COLLEGE OF INTENSIVE CARE MEDICINE
OF AUSTRALIA AND NEW ZEALAND


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# MINIMUM STANDARDS FOR INTENSIVE CARE UNITS SEEKING ACCREDITATION FOR TRAINING IN INTENSIVE CARE MEDICINE

## PURPOSE

The purpose of this document is to outline the requirements of the College of Intensive Care Medicine of Australia and New Zealand (the College) for hospitals seeking and maintaining accreditation for training in intensive care medicine.

## INTRODUCTION

The College determines the duration of general training and the nature of specialty training that may be undertaken in individual intensive care units (ICUs) for the purpose of its regulations relating to training in intensive care medicine. ICUs, including foundation training ICUs, are approved for a five-year accreditation cycle. Training towards Fellowship of the College must be undertaken in hospitals accredited for training.

## RELATED COLLEGE POLICIES

It is the expectation of the College that all ICUs approved for training will meet the standards outlined in the related College policies:

- All specialists employed in accredited units have an obligation to teach trainees, as outlined in *IC-2 Guidelines on Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine*.

- The supervision of vocational trainees follows the principles outlined in *IC-4 Guidelines on the Supervision of Vocational Trainees in Intensive Care Medicine*.

- Where trainees are involved in routine patient care in a High Dependency Unit (HDU), the HDU should meet the criteria described in *IC-13 Guidelines on Standards for High Dependency Units for Training in Intensive Care Medicine*.

- The minimum standards relating to work practice, caseload, staffing and operational requirements, design, equipment and monitoring for Level III, II, I for both Adult and Paediatric ICUs are outlined in *IC-1 Minimum Standards for Intensive Care Units*.

- Supervisors of Training are nominated by the ICU and appointed by the Board of the College. Supervisors of Training are expected to carry out the duties listed in *T-10 The Role of Supervisors of Training in Intensive Care Medicine*.

- For accreditation of rural training, refer to *T-34 Guidelines for the Rural Term*.

## PRINCIPLES

The following principles guide all ICUs in relation to clinical care, education, teaching, research, and administration:

### Culture and wellbeing

The College expects high standards of culture that are conducive to the training, wellbeing, and welfare of all individuals in an ICU. The College expects, and provides support to, all members to ensure high professional standards of clinical practice.

### Cultural safety

The College requires the highest standards of culturally safe behaviour from all its members. ICUs must strive to provide culturally safe and respectful access to care to all, in particular Aboriginal, Torres Strait Islander, Māori, and Pasifika peoples.

### Diversity and inclusion

The College is committed to fostering inclusiveness and valuing diversity within the intensive care community and is committed to creating a supportive and enabling culture that acknowledges the contribution of each member in the multi-disciplinary team to meet the needs of the diverse community.

### Sustainability

The College acknowledges that as a medical specialist training college it has a role in leading its members to recognise the impact their practice has on the environment and on climate change, and where possible put in place sustainable practices while providing high quality care.

### Teaching and research

There must be a formal, documented, and demonstrable program of teaching provided for trainees. This teaching will include an appropriate mix of didactic lectures and more formal tutorials, bedside review of patients with the intensive care specialist on duty for the unit, and simulation sessions.

The ICU should have an active, documented, and demonstrable research program to which trainees are encouraged to contribute. Funding should exist at an appropriate level for research coordinators to support an active research program. As a minimum, funding to support the full-time research coordinator position for a Level III Unit is expected, as is an appropriate part-time position in smaller units, as outlined in *IC-1 Minimum Standards for Intensive Care Units*.

The ICU should have active quality assurance and quality improvement programs. Trainees are expected to take part in these activities including clinical audits, review of Acute Physiology and Chronic Health Evaluation (APACHE) data, and morbidity and mortality reviews.

The ICU should have adequate clerical, data collection, and administrative support.

## 1. GENERAL ACCREDITATION REQUIREMENTS

This section is for accredited ICUs. The requirements for affiliated ICUs are in section 2.5 of this document.

1.1 Accreditation approval is granted for a five-year cycle. ICUs accredited for training by the College must meet the following criteria:

1.1.1 The ICU must fulfil the requirements outlined in *IC-1 Minimum Standards for Intensive Care Units* with Foundation Units being Level I or above and Limited

General Units (C6) being Level II or above. General Training Units (C12 or C24) will usually be Level III Units with some Level II Units also able to provide General Training (C12 or C24) experience.

1.1.2 The ICU must offer trainees a wide spectrum of experience with an acceptable case load.

1.1.3 The hospital should provide a comprehensive range of medical and surgical specialties.

1.1.4 The hospital must provide access to an appropriate spectrum of investigations and therapeutic procedures that are suitable for the case mix.

