and not only do we look forward to seeing you soon, but we hope you become as passionate as we are about our older patients.

Frailty

What is frailty?

Frailty can be described in many ways, but there is no single approved international description or score. It has been described in a genotype model, a phenotype model and a syndrome, but could be summarised as a reduction in ability to respond to a stressor event in one or more of the persons health, social, mental and emotional wellbeing. Small challenges such as a minor infection or a change in medication can have a disproportionate impact on a frail person.

https://www.bgs.org.uk/resources/frailty-hub-introduction-to-frailty

How can we recognise it?

Frailty is a spectrum, which is reflected in the various methods of scoring or assessing a person for frailty. Traditionally patients over 65, those over 85 and in care homes have been automatically seen as frail, however in Emergency Medicine we regularly see patients that do not fit those predetermined criteria. It is crucial that acute and emergency physicians recognise those patients that are frail or are at risk of frailty (vulnerable) to ensure that their care needs are evaluated from a person centric model, as opposed to the traditional diagnosis centric model commonly used in Emergency Departments.

There are a range of frailty scores, the commonest being the Clinical Frailty Score, which has been validated in countries and clinical settings across the world and is very useable in triage. The key message is to screen and score relevant patients for frailty, using a tool that is appropriate for your patients and clinical setting.

https://www.bgs.org.uk/resources/recognising-frailty

#Silvertrauma - The changing demographic of trauma

Trauma has changed since the first ATLS manual, in that most patients that have moderate to severe injuries (Injury severity score >15) are now over 65. Not only that, but our silver trauma patients present with different mechanisms of trauma compared to the traditional high speed RTC, assaults with weapons and falls from height.

Our older trauma patients may still receive injury-based care, rather than discreet mechanism based, or holistic patient centred care, and may also wait longer for triage, investigation and onwards referral.

https://www.embeds.co.uk/wp-content/uploads/2019/10/Hector-manual.pdf

Physiology and outcomes

Most prehospital and in-hospital trauma triage are based upon mechanism, injuries sustained and some physiological parameters, with various outcomes such as need for surgical intervention and mortality. Our older patients have not only a different pattern of injury and more occult injuries,

but the physiology of ageing may not have the traditional parameters to trigger major trauma pathways.

Older patients may have underlying hypertension, are less able to respond to hypoperfusion and are more likely to have heart rate controlling medication. Therefore, higher systolic blood pressures and lower heart rates may be a sign of hypoperfusion which, combined with reduced elasticity of blood vessels and organs leads to increased potential for occult and devastating haemorrhage.

In this course we aim to look at the differences in management of older patients with trauma, and how to change the traditional model of trauma triage, care to a patient centric one.

https://www.c4ts.qmul.ac.uk/downloads/pan-london-major-trauma-system-management-of-older-trauma.-third-editionapril-2021.pdf

Fits, faints and funny turns - "off legs"

There are certain phrases that are guaranteed to raise the heart rate and blood pressure of geriatricians, especially;

- Off legs
- Mechanical fall
- Acopia
- Collapse query cause

Whilst there may not be a single test to evaluate a patient that has fallen or lost consciousness, there are clear and helpful strategies to ensure that the patients gets a holistic approach to their assessment, minimising risk and the risk of hospital admission.

During this course, we aim to give you tips and tricks to assessing the older person for not only commonly missed pathology, but also to allow for the multi-dimensional assessment in the Emergency Department of patients that may not a geriatric focussed approach

The anticholinergic burden

Not all medications are safe in older patients, and several have a significant risk of iatrogenic effects, increased hospitalisation and potentially increased mortality. Certain types of medication have been proved to increase the risk of delirium, falls, reduce cognitive ability and give physical side effects, especially those with anticholinergic properties. http://www.acbcalc.com/

Whilst we may not be able to stop all medication that our older patients take, it is prudent to ensure that those medication have been reviewed to ensure that the risk benefit for each is evaluated and managed.

In the past 20 years there have been over 15 various criteria produced all over the world, used to identify problematic or inappropriate polypharmacy, in this course we aim to give you the introduction into the toolkits that can be used to minimise iatrogenic harm to our older patients through polypharmacy.

Delirium

What is it?

Delirium can be broadly classified into hypoactive, hyperactive and mixed states, which we in EDs see as

- Dorothy is less responsive than normal/wont wake up
- Albert is very agitated and won't take his benzodiazepines

Hyperactive	• Heightened arousal • Restless, wandering • Sometimes aggressive
Hypoactive	• Decreased alertness • Sparse/slow speech • Lethargy, apathy
Mixed	• Combination of above

There are multiple formal methods of defining and assessing for delirium outside of the intensive care setting, but essentially it is a recent onset of fluctuating awareness (consciousness), impairment of memory and attention, with disorganised thinking.

What's the impact?

Patients with an acute confusional state are common in hospital medicine, with increasing prevalence in older patients. It is well known that patients with delirium will have

- An increased length of hospital stay
- A higher risk of complications in both medical and surgical settings
- A higher mortality, in hospital and up to 6 months following discharge

What can we do?

As per patients with frailty, older patients with sepsis and #silvertrauma we need to be aware of not only the presentation, but the subtle differences in our patients that can lead to not only a missed opportunity to screen for delirium but worse outcomes.

During this course we will aim to give you the tools required to screen for delirium but also how to manage it acutely in our Emergency Departments.

Preparing the course

A breakdown of the Geriatric Emergency Medicine workshop components

Time	Topic
07:45 - 08:30	Faculty meeting & room preparation
08:30 - 09:00	Introductions (30 minutes)
08:30 - 08:40	General introduction (program, general notices)
08:40 - 09:00	General introduction into GEM (frailty)
09:00-10:40	Working groups (4x25 minutes)
	Station 1: Scenario older trauma patient
	Station 2: Scenario older patient with sepsis
	Station 3: Table top discussion: Delirium/cognitive impairment
	Station 4: Table top discussion: Pain management
10:40-11:00	Coffee break
11:00-12:40	Working groups (4x25 minutes)
	Station 1: Scenario older patient with abdominal pain
	Station 2: Scenario older patient with syncope
	Station 3: Table top discussion: Polypharmacy
	Station 4: Table top discussion: End of life care in the ED
12:40 - 12.55	Summary and Close
12:40-12:50	Summary of key-learning points
12:50-12:55	Closing & evaluation

Pre training checklist

No	Checklist	Completed Yes/NO	Comment
1	Agree training schedule locally		
2.	Identify link person to liaise with in relation to the training in the relevant organisation.		
3	Seek co-trainers well in advance.		
4	Arrange suitable venue.		
5	Arrange refreshments as appropriate.		
6	Advertise, e.g. send out fliers well in advance of training. Consider asking senior management to send out an email in advance of the training to all services to promote the training and request that staff are released to attend.		
7	Apply for CPD credits for the Geriatric Emergency Medicine workshop well in advance of the training (or your link person in organisation may arrange)		
8	Prepare workshop information pack and power point presentations		
9	Have equipment: Laptop, projector (+/- flip chart) Name labels, Pens, paper Establish IT set up arrangements at the venue Sim set up on phone-tablet (e.g. simpl sim) Simulation ABCDE equipment		
10	Manage registration for workshops		
11	Organise a sign in/attendance sheet. Prepare attendance certificates in advance – will save administration time later		
13	QR link or printed evaluation forms		

Before the course - step by step

There are numerous resources to assist trainers in preparing for and delivering Geriatric Emergency Medicine training including a pre and post training checklist. This is also attached to this document in Appendixes. Please familiarise yourself with all of the resources available prior to commencing your training programme. Careful preparation is the first step towards facilitating a successful workshop.

Getting started:

Develop a training plan for your area – if you are providing this at a hospital / area / country level, you can be more specific to local / national resources and guidelines. It is recommended that you work with at least 5 co-facilitators when delivering the Geriatric Emergency Medicine skills workshop and that the workshop trainers have a variety of experience in geriatric medicine, emergency medicine, geriatric nursing and emergency nursing backgrounds.

Organising the venue:

The room should be large enough to accommodate the number of attendees and to facilitate the training exercises. Seating should be arranged in a semi-circle at the beginning of the workshop preferably as this is conducive to audience participation. Participants will move about and form small groups during the workshop. A theatre style room should be avoided for the workshop as it is difficult in this type of setting to conduct the role plays. Where possible having smaller breakout rooms, rather than 4 corners of a large room reduces noise issues during the workshops. The room should have appropriate lighting and ventilation. Check the IT set up in the room prior to the event to establish what equipment is available, identify any additional equipment you will need to bring with you (see checklists) and to establish any restrictions on the use of outside laptops, USB sticks etc.

If possible, choose a venue which is central for most attendees.

Advertising your event

You may advertise your event by the distribution of fliers, email, posters, group text messages, newsletters, social media etc. Advertise your event at least one month in advance and send out event reminders the week before if the workshop is not already fully booked.

PowerPoint slides

The power point slides for all training sessions are available, as part of the TTT resource pack. There are also workshop facilitator guides included in this pack to assist trainers. The workshop facilitator guides contain key messages and further information.

It is important to remember that this is a facilitated workshop - it is not a slideshow or lecture and the power point slides are used as a tool to keep the workshop on track. Draw the learning from your audience using examples, questions, group discussion, case scenarios, etc.

Attendees

Workshop: Limit the number of attendees to 24-32 at maximum for the workshop, as the time allocated for the workshop will be hard to manage with a bigger group. You may start off with a smaller group such at 12-18 participants for your first few workshops until you are feeling more confident. Send out a reminder email or text to attendees 1-2 days in advance of the workshop. We recommend that workshops are multidisciplinary.

When you are preparing for the work shop the very first thing you should do is to focus on the people. Try to understand who the participants are, what their group dynamic will be like, and how you can best match the workshop to their knowledge.

Trainer note:

It is important to review your Geriatric Emergency Medicine resources so that you are familiar with all aspects of the programme and process.

