



**College of Intensive Care Medicine
of Australia and New Zealand**
ABN: 16 134 292 103

**INTENSIVE CARE SPECIALIST PRACTICE
IN HOSPITALS ACCREDITED FOR TRAINING
IN INTENSIVE CARE MEDICINE**

1. PREAMBLE

These guidelines have been developed to outline the expectations of the College of Intensive Care Medicine with regard to specialist practice in Intensive Care Units accredited for training. They should be read in conjunction with other College Documents and regulations.

2. THE DUTIES OF AN INTENSIVE CARE SPECIALIST

2.1 *Clinical Duties include:*

- 2.1.1 Providing care and assuming responsibility for patients in the intensive care unit and, where appropriate, a co-located high dependency unit.
- 2.1.2 Supervising medical staff including trainees in the intensive care unit and, where appropriate, in a co-located high dependency unit.
- 2.1.3 Being available to medical colleagues for consultation and liaison as appropriate regarding patient care.
- 2.1.4 Being immediately available for urgent consultation and assistance in the resuscitation and subsequent management of critically ill or injured patients.

The intensive care specialist may also be responsible for providing or facilitating:

- 2.1.5 Acute resuscitation in the context of cardiac arrest, trauma and other medical and surgical emergencies.
- 2.1.6 Transport of critically ill patients.

- 2.1.7 Parenteral nutrition and or venous access services to patients in other areas of the hospital.
- 2.1.8 Advice to hospital management and to other bodies outside the hospital (eg. professional and regulatory bodies) on clinical and other matters relevant to intensive care.
- 2.1.9 Assessment and management of patients outside the intensive care unit in 'follow up' and related initiatives

2.2 *Administrative and Educational Duties include:*

- 2.2.1 Ensuring that administrative duties relating to the proper functioning of the unit and the hospital are carried out.
- 2.2.2 Providing and participating in appropriate educational activities for:
 - 2.2.2.1 Trainee specialists.
 - 2.2.2.2 Intern and resident medical officers.
 - 2.2.2.3 Postgraduate nurses.
 - 2.2.2.4 Medical students.
 - 2.2.2.5 Undergraduate nurses.
 - 2.2.2.6 Paramedical staff.
- 2.2.3 Preparing material to be used for teaching.
- 2.2.4 Ensuring and reviewing quality of patient care by participating in audit, peer review and quality assurance programs as outlined in Document IC-8 "Quality Improvement".
- 2.2.5 Maintaining personal knowledge and skills by participating in continuing education and maintenance of professional standards programs.
- 2.2.6 Contributing to hospital committees, and the committees of health authorities and other organisations.
- 2.2.7 Contributing to the activities of the College and other professional organisations. This may include acting as Supervisor of Training (refer Document T-10 "The Role of Supervisors of Training in Intensive Care Medicine").

2.3 *Research Activities*

Participating in or supporting research and assisting trainees in undertaking research and in understanding research methodology and processes.

3. THE APPORTIONING OF TIME BETWEEN CLINICAL AND NON-CLINICAL DUTIES

By its nature, intensive care practice involves a great deal of 'out-of-hours' commitment. This document does not address the industrial issues related to weekend and night-time practice but some consideration of these is relevant. Non-clinical time allocation in this

document refers to half-day sessions undertaken during the course of the normal Monday to Friday (10 session) week.

3.1 *The Intensive Care Staff Specialist*

All intensive care staff specialists, part-time or full time, must have sufficient exposure to clinical practice to maintain their clinical skills. They must also have a commitment to personal continuing education, administration, audit, quality assurance and other educational activities such as a maintenance of professional standards program. Sufficient time must be allocated for these various activities. For the non-clinical duties of an intensive care staff specialist, on average, three half day sessions per week should be allocated. A greater allocation may be required for specialists with a major commitment to research or professional affairs.

3.2 *The Director of Intensive Care*

It is the prime responsibility of the Director to ensure that the intensive care service functions effectively and efficiently. Administrative responsibilities constitute a significant workload. A minimum of three sessions per week should be allocated for these administrative and related activities in addition to the general specialist allocation of three sessions.

3.2.1 In larger units (greater than 20 beds and 750 annual admissions) a Deputy Director should be appointed to assist the Director in its administration with a non-clinical allocation of at least one session per week.

3.2.2 If the Director is not a full time appointee, appropriate time must be provided for administrative duties and personal continuing educational needs.

3.3 *Supervisor of Training*

The Supervisor of Training has a very important role in the co-ordination of all aspects of the training of CICM and other specialty trainees. Specific non-clinical time should be allocated to enable the Supervisor to fulfil this role. The required time commitment will vary with the number of trainees but 1 to 2 non-clinical sessions per week will usually be required.