1.1.5 The hospital must have an orientation program for all new doctors, including trainees, working in the ICU.

1.1.6 The hospital must ensure that training appointments are based in intensive care and should include provision for the trainee to take part in out-of-hours rosters in intensive care. The management of critically ill patients outside the ICU has increasingly become part of ICU core business and the participation of trainees in Rapid Response, Medical Emergency, or Outreach roles is permitted as part of core ICU training. ICUs should ensure these “Out-of-ICU Roles” have adequate intensivist supervision available at all times and trainees continue to have appropriate exposure to critically ill patients. Rostering to night-time shifts should not exceed 50 per cent and ideally would be less than this. The percentage of time a trainee is rostered to out of ICU activities should not exceed 25 per cent. An increase to 33 per cent of rostered time is possible if strategies are implemented to ensure direct supervision by an ICU specialist and clinical exposure to critically ill patients.

1.1.7 ICU policies and rosters must ensure trainees can work adequate hours within the ICU as distinct from HDUs or other rostered duties. This should involve adequate clinical experience including performance of procedures. If the Censor deems that inadequate hours are worked in intensive care medicine, they may rule that the trainee(s) must extend the duration of their core training.

1.1.8 The ICU should have guidelines on effective communication and clinical handover procedures to ensure mutual understanding and retention of information. This should include handovers to or from referring hospitals and retrieval specialists.

1.1.9 Safe working hours for trainees must be maintained and welfare issues addressed. It is expected that trainees will work and learn in an environment that is supportive, respectful, and free from harassment, bullying and undue conflict.

1.1.10 When appointments to the specialist staff are made, the advice of a properly constituted committee must be sought. College nominees are available to committees for this purpose.

1.1.11 When appointments for training registrar positions are made, they must be advertised. The selection process must conform to College guidelines and involve a properly constituted committee that includes a Fellow of the College (FCICM).

1.1.12 All accredited ICUs must allow the College access to data submitted to the Australian and New Zealand Intensive Care Society’s Centre for Outcome and Resource Evaluation (ANZICS CORE) or provide data annually from other relevant databases that allows calculation of the standardised mortality ratio (SMR) and benchmarking with other ICUs.

1.2 The ICU must offer, or provide access to, a program of education, quality assurance and research that includes a formal teaching program readily available to trainees. The program should cover general aspects of intensive care medicine in addition to directed education for trainees preparing for both the First Part and Second Part examinations.

1.3 The ICU must offer on-site access to adequate intensive care educational resources including electronic and internet-based resources, textbooks, journals, management guidelines and protocols or clinical care pathways.

1.4 The hospital must be prepared for the College, at intervals determined by the Board, to carry out visits to the ICU to assess its suitability for training. Information about caseload, staffing patterns and the rosters must be provided.

1.5 The hospital must agree to notify the Board of any changes that might affect training, including but not limited to:

1.5.1 A change in the Supervisor of Training or Director.

1.5.2 A change in the workload.

1.5.3 A significant change in case-mix or acuity.

1.5.4 A reduction in the number of specialist staff working in the ICU.

1.6 The ICU should demonstrate a commitment to diversity through areas such as employment policy, training programs, and cultural advisory inputs.

1.7 The ICU should demonstrate a commitment to cultural safety in its delivery of care and stewardship.

## 2. DESIGNATION OF UNITS FOR TRAINING

### 2.1 Criteria for Determining Designation of ICUs

2.1.1 The College's determination of an ICU's designation is made with regard to points listed in section 1 of this document, the case load, case mix, severity of illness of patients, range and frequency of procedures, supervision of trainees, and facilities of the ICU. ICU designations are listed below in sections 2.2 and 2.3.

2.1.2 Subject to criteria being met, the number of training posts in an ICU accredited for training is unrestricted and determined by workplace practices in the ICU.

2.1.3 ICUs accredited for core training are also suitable for foundation and elective training and, unless otherwise specified, the intensive care component of anaesthesia training. Approval of training time spent in a College accredited ICU towards other medical specialities is determined by the relevant colleges.

2.1.4 The duration of core training that may be undertaken in a given ICU may be limited by case numbers, case mix, and other characteristics.

## 2.2 Designation of Training Time

### 2.2.1 General Training (Gen) / C24 / Unrestricted Core Training

This designation is granted only to Level III ICUs and Paediatric ICUs, where in addition to the Level III status the Board deems it is possible for a trainee to spend an otherwise unrestricted amount of their core intensive care training, although the College encourages trainees to seek exposure to different units during their training. These ICUs are major intensive care units and may be in tertiary referral hospitals or in larger district general hospitals. They should usually have more than **six specialists** who are FCICMs, four of whom have at least a 50 per cent full time equivalent (FTE) involvement in the ICU. The ICU is expected to have well established teaching, research and quality assurance programs, and the patients have a high level of illness severity. The case mix will be diverse, including a large number of general intensive care patients (medical and surgical) with a high level of complexity. Such ICUs may also meet requirements for specialty training, but this is additional to meeting requirements for general intensive care training. Exposure to burns, spinal injuries and transplant services is desirable. Total case numbers usually exceed **1000 patients** per year with at least **400 ventilated patients** (either invasive or non-invasive) per year (High Flow Nasal Oxygen is not considered ventilation).