The Geriatric Emergency Medicine trainer as a facilitator

Facilitation is the art of leading people through processes towards agreed-upon objectives in a manner that encourages participation, ownership and creativity by all those involved

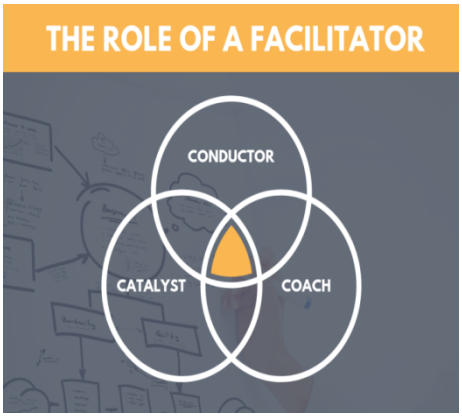
"The facilitator's job is to support everyone to do their best thinking and practice. To do this, the facilitator encourages full participation, promotes mutual understanding and cultivates shared responsibility. By supporting everyone to do their best thinking, a facilitator enables group members to search for inclusive solutions and build sustainable agreements" – Kaner et al(2007)

A facilitator has a wide range of tasks to perform in order to 'make things easier' for people who participate in a facilitated discussion:

- Support individuals within a group in understanding their common objectives.
- Help people collectively move through a process.
- Structure conversations and apply appropriate activities to keep discussions effective.
- Foster participation and get people to come up with ideas, thoughts and perspectives that add value.
- Get all individuals in the room to feel like they are in a group with a shared interest.

If we really want to understand the different angles of the facilitator's role, then the following similes may help. A facilitator can be perceived as:

- A **'catalyst'** for discussion: He/she makes possible the transformation of input (ideas, opinions) to desired outcome (refined ideas, decisions, strategies, etc.) without being an active part of the conversation him/herself.
- A '**conductor'** of an orchestra: He/she synchronises all the musicians (group participants), optimally guiding the use of their instruments toward the desired result – a harmonic musical expression of the musicians' complex interactions, creativity, and expertise. As the "conductor" guides the participants, a system is organically created wherein the facilitator helps every individual comply with the agreed-upon rules and norms to be followed. In this way, his/her efforts enable each person in the "orchestra" to create something greater than themselves.
- A '**coach':** He/ she helps the group form a constructive way of working together, identify its needs and wishes, and reach the outcome they would jointly like to achieve.



The facilitator should act when appropriate to prevent digression, to ensure that questions are formulated in a non-leading way, and to keep things to time. This may involve, from time to time, pointing out helpful and unhelpful ways in which the group might interact (for example, pointing out that the group seems to get a bit lost if they stray out beyond their area of control/influence). The facilitator also ensures, in as far as possible, that the workshop is a 'safe space' for people to learn – this means that it has to be safe enough for people to admit to their own ignorance or area for development or feeling lost, without being judged or ignored.

The facilitator may intervene with a question or statement, such as "Can you put that in another way?" or "I'm wondering if we have lost sight of some aspects of this issue" e.g. the presenter's own way of being/doing things, or the presenter's team relationships, or other demands/pressures which might be playing a role in the wider environment. The facilitator might also encourage the group to ensure that they are giving each other time and space and treating each other with respect.In these ways, the facilitator sets the tone for the workshop. S/he can also demonstrate the actions of being a good role model (listening, attending to others, redirecting if necessary, empathising and questioning)

References :Kaner, S. with Lind, L., Toldi, C., Fisk, S. and Berger, D. *Facilitator's Guide to Participatory Decision-Making*, (2007)

Robert Cserti *How to Improve Your Facilitation Skills(and be a great facilitator*(2019)

General advice to help you prepare for this course delivery

- Arrive at the venue at least 30 minutes to 1 hour prior to the commencement time to allow time to set up and to deal with any issues which may arise.
- Ensure that everyone is wearing a name badge as it is more personable to address an attendee by their name.
- Set and agree your ways of working (sample in Appendix A) – ask your audience to contribute to this.
- Know who is in the room, use the experience of the participants in the room and draw on their expertise and knowledge.
- Keep the workshop relevant to the attendees; ensure that the case scenarios used are relevant to their area of work and use scenarios as appropriate to help explain points you are making.
- Acknowledge and empathise with the difficulties which attendees identify but do not get drawn into matters that are out of your remit to resolve e.g. resource issues.
- Try not to get pulled into other topics for too long e.g. major trauma, inappropriate use of emergency services, etc.
- Use the "Park" facility if a question arises which you cannot answer at that time or is going to be covered at a later stage in the workshop.
- You don't need to know all the answers but do follow up on any queries raised and agree a plan regarding how you will assist/support getting clarification on questions not answered in the training session.
- Keep the workshop positive, lively and encouraging and manage any challenges that arise professionally.
- Manage time effectively by keeping things moving.

During the course

1. Set the scene

Before the workshop participants arrive at the venue, you can do a lot to create the kind of atmosphere you want. Do you want people to feel calm, energetic, or relaxed? Think about how the room is set up and how the furniture is organised. Put signs up on the door and to provide direction if needed to help participants find the venue.

Check that you have all infection prevention precautions in place.

2. Complete a check-in

- Ask participants to complete a sign in sheet with their name, title and contact details.
- Seek permission for taking any photographs during the training session.
- Provide a name badge sticker and ask participants to write their first name clearly.

You can consider giving each participant a workshop pack (or providing digital resources) which may include:

- Participant self-reflection
- Copy of presentations or resources
- Evaluation Pack

Ask participants to complete their own self-reflection while they wait for everyone to arrive.

Once everybody is settled in, it's time to go around the room and introduce all faculty and participants. Welcome all participants and be aware of group dynamics.

Introduce yourself and your background.

Ask your participants to do the same and to state one objective for the workshop.

This is a chance for the participants to share what they're bringing to the workshop today, what they're feeling right now, and what kind of mood they're in. Are they excited about the workshop or did they have a terrible time dropping off their kids in the morning? You'll never know unless you ask.

Ask your faculty to introduce themselves and their background.

3. Agree ways of working

It is important to take time at the beginning of the workshop to set some ways of working and housekeeping arrangements. Where the bathrooms are, what time there will be breaks, Infection Control arrangements and what the rules of engagement during the day will be.

However, it's also important to note that the rules of engagement shouldn't just be limited to the physical environment. Instead, we should adopt the same approach to each other. And by making it obvious that the same rules will apply even after the workshop.

4. Share the agenda and set expectations

Before kicking off the first real exercise, it's good to walk through the agenda together with the participants. Remember to also share the purpose and goal of the workshop, so that they'll be able to recognise whether or not their discussions throughout the workshop will help you achieve the shared goal.

Provide information on the resources provided.

Make sure to also remind the participants that the work doesn't end when the workshop ends. Set realistic expectations and make sure that everyone in the room knows what's expected of them going forward.

5. Consider if an icebreaker is appropriate if time allows

Especially if the participants are unfamiliar to each other, it's a good idea to take some time in the beginning of the day to build trust and share some personal information or anecdotes. An icebreaker may seem silly, but the lighter mood you'll get as a result will be worth all the awkwardness. To get the discussions going, it's always good to start talking about something you know and the easiest way to do that is through personal introductions.

6. Time Keeping

Keep a close watch on time keeping during the workshop. Aim to start and finish at the scheduled time. Ensure that the workshop time is well managed. Prompt groups to start/complete each station and record any feedback before moving to the next topic. Also monitor the timing of each exercise to balance participation and completion. Draw the key learning from each with reference to the facilitator guides.

GeriEM introduction

Format:

15-minute lecture

Requirements:

Laptop/tablet with slides.

Resources: (both for faculty and as extra-reading resources for candidates)

Candidates will have received pre-reading on GeriEM and frailty

Objectives:

1. Introduce geriatric emergency medicine as a necessary intervention for an ageing population.

Delivering the session

We use this first session to introduce Geri-EM as a necessary intervention for an ageing population.

	Time	Resources
Lecture	15 mins	People are living to older age, but are not having longer periods of good health. Therefore, more people are living with frailty. There is a slide on frailty and an overview of the comprehensive geriatric assessment (CGA). These are crucial Geri-EM concepts: they are relevant to all the later sessions but are not specifically covered in detail, so should be explored in this lecture. We discuss the extent of CGA which we can perform in urgent care, and briefly explore competencies: this is restricted to geriatric and emergency medicine perspectives (rather than nursing, therapy, social work etc) as we use this slide to show that Geri-EM practitioners must develop competencies which span across traditional professional boundaries.

Workshops

Trauma

Format:

25-minute Simulation with discussion

This Station has accompanying power point slides to assist and reinforce learning

Requirements:

- Laptop/tablet with slides
- Role Player to receive briefing before session:

  This is an older person with dementia that lives alone. They have fallen down a flight of steps. They are confused and refusing to wear a cervical collar. They say they feel fine and are asking when they can go home.

  The person will agree to what the candidates recommend, but is persistent about asking when they can go home and asking why interventions are being recommended.
- Equipment for simulation (collar/blocks/IV fluids/Blanket/Wig)

Resources: (both for faculty and as extra-reading resources for candidates)

- HECTOR manual - https://www.embeds.co.uk/wp-content/uploads/2019/10/Hector-manual.pdf
- GeriEM poster and links https://posters.geriemeurope.eu/posters/p07/
- Management of older major trauma patients. Third Edition. Pan London Major Trauma April 2021 https://www.c4ts.qmul.ac.uk/downloads/pan-london-major-trauma-system-management-of-older-trauma.-third-editionapril-2021.pdf
- Chapter on Geriatric Trauma in the ATLS Course Manual
- https://geri-em.com/trauma-falls/introduction/
- https://em3.org.uk/leicgem-lecture-3

Objectives:

1. Describe an overview of approach to managing trauma in an older patient, including risk assessment; triage safety nets and occult shock.
2. Recognise the difficulty in early identification of significant injuries in older patients may be caused by:

   - low energy transfer mechanisms of injury (low level falls vs young adult RTAs.)

   -co-morbidities which make the presentation less obvious

-signs of significant injury may take longer to manifest

3. Discuss how primary and secondary survey are adapted for older people. Particular note of cervical spine individualised care.
4. Discuss Silver Survey – purpose and components, including assess for
   1. concomitant life-threatening illness - sepsis, MI preceding or in setting of trauma;
   2. delirium - present or risk;
   3. CGA - 5Ms, early mobility…

Common candidate questions / diversions:

- Use of cervical collar in older confused patient
- Signs of occult haemorrhage

Facilitation of Simulation

e.g. Below is a sample 20 minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included. Sample case contained in PPT slides.