3.4 *The Visiting Intensive Care Specialist*

Visiting intensive care specialists have similar needs to intensive care staff specialists and proportional provision should be made for administrative and educational duties.

4. **GUIDELINES ON CLINICAL AND TRAINEE SUPERVISION**

These guidelines are based on a practice norm in which the major decisions related to patient care are determined during repeated ward rounds undertaken by the Intensive Care team during the daytime. The intensive care team consists of specialists and more junior medical officers (who may or may not be undertaking vocational training in intensive care medicine), working with other intensive care staff and primary and consulting medical teams. Outside routine ward rounds, clinical and trainee supervision is undertaken on an 'as needs' basis, based on a clearly established relationship between

senior and junior medical staff. This relates to the assessment and management of new patients as well as changes in established patients. This clinical pattern of supervision pertains seven days per week although most formal teaching and related training activities occur during regular weekday hours.

For the purposes of these guidelines, a single ICU is one with a single administrative structure with a single administrative head and reporting responsibilities. This does not preclude clinical sub-delineation based on patient specialty or acuity and is thus applicable to high dependency units administered in conjunction with intensive care units. A single unit is usually geographically continuous in a single building. Two or more ICUs in separate buildings on the same continuous campus site should not be considered as a single unit even though they may beneficially collaborate in many aspects of practice.

The maximum number of patients whose care can be satisfactorily supervised by a single intensive care specialist at any given time will vary depending on many factors including the experience and capabilities of the specialist, the nature and illness acuity of the patients and the availability of senior trainees who require less immediate supervision. These factors will need to be taken into account in individual units. The direction-setting, ward round component of intensive care practice requires a different level of Specialist commitment than does the out-of-hours on call component. Hence the maximum number of patients that can be safely managed will be different for these different components.

It is expected that there will be sufficient specialist staff appointed to ensure appropriate levels of specialist cover at all times with due consideration to safe practice principles. It is also expected that rostering and administrative practices will ensure adequate handover amongst specialists together with initiatives to maximise continuity of care. For all clinical aspects of practice, the experience and capabilities of the individual specialist should be considered with appropriate support provided where needed, especially for more junior specialists.

- 4.1 During regular, weekday hours, the supervising specialist should be present within the Unit most of the time. This requirement precludes service provision in two separate units during regular hours even if the 2 units are co-located on a single campus.
- 4.2 Outside regular, weekday hours, the supervising specialist may be simultaneously rostered to more than a single ICU but only if the units are on a single, geographical campus.
- 4.3 The supervising specialist must be exclusively rostered and immediately available to attend patients within the ICU. Other clinical and non-clinical commitments which might preclude immediate availability may only be undertaken when another suitable specialist is immediately available.
- 4.4 Formal cover arrangements need to be established when it is possible that the supervising specialist may not be immediately available to proceed to the ICU when required. This includes:
 - 4.4.1 Regular, weekday hours when the rostered specialist may have other clinical or non-clinical commitments which might restrict availability
 - 4.4.2 Any time when the supervising specialist is rostered to more than a single unit (on a single campus) where attendance in one unit may preclude immediate availability at the other.

- 4.5 For the daytime, ward round based component of practice, the maximum number of patients managed by a single specialist should not exceed 12 to 16. Short-term expansions of this workload may be necessary though not ideal. For practices that routinely operate at the limits of this workload:
 - 4.5.1 Patients should also be managed by a senior trainee requiring less close supervision.
 - 4.5.2 Appropriate specialist backup should be available at all times should the need arise.
 - 4.5.3 The patients should be managed within a single, geographical Unit.
 - 4.5.4 The case mix should be limited and / or the illness severity not excessive.
- 4.6 For the on-call component of practice, intensive care specialists should not be responsible for the care of more than 30 patients. This number is clearly excessive for the clinical supervision of the normal, ongoing care of critically ill patients and can only be justified if:
 - 4.6.1 The patients are managed within a single geographical Unit.
 - 4.6.2 A senior trainee requiring less close supervision also supervises patient care.
 - 4.6.3 There is a functional 'second-on-call' arrangement to cover times of greater need.
 - 4.6.4 There is some limitation on case mix or severity of illness (ie. several of the patients must be of a more predictable, or routine nature).

These guidelines should be interpreted in conjunction with the following Documents of the College of Intensive Care Medicine:

IC-1 "Minimum Standards for Intensive Care Units"
 IC-4 "The Supervision of Vocational Trainees in Intensive Care Medicine"
 T-10 "The Role of Supervisors of Training in Intensive Care Medicine"
 IC-8 "Quality Improvement"

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This policy document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have regard to the particular circumstances of each case, and the application of this document in each case.

Policy Documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Policy Documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

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