	Time	Resources
Introduction	3-5 mins	The scenario session focusses on a systematic approach to managing trauma in an older patient.
Patient encounter	5 mins	Introduce the role player Show the case history – older patient who has fallen down flight of steps. They are confused and want to go home.
Facilitate Discussion	10-12 mins	Invite recommendations for interventions from the candidates. Discuss why cervical collar is not indicated in a confused older patient Approach to primary survey and focused CT scan to identify injuries Identify signs of occult haemorrhage Time permitting – discuss secondary and silver survey
Summary	1-2 mins	Key Learning points in approach to trauma in older patient Resources for further reading

Sepsis

Format:

25 minute Simulation Scenario

This Station has accompanying power point slides to assist and reinforce learning

Requirements:

- Laptop/tablet with PPT slides.
- Volunteer patient who needs to be instructed before we start.
- Simulated monitor (apps are available to connect phones and tablets - optional).
- Non-rebreather mask, nasal cannula for oxygen administration (optional).
- IV cannulae and tape (optional).
- 2x 500 ml of normal saline or ringers lactate (optional).

Number of persons needed:

- One participant needs to be the doctor
- One participant needs to be the non-obstructive nurse.
- Two participants are asked to observe and register if appropriate actions were taken on the checklist.
- One instructor is leading the scenario and provides information if asked and provides feedback on the initiated actions (see below).

Resources: (both for faculty and as extra-reading resources for candidates)

Nickel C et al Geriatric Emergency Medicine

Objectives:

1. Recognition of sepsis in older people – including differences in vital signs
2. Understand the limitations of triage
3. How to manage fluid resuscitation in older people

Facilitation of simulation scenario

Below is a sample 25-minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Set:	0-3 min:	-Explanation of how the scenario is played and what is expected of the candidates. -In general: ATLS style (assuming most of the candidates did their ATLS). For those who did not: -"NO PLAY" indicates that someone feels really sick (is not acting for the scenario). In that case the scenario is stopped. -Try to be as realistic as possible. -Assessment: ABCDE style. You hear what you here. If you have a question: Ask the patient (She can talk!) If you want to know what you are seeing ask what you want to know. -Assessment: If you want to have vital signs: Ask the instructor -Treatment: If you want to administer O_2, fluids, or medication ask the non-obstructive nurse. She will give what you want. -Communicate what you think is wrong or what worries you.
Start scenario:	4-15 min:	**History for instructor to tell candidate who is the ED physician:** The 80-year old Mrs Johnson is brought in to your emergency department by her daughter. Although her mother has no complaints her daughter is worried. The daughter tells you that during the day her mother seemed to be somewhat confused. The daughter also tells you that: **Past Medical History:** 1998:COPD Gold 2 2008: DM2 2010: Anterior myocardial infarction **Medication:** Seretide dosis aerosol Metformin 1dd500 mg Asperin 1dd 100 mg Perindopril 1dd2 mg Nitroglycerin Furosemide 1dd20 mg

… Start scenario:	…4-15 min:	**Assessment** (Information to be provided by instructor if asked by candidate): **Clinical impression:** Not ill appearing lady. She tells that she is feeling fine. She denies ANY complaint but wonders why she is here. **Airway:** Non-obstructed airway. Notice that the tongue is very dry. No signs of inflammation. **Actions:** No specific actions needed. **Breathing:** Symmetric thoracic movements without retractions, SO_2 97%, Respiratory Rate 30/min, Normal and symmetric breaths sounds with fine crepetations dorsobasally. **Actions:** -The candidate should communicate that the patient is ill and that the tachypnea may indicate a B or C problem. -The candidate may request supplemental oxygen. **Adjuncts:** A chest X-ray could be requested. **Circulation:** -Respiratory rate 30/min, flat jugular veins, heart rate 75/min with normal heart sounds, NIBP 120/75 mmHg, capillary refill time (on chest) 5 seconds. Slightly cold hands. If you look very closely the candidate may notice that his or her finger nails are more pink than those of Mrs Johnson). -No signs of external blood loss or trauma, no melena. -Abdominal examination: Mild tenderness in the upper abdomen. **Actions:** -Candidate should communicate that the patient has signs of shock (elevated respiratory rate and capillary refill time). -Candidate should communicate what type of shock may be present. Most likely hypovolemic or distributive (sepsis). -Candidate should ask the nurse to place two intravenous catheters and start crystalloids with 20 ml/kg = around 1500 ml in 250 ml bolusses with close monitoring of effect.

… Start scenario:	…4-15 min:	**…Actions:** -Candidate could order two sets of blood cultures, lactate and additional testing for focus of sepsis like chest X-ray, abdominal ultrasounds and urinalysis. Instructor explains that these take time to acquire. **If fluids are not initiated:** During continuation of assessment (D and E) the blood pressure start to decrease to 90/40 mmHg and Mrs Johnson becomes a little dizzy and less responsive (GCS 14). If candidate is still not initiating fluid resuscitation Mrs Johnson's blood pressure will continue to decrease, and the SO2 measurement gives erroneous readings and alarms (due to poor peripheral circulation). If still no actions by candidate: Patients quickly deteriorates and goes into cardiac arrest (PEA) **Adjuncts:** -Arterial or venous blood gas with a lactate and Hb could be considered. -Abdominal ultrasound could be considered. **Disability:** -GCS appears to be 15 but only if specifically assessed Mrs Johnson appears to believe it is 1973 (instead of 2018). Pupils are PEARL. No neck stiffness. No lateralization. **Actions:** -Candidate should communicate that patient has altered mental status (and that this may indicate brain hypoperfusion or delirium or both). -Candidate should realize that fluid resuscitation is critical and suggest that antibiotics may be needed. **Adjuncts:** Glucose is 8.5 mmol/L. **Exposure:** If the blanket is removed it appears that the legs of Mrs Johnson are marmered and cold. Temperature 37.9 ^{o}C. No petechiae.

… Start scenario:	…4-15 min:	**Actions:** -Candidate should now realise this patient is seriously ill and has shock. -Differential diagnosis: Sepsis is something to be considered. Look for suspected source of infection (abdominal should be considered). Symptomatic abdominal aortic aneurysm or abdominal ischemia could also be considered. The candidate could perform an ultrasound of the abdomen. If done, AAA is not present. If asked for distended bile ducts are seen with an obstructing gallstone. **Adjuncts:** -Candidate could consider doing an arterial or venous blood gas with lactate and blood cultures, if not ordered before. -Instructor could mention that chest X-ray is normal and urinalysis does not reveal any abnormalities. **Time course:** Patient is deteriorating quickly and does not respond to fluid resuscitation of 1500 ml. **Actions:** -Candidate should initiate more fluids and consider norepinephrine on a peripheral i.v. access. -Disposition: Candidate should realize that IC admission could be considered but should also evaluate wishes of daughter and patient. Has end of life discussion taken place before? **End of scenario.** General remark: It should be mentioned that this was a real patient who went into cardiac arrest (PEA) two hours later in the ICU and died (presumably of an abdominal sepsis)
Facilitate Discussion	16-25 mins	Review of the case and key learning points with information from slides It is not necessary to use all slides – review the notes in the slides prior to the session

Delirium

Format:

20-minute table-top discussion

Requirements:

Laptop/tablet with PPT slides.

Helpful to have some handouts: see resources below

Resources: (both for faculty and as extra-reading resources for candidates)

https://posters.geriemeurope.eu/posters/p04/

https://www.the4at.com/

https://deliriumnetwork.org/about/delirium-research-resources/

Objectives:

1. What is delirium and why is it important not to miss it?
2. Learn about subtypes of Delirium.
3. How to identify delirium in the ED.
4. What are the risk factors for developing delirium?
5. What is the management of delirium?
6. Know about non-pharmacological and pharmacological management of challenging behaviour associated with delirium in the ED.

Common candidate questions / diversions:

Often there is a discussion around the differential diagnosis between delirium, dementia and depression – You may need to limit this.

Facilitation of Table-Top Discussion

Below is a sample 20 minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Introduction	1-2 mins	Explain purpose of the workshop
Read through case	5 mins	Use sample case - PPT slides
Facilitate Discussion	12 mins	Use sample questions (PPT) to open discussion or consider questions below. 1. Does this patient have delirium? Yes 2. What symptoms do you recognize? acute onset, altered level of consciousness, fluctuating course, inattention, cognitive deficits, psychomotor disturbances, emotional disturbances, altered sleep-wake cycle, disorganised thinking, perceptual disturbances. 3. What type of delirium is this? Hypoactive/hyperactive/ mixed 4. Do you use a screener in clinical practice to detect delirium in all ED patients? If yes, which one? (Show 4AT/ 6CIT example) At what moment of ED arrival do you screen for delirium? 5. What diagnostics would you like to do? 6. What other factors are you going to assess? Show model of precipitating/predisposing factors. X-ray, lab, urine sediment. “PINCHME” 7. What precipitating factors does this patient have? (age, hearing problems, sleeping problems, use of lorazepam and nortrilen) 8. What pharmacological treatment would you consider?

Sample Case:

Case description

The ambulance brings in Mrs. Robinson, an 86-year old woman. Her only son called 999 (112/911) because he was worried about her. She lives alone and he brings her groceries three times a week. Yesterday he arrived in the afternoon and found her in her pyjamas, while she usually is always dressed perfectly. She did not understand why he visited her and what day it was. She kept asking about her departed husband.

Because he was so worried he stayed the night, but during the night she was constantly walking around the house. She also was seeing crows flying around the room. This morning, she was also a bit groggy and fell in the living room, after which he decided to call an ambulance.

Upon arrival in the ED she does not want to talk to you. She seems scared and keeps waving with her arms. She has normal vital signs, but a slightly elevated temperature and some crepitus upon auscultation of the lungs.

Medical history:

- Hearing problems
- Hypertension
- Hypercholesterolaemia
- Atrial fibrillation
- Sleeping problems

Medication use:

- Elanapril
- Metoprolol
- Simvastatin
- Nortrilen (antidepressant)
- Lorazepam

Social:

Lives alone, one son. Could manage with help of her son and daily delivery of a meal service.

Sample Questions:

1. Does this patient have delirium? Yes
2. What symptoms do you recognize? acute onset, altered level of consciousness, fluctuating course, inattention, cognitive deficits, psychomotor disturbances, emotional disturbances, altered sleep-wake cycle, disorganized thinking, perceptual disturbances
3. What type of delirium is this? Hypoactive/hyperactive/mixed
4. Do you use a screener in clinical practice to detect delirium in all ED patients? If yes, which one? (Show 4AT/6CIT example) At what moment of ED arrival do you screen for delirium?

The 4AT

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

	Normal (fully alert, but not agitated, throughout assessment)	**0**
	Mild sleepiness for <10 seconds after waking, then normal	**0**
	Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

	No mistakes	**0**
	1 mistake	**1**
	2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

	No	**0**
	Yes	**4**

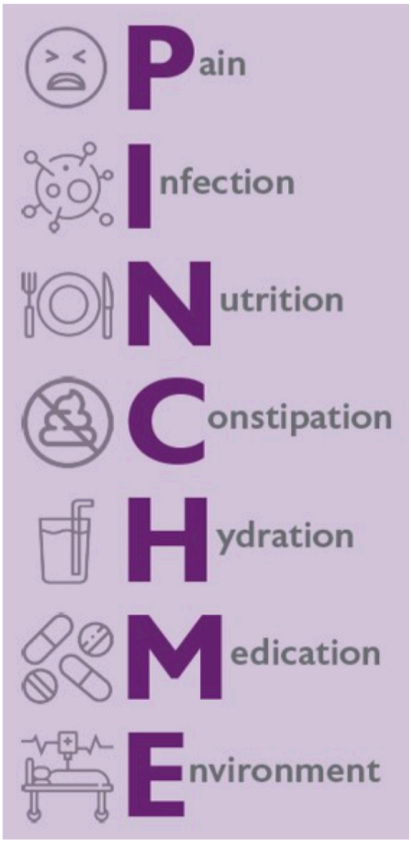
---

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but

4AT SCORE ☐

Question	Score Range	Score
1. What year is it?	**0 – 4** Correct - 0 points Incorrect – 4 points	
2. What month is it?	**0 – 3** Correct – 0 points Incorrect – 3 points	
3. Give the patient an address phrase to remember with 5 components, eg **John, Smith, 42, High St, Bedford**		
4. About what time is it (within 1 hour)	**0 – 3** Correct – 0 points Incorrect – 3 points	
5. Count backwards from 20-1	**0- 4** Correct - 0 points 1 error – 2 points More than I error – 4 points	
6. Say the months of the year in reverse	**0- 4** Correct - 0 points 1 error – 2 points More than I error – 4 points	
7. Repeat address phrase **John, Smith,** **42, High St,** **Bedford**	**0 – 10** Correct - 0 points 1 error – 2 points 2 errors – 4 points 3 errors – 6 points 4 errors – 8 points All wrong – 10 points	
TOTAL SCORE	**0 – 28**	**/28**

5. What diagnostics would you like to do?



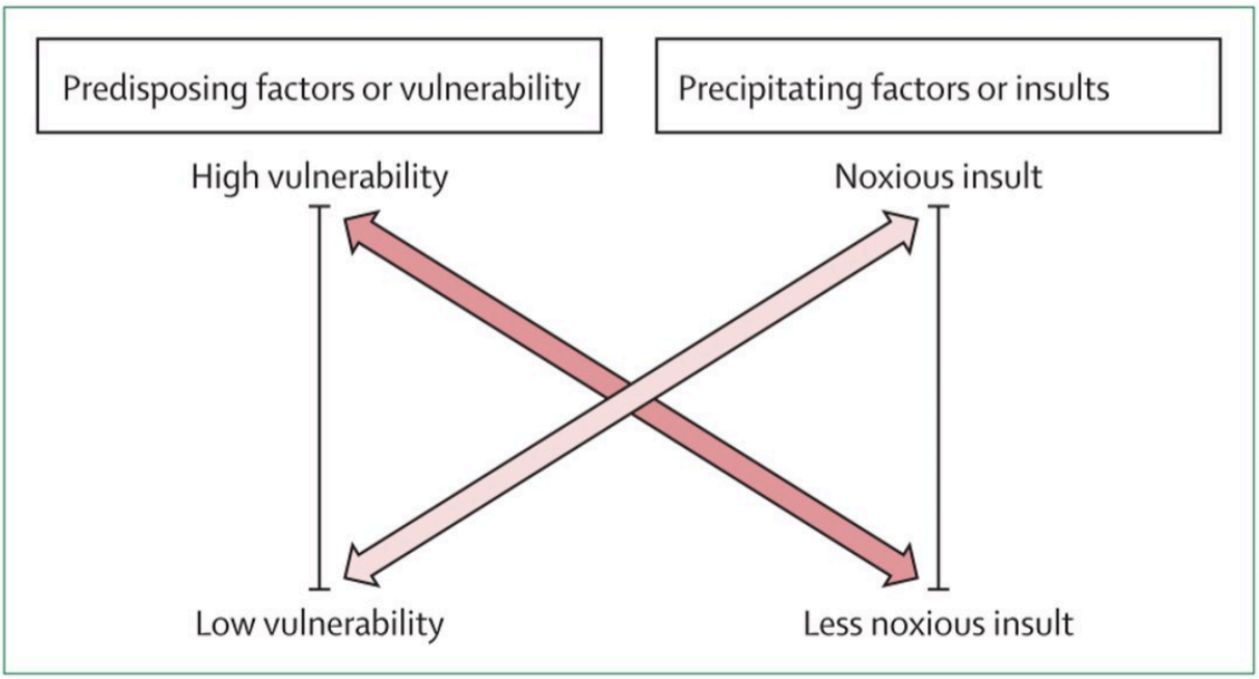


***Figure*: Multifactorial model of delirium in older people**

6. What precipitating factors are you going to assess? Show model of precipitating/ predisposing factors. X-ray, lab, urine sediment.

Predisposing risk factors for delirium

Demographics	Comorbid Disease	Drugs
Advanced age	Number of comorbidities	Polypharmacy
Male gender	Severity of comorbidities	Psychoactive medication use
	Visual impairment	Alcohol abuse
	Hearing impairment	Drug abuse
	Dementia	
	Depression	
	History of delirium	
	Cerebrovascular disease	
	Falls	
	Functional impairment	
	Terminal illness	
	Malnutrition	

Precipitating causes of delirium

Systemic disease	Primary CNS disease	Drugs	Environmental
Infection/sepsis	Stroke	Polypharmacy	Prolonged ED stay
Dehydration	Meningitis	Withdrawal	Sleep deprivation
Hypoxia	Encephalitis	Drugs or alcohol use	Physical restraints
Hypercarbia	Subdural hemorrhage	Anticholinergics	Indwelling urinary catheter
Shock	Epidural hemorrhage	Sedative-hypnotics	Pain
Hypo/ hyperglycemia	Intracerebral hemorrhage	Opoids	Surgery or procedures
Hypo/ hyperthermia	Seizures/postictal state		
Trauma			
Acute myocardial infarction			
Electrolyte abnormalities			

7. What precipitating factors does this patient have? (age, hearing problems, sleeping problems, use of lorazepam and nortrilen)

8. What pharmacological treatment would you consider?
    i. Pharmacological: Mild delirium: 0.5mg-1mg haloperidol oral 1-2max. Severe delirium: give up to 7mg in 1-2 doses per day. Very severe delirium: 5-10mg intramuscular/intravenous
    ii. In case of Parkinson/lewy body: Clozapine 6,125 mg oral 1-3dd
9. What non-pharmacological treatment would you consider in the ED and what when she is hospitalised?
    a. Provide day-night rhythm, clock, calendar, glasses, hearing aid, quiet environment, calm and clear approach of the patient, talk calmly, don't make any unexpected noises or sounds. Comfort patient and family, involve family. Make sure patient receives enough fluids and food. Look for signals that could stimulate confusion -> full bladder, obstipation, pain, itch. Prevent further injury, in extreme cases limitation of freedom with restraints.
10. Prevention of delirium -> do you test for cognitive impairment in the ED? Do you start preventive measures in the ED?
11. What model of care do you have in the ED? Do you work with a multidisciplinary approach? Is the geriatrician involved?

Sample Case Outcome:

The chest x-ray shows an infiltrate on the lower left lobe. CRP is 60. You diagnose pneumonia and admit her to the hospital. You start non pharmacological measures and start 1mg haloperidol oral 2 times a day. You give her penicillin for her pneumonia.

Pain Management

Format:

25-minute table-top discussion

Requirements:

Laptop/tablet with PPT slides.

Resources: (both for faculty and as extra-reading resources for candidates)

https://www.gloshospitals.nhs.uk/media/documents/Abbey_pain_scale.pdf

https://www.britishpainsociety.org/static/uploads/resources/files/book_pain_older_people.pdf

https://geriatricpain.org/painad

https://www.uptodate.com/contents/treatment-of-persistent-pain-in-older-adults

http://www.bgs.org.uk/pdfs/pain/age_ageing_pain_supplement.pdf

Objectives:

1. Learn to recognise pain in older people with cognitive impairment
2. Understand how to weight risk-benefit of medications.
3. Understand principals of dosing in those with kidney disease or low body weight
4. Be aware of the role of atypical analgesics and specific conditions they can be used for
5. Understand role of chronic pain teams and palliative medicine in managing pain

Common candidate questions / diversions:

Pain medications do differ from one country to another so focus on principles of management

Facilitation of Table-Top Discussion

Below is a sample 20 minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Introduction	1-2 mins	Introduction and establish ideas of group around pain management ((Importance of topic, how common it is- 50% > 65 have pain, 45-83% of patients in care have at least one painful problem)
Read through case	5 mins	Use sample case - PPT slides
Facilitate Discussion	12 mins	Use sample questions (PPT) to open discussion or – see notes below

Case:

Initial information:

Name: *Edna Jones*

Age: *79*

Presenting complaint: *lower back pain, nausea, abdominal distention*

PMHx:

- *CKD2*
- *Controlled hypertension*
- *Previous stroke – expressive dysphasia*
- *Osteoarthritis - knees*
- *Fibromyalgia*

Medication:

- *Aspirin*
- *Bisoprolol*
- *Amlodipine*
- *Simvastatin*
- *Citalopram*
- *Co-codamol 8/500mg*
- *Ferrous fumarate*

Social history:

Lives alone in a 3 bedroomed flat

Stairlift

Carers twice per day for washing and medication

Can walk 2-3 metres due to knee and lower back pain

Weight *52 kg*

Discussion point 1: How will you assess Mrs Jones's pain? Location, chronicity and severity?

Learning point 1: Pain map, Numeric pain scale, Abbey pain scale, pain thermometer

https://www.britishpainsociety.org/static/uploads/resources/files/book_pain_older_people.pdf

Many will volunteer that they score pain 1-10, some may mention pain maps or visual scores all of which may be useful.

If not volunteered discuss behaviour scores e.g PAINAD – (pain in Alzheimer's disease) developed in the USA - behavioural score or Abbey pain score. Both of these also give a result out of 10 making communication of pain score clear.

Further history:

Mrs Jones has had unchanged bilateral knee pain and lower back ache for several years, following a fall three months ago she was started on oral co-codamol 8/500mg as required. Her carers changed last week, and her medicines chart show she has received 8 tablets per day.

Discussion point 2: What is worrying about Mrs Jones' presentation, medication and social history?

Learning points 2:

The possibility of serious illness should be considered. Look for red flags for Cancer / AAA.

Weight based dosing – lots medications not licensed for people <50Kg, weight-based toxicity, side effects of medication such as constipation can increase chronic pain.

Safeguarding issues around medication, new carers.

Diagnosis is Constipation with Delirium.

Further examination and tests

Mrs Jones' examination is mostly normal, there is a soft fullness in the left iliac fossa, some hard stool in her rectum but her bloods are essentially normal apart from a slightly chronically raised urea and creatinine (7 and 70). And abdominal xray performed from triage shows an old wedge fracture of L3.

Discussion point 3: How will you manage Mrs Jones?

Learning point 3: Remember to think about treating the cause of the symptoms, rather than given extra analgesia. Discuss risk versus benefit of paracetamol, NSAIDs, weak opiates, strong opiates, parenteral analgesia

- Paracetamol
- NSAIDS and COX-2 inhibitors. Topical NSAIDs - should be well tolerated in CKD, just need to be monitored
- Weak opiates and side effects – reduce dose by 25% - 50%
- Strong opiates maybe better parenterally or in modified release preparations. Buprenorphine increases the risk of opiate withdrawal when given with Morphine. Topical

fentanyl or oxycodone may be better tolerated but oxycodone has 7 times increased risk of constipation.

- Consider Joint injection, knee replacement… role of the pain team

Other things that might come up

- "Observation unit" / Short stay unit – keeping someone to for up to 24 hours for observation and to initiate treatment
- Role of functional assessment
- Constipation - enema and oral laxatives
- Bracing - difficult in low weight; what you are achieving (if mobilising without, not shown benefit to reduce pain)

Discharge planning: ***As you plan to discharge her with appropriate analgesia, her daughter mentions if she should still take the night time special pain killer for restless legs?***

Discussion point 4: Use of atypical analgesics in older patients

The "special medication" may be a sleeping tablet, herbal or unprescribed medication. If the pain is bad enough, patient can have tried anything - Worth bearing in mind side effects of atypical analgesics.

Learning point 4: Side effects of atypical analgesics

- TCAs = urinary retention, postural hypotension, cardiac arrhythmias. 1 in 5 stop due to adverse effects
- SSRI/SNRI = minimal evidence base but duloxetine has shown efficacy for neuropathic pain, especially diabetic
- Anti epileptics = older medication such as carbamazepine and phenytoin have central adverse events and require blood monitoring. Newer phenytoin and gabapentin have shown efficacy and fewer side effects.
- Topical NSAIDs have been demonstrated in several studies as efficacious in none neuropathic pain.

Discussion point 5: Mrs Jones asks about specialist follow up for her pain, and any interventions?

Learning point 5:

- Referral to chronic pain teams may help
- Corticosteroid injections give short term relief
- Physio, exercise and CBT have shown to help chronic pain
- Vertebroplasty for painful acute vertebral fractures

We have the pain and constipation managed, temporarily we have a plan. Not all referrals need to happen from ED - consider from who in the community could coordinate care.

Social prescription; keeping mobile.

MDT - Physiotherapy, geriatric falls clinic, pain team, OT, GP, Acupuncture, CBT.

Ask 'What do you have in your own countries'?

Learning points

- 50% aged >65 have pain, 45-83% of patients in care have at least one painful problem
- Assessing pain can be difficult, especially in patients with a cognitive or communication impairment (Various pain scores exist: pain body map, numeric rating scale, pain thermometer, abbey pain scale)
- Most patients will present with nociceptive pain secondary to osteoarthritis, soft tissue pain and visceral pathology
- Detecting neuropathic pain is essential as management differs
- Attempt non-pharmacological treatments first (physio, acupuncture, CBT)
- Try to avoid opioids and opiates, start low and go slow (dose reduced by 25% in 60 year old, 50% in 80 year old)
- Topical analgesics have lower systemic adverse effects
- Regular pain assessments are key
- If discharging with opiates give bowel protection

Abdominal pain

Format:

25-minute simulation scenario

Requirements:

Laptop/tablet with slides.

Role player to receive briefing before sessions:

Resources: (both for faculty and as extra-reading resources for candidates)

Diagnosis of acute abdominal pain in older patients. Am Fam Physician. 2006; 74(9): 1537-1544

Objectives:

1. Identify causes of abdominal pain in older adults
2. Use of investigations like ultrasound and CT in diagnosing AAA

Common candidate questions / diversions:

- Urine analysis and renal colic
- Ultrasound or CT for diagnosing AAA

Facilitating the session

Below is a sample 25-minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Introduction	1-2 mins	The scenario session focuses on the assessment and management of abdominal pain in older people presenting to the ED
Patient encounter	4 min	Introduce the role player. Invite the candidates to take a short focussed history – it will quickly become evident that little information is available.
Discussing a Person centred plan	5 mins	Invite recommendations for interventions from the candidates. Discuss the benefits and drawbacks of interventions such as CT imaging or admission. Invite the candidates to ask the simulated patient what they think.
Summary	15 mins	Discussion on differential diagnosis of abdominal pain and rationale for different approaches Use slides to structure wrap-up of key learning points

10 minute scenario

This 76-year old Mr Cleaver is brought in to your emergency department with his wife. He is send by his General Practitioner who first gave him some diclofenac. Mr Cleaver has acute abdominal pain since a couple of hours.

P/C: Pain started 2h ago, at home, sitting in garden. Sudden severe abdominal pain in lower abdomen, radiation to flank and right groin. Pain comes and goes. Nausea +, vomiting -. Normal stool, normal urination without pain.

PMHx:

- Hypertension
- chronic kidney failure,
- diverticulitis,
- cataract

(if asked: no kidney stones in history)

Medication:

- metoprolol,
- furosemide,
- simvastatine,
- ascal,
- colecalciferol

Allergies – Social Hx: Smoking +

Examination: Painful man, restless, adequate response to questions

A: non-obstructed airway

B: Respiratory Rate 20/min. Saturation 95% without Oxygen. Normal and symmetric respiratory breaths.

C: Capillary refill time 2 sec. Pulse 80/min. Blood pressure 105/80. Normal cor sounds, no souffles. Cold extremities.

Adipose belly, no peritoneal irritation, no rigidity, pain poorly localised by patient in lower abdomen. Pulsations in groin +/+

D: EMV 15, Glucose 5.5

E: Temperature 37.5 degrees

Investigations:

Lab: Hb 8.0, Lactate 10.7, eGFR 28

Urine: microscopic haematuria

(may indicate kidney stone or may accompany a ruptured aortic aneurysm)

Ultrasonography: kidney, ureter and bladder normal, no kidney stones.

(Ask audience: should we ask the radiologist to examine other parts of the abdomen? ⍰ aorta not visible due to air in intestines)

CT scan: *(Ask audience: should we first pre-hydrate the patient with an eGFR of 28?)*

Some free fluid in abdomen. Contained rupture of abdominal aortic aneurysm, infrarenal

15 minutes background

Background AAA

Up to 10% of men older than 65 years will be diagnosed with an abdominal aortic aneurysm. Age is the greatest risk factor. Other risk factors: male gender, smoking, positive family history, coronary artery disease, hypercholesterolemia, hypertension and atherosclerosis.

Classic portrait of ruptured AAA is an older patient who presents with back pain/associated abdominal pain, hypotension and a pulsatile abdominal mass.

- Hypotension is absent in nearly 65% of cases
- Palpable mass is absent in 25% of cases

30% of AAAs are missed on initial presentation

The most common misdiagnosis of ruptured AAA is renal colic. Many of the signs and symptoms of these two disorders overlap: flank pain that may radiate to the groin accompanied by microscopic haematuria from the AAA irritating the ureter.

Rule: new-onset kidney stones after age of 50? = imaging of the aorta before discharge, either by ultrasound or CT.

Consequence of missed AAA is significant, mortality in up to 90% of patients.

Ultrasound is first choice of imaging for AAA: sensitivity 95%, specificity 100%. Good for detection of intra-abdominal free fluid and size of the abdominal aorta, but may not be able to determine aneurysm rupture.

CT scan has a sensitivity and specificity of approximately 100%.

Given the high prevalence of atherosclerosis in this population, vascular catastrophes should always be considered early in work-up:

- Ruptured abdominal aortic aneurysm
- Acute mesenteric ischemia

Other common diagnoses:

- Bowel obstructions
  - Small bowel obstruction
  - Large bowel obstruction – cancer, volvulus
- Diverticulitis
- Peptic ulcer disease

Less common:

- Biliary tract disease (acute cholecystitis)
- Pancreatitis
- Diverticular disease
- Appendicitis is challenging: classic triad only present in 20% of older patients!

Extra abdominal causes of abdominal pain:

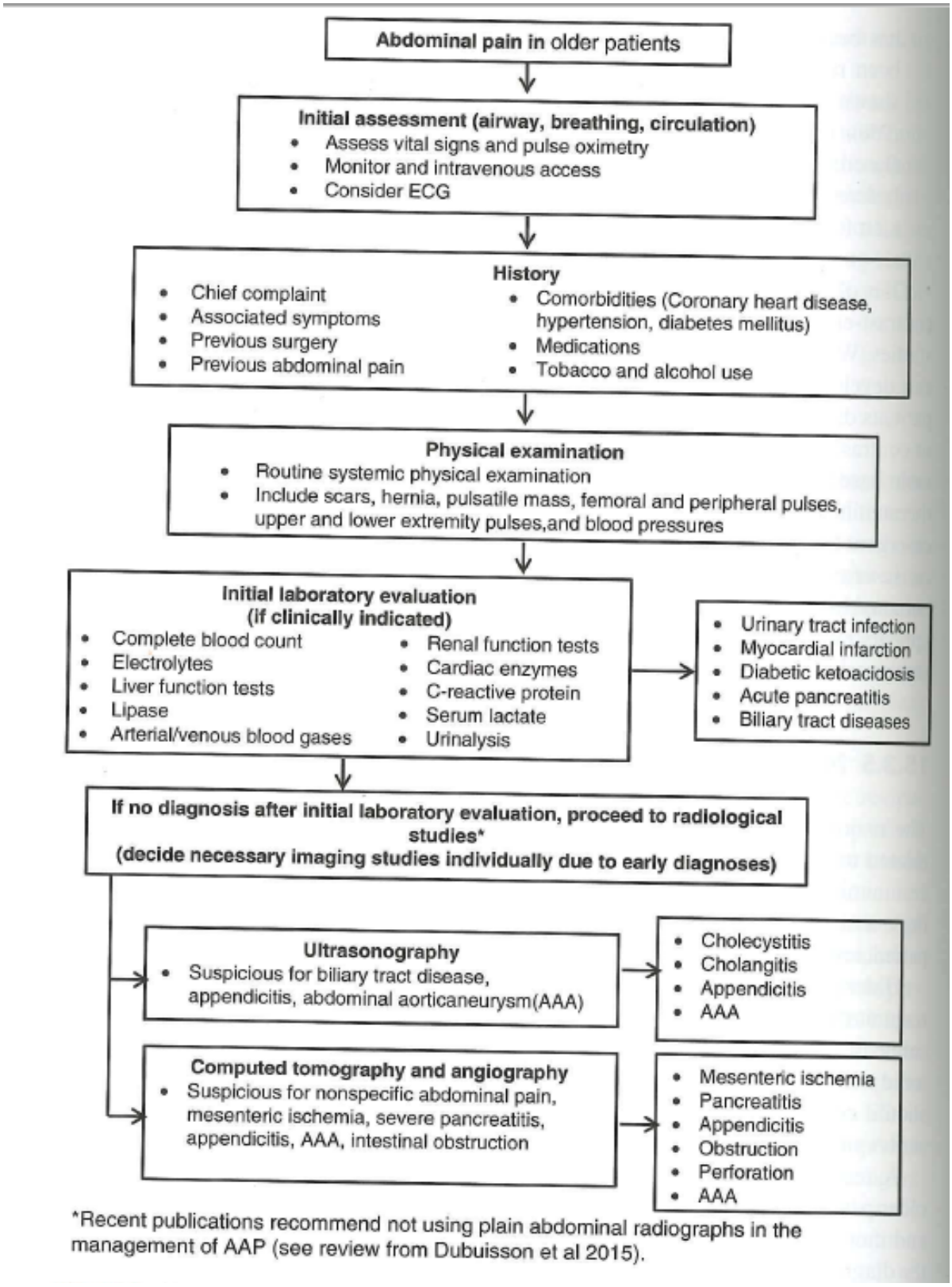
Broad differential list; one of the most serious causes is cardiac

* don't forget myocardial infarction

Table 3
Extra-abdominal causes of abdominal pain in the elderly

Cardiac	Myocardial infarction, pericarditis, heart failure
Pulmonary	Lower lobe pneumonia, pneumothorax, pulmonary embolism
Metabolic	Diabetic ketoacidosis, adrenal insufficiency, hypercalcemia, uremia
Infectious	Herpes zoster, cellulitis, urinary tract infections
Genitourinary	Prostatitis, neurogenic bladder, uterine prolapse
Medication	Narcotic withdrawal, iron overdose, antibiotics
Hematologic	Acute leukemia, rectus sheath hematoma (anticoagulated patients)

Algorithm for acute abdominal pain management in older patients:



Syncope

Format:

25-minute discussion based on scenario

Requirements:

Laptop/tablet with slides.

Role player to receive briefing before sessions:
This is an older person who lives alone with mild dementia and uses warfarin. They have fallen backwards while reaching for something, but now they cannot remember what happened. They say they feel fine and are asking when they can go home.
The person will agree to what the candidates recommend, but is persistent about asking when they can go home and asking why interventions are being recommended – e.g. "what will that achieve?"

Resources: (both for faculty and as extra-reading resources for candidates)

ESC 2018 syncope guidelines: https://doi.org/10.1093/eurheartj/ehy037

Objectives:

1. Describe syncope
2. Recognise the limitations of guidelines applied to older people living with frailty
3. Apply evidence and person-centred assessment during shared decision-making

Common candidate questions / diversions:

There is often discomfort when the facilitator suggests the idea of not referring the patient for CT scan or not admitting them to hospital. Be prepared to discuss what these interventions might achieve (potentially something, potentially nothing!) and how they may or may not be in line with what the person would like.

Facilitating the session

Below is a sample 25-minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Introduction	1-2 mins	The scenario session shares an evidence based approach to evaluating and managing syncope. However, this might not suit the needs of our simulated patient, and so we will spend around half the session forming a person-centred plan.
Classification of syncope	3 mins	Use the slides to define, classify and risk-stratify syncope. The guidelines typically recommend admission (for observation) for people with high risk or without low risk features, so this may well be most older people living with frailty! Unexplained falls in older people should be treated as syncope.
Patient encounter	5 mins	Introduce the role player. Show the ambulance report card (in the slides) – this is an older person who lives alone with mild dementia and uses warfarin. They have fallen backwards while reaching for something, but now they cannot remember what happened. They say they feel fine and are asking when they can go home. Invite the candidates to take a short focused history – it will quickly become evident that little information is available.
Discussing a person-centred plan	8 mins	Invite recommendations for interventions from the candidates. Discuss the benefits and drawbacks of the proposed interventions such as CT imaging or admission. Invite the candidates to ask the simulated patient what they think. Explanation of automated measure of orthostatic hypotension: a small drop will be measured too late by the machine. The advice is to measure it by hand or ask if the patient gets symptomatic when standing. Form a person-centred plan and agree the decision with the simulated patient.
Summary	2 mins	Evidence and guidelines often do not represent older people living with frailty and so we need to apply person-centredness to reach an appropriate plan. This can be uncomfortable: if in any doubt, remember to involve relatives and consider discussing with hospitalist specialists around what various options may achieve.

Polypharmacy

Format:

25-minute table-top discussion

Requirements:

Laptop/tablet with PPT slides.

Resources: (both for faculty and as extra-reading resources for candidates)

http://www.polypharmacy.scot.nhs.uk/about/

http://www.acbcalc.com/

http://www.medstopper.com/

http://ageing.oxfordjournals.org/content/early/2014/10/16/ageing.afu145.full.pdf+html

Objectives:

1. Recognise the difference between Inappropriate versus appropriate prescribing.
2. Recognise that adverse drug reactions and drug-drug interactions are common.
3. Note the limitations of doing medicines reconciliation in the ED.
4. Medication rationalisation should be a patient centred discussion.
5. Be familiar with tools to assist deprescribing.

Common candidate questions / diversions:

Often there is a discussion around the number of medications verses appropriate medications – you may need to limit this.

You will need to explain that it is a complex topic - they won't be a pharmacist at the end of this session, they won't feel comfortable to completely deprescribe, but we'll suggest an approach.

Facilitation of Table-Top Discussion

Below is a sample 25-minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Introduction	1-2 mins	Introduction and establish ideas of group around polypharmacy
Read through case	5 mins	Use sample case - PPT slides and script below
Facilitate Discussion	12 mins	Use sample questions (PPT) to open discussion or – see notes below

Polypharmacy table top discussion

Initial information:

Name: Mrs Smith

Age: 85

PC: Attends with daughter: Confused and drowsy for 28 hours with reduced oral intake

PMHx:

- Cardiac failure
- Atrial fibrillation
- CKD stage 3
- Stroke
- Rheumatoid Arthritis
- Hypertension
- Duodenal ulcer

Discussion point 1: With Mrs Smith's known medical history, which list of drugs is more concerning?

List A:	List B
Edoxaban	Edoxaban
Celecoxib	Bisoprolol
Prednisolone	Ramipril
	Sulfasalazine
	Digoxin
	Furosemide
	Paracetamol
	Buprenorphine patch

Learning point: Inappropriate versus appropriate more useful than numbers based definition.

Further information becomes available:

The cardiac nurse specialist saw Mrs Smith 5 days ago and doubled her dose of furosemide. Her GP recently increased her dose of digoxin 1 week ago on the advice of a discharge summary from the local hospital (which was 7 weeks late in arriving)

Bloods available:

Urea	24
Creatinine	350 (baseline 180)
Sodium	130
Potassium	1.9
Digoxin level	6.5

Discussion point 2: What has happened? Mrs Smith has presented confused and drowsy with symptoms suggestive of digoxin toxicity (precipitated by hypokalaemia induced by the furosemide)

Fair to discuss hydration and management strategies here but keep focus on medication side effects and reactions.

Learning points:

Frail older adults are often under multiple specialists, communication between providers can be poor - very high risk for Drug Drug Interactions (DDIs).

DDI and Adverse Drug Reaction (ADR) are a common cause of attendance and admission and this increases with every additional medications

Medicines reconciliation in the ED is important but remember you are likely to be working with incomplete information

Further information:

She becomes very agitated and is given diazepam. What sort of dose should she get?

Discussion point: 3: Ageing physiology affects drug metabolism, distribution, bioavailability and clearance

- Increased fat:protein ratio: increased bioavailability of lipid soluble drugs (benzos) and decreased bioavailable of water soluble drugs
- Hypoalbuminaemia causes reduced bioavailability of protein bound drugs
- Reduced hepatic and renal blood flow affects clearance and metabolism

Reasonable to allow discussion on merits of choosing a benzodiazepine here – will be covered more in the delirium session.

Learning point: Start low, go slow is a good approach for prescribing ANYTHING in an older person living with frailty.

Additional discussion /learning points:

Drugs to avoid and consider stopping:

- Benzodiazepines
- ANYthing beginning with Z
- Compound analgesics
- Tramadol

Drugs that should always be given (and sourced out of hours if necessary) if the patient is normally on them:

- Dementia drugs
- Parkinsons medications
- Antipsychotics

Medication rationalisation should be a patient centred and informed discussion. STOPP/START criteria exist but not ED friendly.

Additional points regarding the slide resources

- NHS ScotlandManageMeds https://www.alliance-scotland.org.uk/blog/news/manage-medicines-a-new-toolkit-for-polypharmacy-patients-and-carers/
- deprescribing.org App
- Medstopper can give pictorial version of meds (US based so not all European meds on it).
- ACB calc can be helpful if unsure if a medication may be contributing to cholinergic burden.
  - Lots of drugs you won't expect cause ACB
  - Furosemide, Warfarin, Digoxin, Prednisolone.
  - The burden score - how likely it is to cause confusion-you don't need a very high score to become clinically significant.
  - Drugs interact with each other and increase the score. This lady has a baseline high burden on her cognitive ability.

Key points demonstrated by the case and hopefully discussed over the course of the tabletop

1. Inappropriate versus appropriate more useful than numbers based definition
2. ADRs and DDI are common cause of ED attendance and admission in older people
3. Medicines rec in the ED is important but remember you are likely to be working with incomplete information
4. Start low, go slow is a good approach for prescribing ANYTHING in a frail older person.
5. Medication rationalisation should be a patient centred discussion and tools exist to help with this.

End-of-life care

Format:
25-minute table-top discussion

Requirements:
Laptop/tablet with PPT slides.

Helpful to have some handouts: see resources below, and in particular:

https://www.marymount.ie/wp-content/uploads/2020/06/Non-Pharmacological-Care-of-Dying-V5.pdf

https://www.marymount.ie/wp-content/uploads/2020/06/Anticipatory-Prescribing-V4.pdf

Resources: (both for faculty and as extra-reading resources for candidates)
https://posters.geriemeurope.eu/posters/p08/

https://eusem.org/wp-content/uploads/2017/10/EuSEM-Recommendations-End-of-life-care-in-EDs-September2017.pdf

https://www.bgs.org.uk/resources/end-of-life-care-in-frailty-urgent-care-needs

https://iaem.ie/wp-content/uploads/2020/09/IAEM-CLINICAL-GUIDELINE-EOL.pdf

https://www.marymount.ie/support-hub-for-healthcare-professionals/end-of-life-covid-19-resources/

Objectives:
1. Can we recognise natural dying? Explain 4 main “dying trajectories”. (geriemeurope poster)

2. How comfortable do you feel speaking with a patient or their relevant people about uncertain prognosis - “I think you/they may be sick enough to die”?

3. How comfortable are you prescribing for patient comfort “palliative care’?

Note: **Need to be cognisant that different cultures / societal norms within Europe mean that candidates will have very varied experiences of End of Life Care. (Prospective decisions to withhold cardio-pulmonary resuscitation (CPR) are allowed in some European countries, whilst in other countries or religions the withholding of CPR is not allowed or is illegal)

Common candidate questions / diversions:
“These patients should be cared for in the community / These decisions should be made pre-hospital”…

Note: This is a GEM course - i.e. related to providing better Geriatric Emergency Medicine care. We can only improve care in the context of where **we** provide it.

Use dying trajectories slide to show that the vast majority of patients with frailty do die in the community / without requiring EM care. The patients we see in the emergency dept (or pre-hospital or inpatient services, depending on their working context) are those patients who have slipped through those nets and we are here to talk about **our own comfort with providing EOLC in our own working context**.

Facilitation of Table-Top Discussion

Below is a sample 25- minute discussion. The clinical case and questions each facilitator uses can be adapted to the country and experience of the candidates; provided that the above objectives are included.

	Time	Resources
Introduction	1-2 mins	Let candidates know that the workshop is looking at providing EOLC to patients. Remind candidates "You only have one chance to get it right". Acknowledge varied practice and legality of DNARs in different countries. We're going to talk through a patient scenario. I'll read the scenario to you and then we can talk about - whether you can recognise this as a common scenario; could anything have been done differently; any changes you could have made.
Read through case	5 mins	Use sample case - PPT slides
Facilitate Discussion	12 mins	Use sample questions (PPT) to open discussion or consider questions below. Other avenues to facilitate discussion on (bringing back to physician comfort in EOLC): What does a good death look like? - patient's wishes and preferences. Is the Emergency Dept the correct place to initiate EOLC?

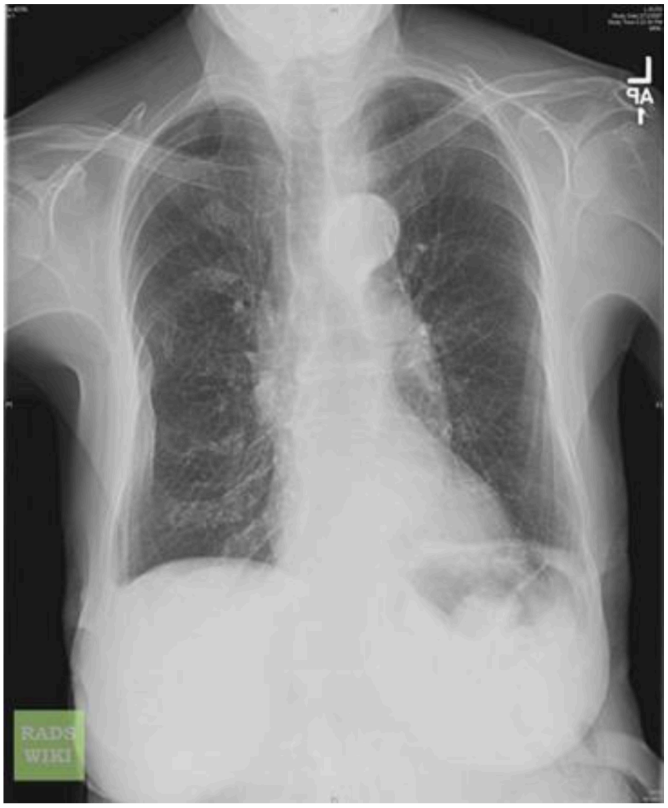
Ethel was an 84 year old lady who had been treated at her nursing home by her GP for increasing breathlessness over about a week or so. The nursing home staff were worried about her as she did not seem to be improving despite oral antibiotics. She was still breathless and just not her usual self. Although she had advanced dementia, requiring help with all activities of daily living, she was more drowsy and requiring more help than usual, for example with eating and drinking.

The nursing home called the surgery at 4pm, but the duty doctor was already booked up and so they were advised to send Ethel into the ED for further assessment. The ambulance crew arrived at about 5pm, and found her to be drowsy and uncommunicative. The initial assessment revealed GCS 13, pulse 104, BP 90/50, SaO2 87%, respiratory rate 28, chest clear, abdomen soft. Oxygen was administered, along with iv fluids and she was conveyed to hospital.

In assessment bay, sepsis was diagnosed, iv Meropenem started, fluids continued and investigations showed:

Blood gases showed:

pH	7.367	
pCO_2	5.53	kPa
pO_2	7.00	kPa
cNa^+	137	mmol/L
cK^+	3.9	mmol/L
cCrea	98	µmol/l
cCa^{2+}	1.22	mmol/L
cCl^-	106	mmol/L
cGlu	5.1	mmol/L
cLac	3.3	mmol/L
ctHb	149	g/L
FCOHb	3.8	%
FMetHb	0.7	%
sO_2	86.2	%
$cBase(Ecf)_c$	-1.3	mmol/L
$cHCO_3^-(P,st)_c$	22.9	mmol/L



History continued

She was referred to the Acute Frailty Unit, where she arrived at 1am. Her oxygen levels had improved with 28% oxygen which she was keeping on – saturations now 94%. Blood pressure had improved to 110 systolic, but pulse still around 100; she remained drowsy and it proved difficult to elicit additional information from her.

The assessing doctor called the nursing home, but the duty nurse was banking and did not know Ethel very well. She advised the doctor to read the care plan that was with her. The care plan described Ethel's deterioration over recent months, to a point where she was fully dependant, bed-bound, doubly incontinence, but still usually able to eat with prompting. She was unable to make any high level choices.

Although there was a DNACPR order in place, there was little additional information about her wishes and preferences, although her daughter was mentioned as next of kin.

By the time of the consultant ward round at about 8.30am, Ethel was little changed – essentially stable. He bloods showed little additional information other than a WCC of 11.4 and a CRP of 24. The antibiotics were continued and she was transferred to a base ward.

Ethel died in hospital a few days later. Her daughter was with her when she died. Ethel was comfortable, well cared for, pain free. Her daughter expressed her thanks to the team for the care they had provided. A post mortem was not undertaken and the death certificate was issued as 1a Community acquired pneumonia, 2 dementia.

Sample Questions

1. Was this a good end of life experience for Ethel?
2. What could have been done differently in the nursing home, by the ambulance crew, in the ED or in the frailty unit?
3. Do you agree with the death certificate?
4. How much of this was predictable?

Summary and close

Closing the course

- Use the summary slides to capture the main points
- Check with your attendees that you have addressed all of the stated objectives and ensure that all questions have been addressed.
- Establish if there are any outstanding questions/concerns.
- Provide information on where additional resources are available.
- Collect evaluation forms - either paper or digitally - best evaluation will be given directly after the course, don't delay.
- Thank your attendees for their input and contribution to the workshop.
- As workshop facilitator you will also complete a self-reflection immediately following the workshop to reflect on what went well and any learning for next time.

After the workshop

First pat yourself on the back! Workshops can be quite intense, but after you've had some time to rest and re-energise, it's time to pick up where you left off and carry on with the process.

1. Openly review your evaluations; consider how you can improve your next course.

While it's always great to receive positive feedback from your evaluations; negative, critical or constructive feedback can actually have a much bigger impact on improving courses moving forward.

2. Provide certificate of attendance

Provide a certificate of attendance to all participants and thank them for their participation and interest.

3. Paint the big picture and communicate progress

You can reach out to the participants and continue to support and guide them in their day to day role. By making sure that every single one of the participants has anchored some personal meaning to the process, you're likely to see much better results.

Keep people engaged by sending them reminders and any updates received that help them stay focused; remember this part is crucial because it's where most of the actual work happens.

Post training checklist

No	Checklist	Completed Yes/NO	Comment
1	Review evaluations and identify learning for future workshops		
2	Circulate certificates of attendance – see samples		
3	Follow up on any actions agreed – e.g. circulation of resource materials		
4	Complete your own facilitator self-reflection following delivery of this workshop and consider any actions / changes required prior to future delivery		

Appendixes

Appendix 1: Sample timetable

GEM course				
Time	**Topic**	**Faculty**	**2nd**	**Volunteer**
07:45-08:30	Faculty meeting & room preparation	All faculty		
08:30 - 08:40	General introduction (program, general notices)	Director		
08:40 - 09:00	General introduction into GEM (frailty)	Faculty 1		
09:00-10:40	Working groups 4x25 minutes – groups of 6			
	Station 1: scenario older trauma patient	Faculty 1	+/-	+
	Station 2: scenario older patient with sepsis	Faculty 2	5	+
	Station 3: Table top discussion: delirium/ cognitive impairment	Faculty 3	+/-	
	Station 4: Table top discussion: pain management	Faculty 4	+/-	
10:40-11:00	Coffee break			
11:00-12:40	Working groups 4x25 minutes			
	Station 1: Scenario older patient with abdominal pain	Faculty 1	5	+
	Station 2: Scenario older patient with syncope	Faculty 2	+/-	
	Station 3: Table top discussion: polypharmacy	Faculty 3	+/-	
	Station 4: Table top discussion: end of life care in the ED	Faculty 4	+/-	
12:40-12:50	Summary of key-learning points	All faculty		
12:50-12:55	Closing & evaluation	Director		

Appendix 2: Sample ways of working (ground rules) for training

What are ways of working?

Ways of working articulate a set of expected behaviours for group conduct. They can be set up by the facilitator or by the participants themselves

It is important that Ways of working are established and agreed at the beginning of the training module. The facilitator should explain the purpose they serve to support full participation by all participants while ensuring that respect and dignity are maintained. It is important that all course participants agree the ways of working.

Additions or changes to the ground rules can only be made with the consensus of the group and facilitator(s).

Suggested ways of working:

1. Punctuality:

- Arrive on time for training and return on time from coffee break and lunch break.
- Arriving late is a sign of disrespect to your colleagues and to your trainers.

2. No Disturbances:

- Mobile phones to be turned off or put on silent mode for the duration of training.
- Avoid side conversations: If you are unsure of anything being discussed in training please ask the trainer to clarify.
- Laptops may be used for legitimate training activities i.e. note taking and should not be used for any other purposes during training.

3. Dignity and Respect:

- Respect other course participants and the trainer(s).
- Do not interrupt others when they are speaking.
- Listen actively.
- No hostility or personal attack.
- No strong language.
- Encourage free expression of thoughts, views and opinions.
- No monopolising.
- Agree to disagree: Respect others views and opinions and have an understanding and acceptance that there will be differences in opinion. Challenging/disagreeing is welcome but should be conducted respectfully. Critique ideas/opinions and not the person delivering them.
- Discussions should be open and frank and should not be seen as personal attack.

4. Confidentiality:

- All participants bring a wealth of experience to the training.
- Matters discussed in training specifically relating to individual experiences/case histories must be regarded as confidential and must not be discussed outside of the training programme.

5. Audience Participation:

- Training will only be effective if there is audience participation and if there is a two way process between the trainer(s) and course participants..
- Success will be dependent on the inclusion of every individual view.
- The course participants bring a wealth of knowledge to the training and therefore contribute significantly to the course content.
- Everyone should be given an opportunity and encouraged to contribute to the training.

6. Ask Questions:

- All questions, however trivial they may appear to you, are important so don't be afraid to ask.
- If you have difficulty asking a question in the group please ask a trainer during break time.
- If the question is related to something that will be covered later in training agree to "park" the question and make a note on the flipchart to remind the trainer of all questions asked to ensure they have been addressed at the end of the training.

7. Follow the Agenda:

- The trainer(s) will endeavour to stick to the agenda as set for the programme as far as is reasonably practicable.
- The use of the "Park Questions" resource will be utilised to support this.
- Audience participants should co-operate also in sticking to the agenda as far as is reasonably practicable.
- It is inevitable that there will be some divergence from the main topic which will be managed within allocated time resources.

8. Provide honest feedback:

- At the end of the programme you will be asked to complete an evaluation form.
- It is important that you are honest in your evaluation as your evaluation will influence future training programmes and can be used to improve future training.
- Constructive criticism is important and appreciated as it is the only way we can improve this programme.

Appendix 3: Training checklists

Pre training checklist

No	Checklist	Completed Yes/NO	Comment
1	Agree training schedule locally		
2.	Identify link person to liaise with in relation to the training in the relevant organisation.		
3	Seek co-trainers well in advance.		
4	Arrange suitable venue.		
5	Arrange refreshments as appropriate.		
6	Advertise, e.g. send out fliers well in advance of training. Consider asking senior management to send out an email in advance of the training to all services to promote the training and request that staff are released to attend.		
7	Apply for CPD credits for the Geriatric Emergency Medicine workshop well in advance of the training (or your link person in organisation may arrange)		
8	Prepare workshop information pack and power point presentations		
9	Have equipment: Laptop, projector (+/- flip chart) Name labels, Pens, paper Establish IT set up arrangements at the venue Sim set up on phone-tablet (e.g. simpl sim) Simulation ABCDE equipment		
10	Manage registration for workshops		
11	Organise a sign in/attendance sheet		
12	Prepare attendance certificates in advance – will save administration time later		
13	QR link or printed evaluation forms		

Post training checklist

No	Checklist	Completed Yes/NO	Comment
1	Review evaluations and identify learning for future workshops		
2	Circulate certificates of attendance – see samples		
3	Follow up on any actions agreed – e.g. circulation of resource materials		
4	Complete your own facilitator self-reflection following delivery of this workshop and consider any actions / changes required prior to future delivery		

Appendix 4: Facilitator Guidance

5 THINGS FACILITATORS CAN DO WHEN CONVERSATIONS GET HOT

January 4, 2021

Blog by Meg Griffiths Associate and the Assistant Director of Programs at Essential Partners.

https://whatisessential.org/5-things-facilitators-can-do-when-conversations-get-hot

When I'm working with new facilitators, one of the most common questions I get is some version of, "What do I do when things go off the rails?"

This question is often rooted in fear and worst case scenario thinking. But there are also times when that question is rooted in a particular experience of destructive or dysfunctional communication patterns. Perhaps you've witnessed it happen in your own classroom or staff meeting and you've felt stuck, unsure of how to proceed, repair the harm done, and keep the group moving forward together.

In our work, we think of ourselves as designers first and facilitators second. We believe that 80% of the work of dialogue must happen before people enter the room, following the old adage that an ounce of prevention is worth a pound of cure. If you have designed a conversation carefully, prepared the participants and yourself thoughtfully, and designed and implemented the structures and processes necessary to achieve your purposes, then the *need* for intervention will be minimal.

And yet—even with all that prevention—things can still go sideways. Someone might slip up on a ground rule or go off on a tangent. A participant might speak in a way that feels presumptuous or disrespectful to others. The conversation might unfold in such a way that one participant feels attacked by another, even if that wasn't the speaker's intention. What can facilitators do to get the conversation back on track?

Here are five tried-and-true practices to reach for when you need to intervene.

1. SLOW THINGS DOWN

Neuroscience studies tell us that when we perceive a threat, it takes just one-fifth of a second for the thinking part of our brain to shut down. As a result, we lose access to our inner resources, or, as our colleague Dave Joseph puts it, "conflict de-skills us."

We can counteract that neurobiological response by slowing things down, taking a few deep breaths, and even taking a time-out from the situation for a few minutes.

Suggesting 2-5 minutes for individual reflection and writing can help participants process what they are thinking and feeling in a constructive way. It can also allow you, as the facilitator, a few moments to collect your own thoughts and discern what the best next step might be for the group.

2. TRANSPARENTLY MANAGE THE DILEMMA

A facilitator doesn't have to have all the answers. You don’t need to solve the group’s problems on your own in the moment.

When the conversation gets stuck or heats up, simply naming what you observe can help the group look at it from a more detached or objective perspective. Participants can also play an important role in determining how to move forward.

You might say, “I’m feeling a little stuck right now. I’m noticing that there is a lot of emotion in the room and I wonder if others notice it too.”

Inviting the group to notice their own internal and interpersonal dynamics—and the ways in which they may have slipped into old, unhelpful patterns of communication—can be a powerful first step in managing this moment together.

3. STAY ROOTED IN PURPOSE

It’s helpful to name the purposes for this dialogue, to help the participants—and yourself—reground yourselves in the stated goal.

Frequently, the reason that a conversation gets out of hand is because people forget, in the course of the discussion, that their goal is to find mutual understanding, to hear one another, and to be truly heard. It’s natural for people to slip back into old habits and patterns.

A gentle reminder can help people find their way back into the space of dialogue.

4. ASK QUESTIONS

A good question can help people get unstuck. When things get hot, pause the conversation and invite the group to answer some reflective questions that might prepare them to re-enter the dialogue either in the moment or at a later time. Some examples include:

- How have you been impacted by the conversation?
- What do you wish people knew about your thinking or feelings about this issue?
- What question do you wish you could ask right now, but don’t feel like you can?
- What question do you wish someone else would ask you?
- Where are you feeling stuck in this conversation? Why?
- What do you need to bring forward or hold back in yourself in order to re-engage?
- What do you need from others, including the facilitator, in order to re-engage?

5. BE COMPASSIONATE (WITH OTHERS AND YOURSELF!)

It's unproductive for interventions to feel like a reprimand or a judgment, particularly in response to an individual's comments or behaviour.

To avoid that, focus on the behaviour and its impact, not on the person or people involved. Speak with care and express compassion. Stay curious as well. Don't assume that you know the person's intention, even if you know the impact.

Finally, practice some self-compassion as well. This work can be messy and challenging. You won't always have the right words. You won't always know the best way to intervene. If your intervention falls short, grant yourself the same compassion you would a participant, get curious, and try again.