Pre-2014 trainees are required to spend at least one year of core intensive care training in an ICU with a C24 classification.

Dedicated Paediatric ICUs may see lower case numbers and ventilation rates and still provide an appropriate training experience.

### 2.2.2 General Training (Gen12) / C12 / Limited to 12 Months Core Training

This classification is granted to Level III ICUs and Paediatric ICUs, and occasionally to Level II ICUs, where the caseload and case-mix are adequate, but where the Board considers it would be unsuitable for a trainee to spend the whole of their core intensive care training. C12 accredited ICUs will usually have more than **four specialists** who are FCICMs and have at least a 50 per cent involvement in the ICU. The case mix is diverse including general medicine, and general surgery and may also include acute cardiology, cardiac surgery, trauma, and neurosurgery. Total case numbers will usually exceed **750 patients** per year with at least **300 ventilated patients** (either invasive or non-invasive) per year (High Flow Nasal Oxygen is not considered ventilation).

Dedicated Paediatric ICUs may see lower case numbers and ventilation rates and still provide an appropriate training experience.

### 2.2.3 Limited General Training (Gen6) / C6 / Limited to Six Months Core Training

This designation is granted to Level II, Level III or Paediatric ICUs where the case load, case mix, supervision or facilities are limited, such that the period of core training in that ICU should be restricted to six months. As outlined in document *IC-1 Minimum Standards for Intensive Care Units*, Level II ICUs would normally have at least six beds, at least four FTE medical specialists and normally more than **200 ventilated patients** per year. Even if the case load meets the description of General Training (see section 2.2.1 of this document), the case mix may be more limited. This may reflect a case load that is predominantly surgical or the general medical case load is limited. This designation is not a reflection on the quality of care in that ICU. Rotation to ICUs with this designation from larger ICUs is encouraged. Normally, not

more than one period of six months core training in an ICU with this designation can be accredited. A second period of training in any such ICU requires prior approval of the Censor and will only be granted if specific benefit to training can be demonstrated.

## 2.3 Requirements for ICU Specialty Training

### 2.3.1 Neurosurgical Intensive Care Training

ICUs are designated as Neurosurgical Intensive Care training sites if the hospital has a dedicated neurosurgical department and manages complex neurosurgical and / or neuro-trauma patients with a minimum ICU case load of **100 cases per year**. The case mix should provide a balance of acute and elective cases covering a broad range of neurosurgical conditions. ICUs may be so designated whether the patients are managed within a dedicated geographical site or intermingled amongst a more general ICU population. Trainees must have direct involvement in patient care under the supervision of an intensive care specialist.

### 2.3.2 Cardiac Surgical Intensive Care Training

ICUs are designated as Cardiac Surgical Intensive Care training sites if the hospital has a dedicated cardiac surgical department and manages complex cardiac surgical and major aortic surgical patients with a minimum ICU case load of **250 cases per year.**

Paediatric ICUs are designated as Paediatric Cardiac Surgical Intensive Care training sites if the hospital has a dedicated cardiac surgical department and manages complex cardiac surgical (including Risk Adjustment for Congenital Heart Surgery - RACHS category 5 and 6) with a minimum ICU case load of **250 cases per year**. ICUs may be so designated whether the patients are managed within a dedicated geographical site or intermingled amongst a more general ICU population. Trainees must have direct involvement in patient care under the supervision of an intensive care specialist.

### 2.3.3 Trauma Intensive Care Training

ICUs are designated as Trauma Intensive Care training sites if the hospital has a designated trauma unit or department and manages complex trauma patients with a minimum ICU case load of **100 cases per year**. ICUs may be so designated whether the patients are managed within a dedicated geographical site or intermingled amongst a more general ICU population. Trainees must have direct involvement in patient care under the supervision of an intensive care specialist.

### 2.3.4 Paediatric Intensive Care for General Intensive Care Training

Paediatric ICUs meeting the requirements for either limited (six months) or general paediatric training are suitable for the paediatric component of general intensive care training. Additionally, adult or mixed ICUs will be designated as paediatric training sites for this purpose if the ICU admits and manages a sufficient paediatric case load and case mix. Trainees must have direct involvement in the care of these patients under the supervision of an intensive care specialist. Units admitting and managing more than **100 paediatric patients annually** will be designated Paediatric six month sites due to having more exposure to paediatric patients, while those admitting and managing **between 50 and 100 patients** will be designated Paediatric 12 month sites.

#### 2.3.5 Rural / Regional Intensive Care Training

The College encourages trainees to spend time in a rural or regional hospital. The criteria for rural time are outlined in *T-34 Guidelines for the Rural Term*.

### 2.4 Criteria for Foundation Training Accreditation

Guidelines for hospitals seeking accreditation for foundation training in intensive care medicine are outlined in *IC-33 Minimum Criteria for Hospitals Seeking Accreditation for Foundation Training for Intensive Care.*

Endorsement of the completed foundation training application by the local Regional Committee is required prior to consideration by the Hospital Accreditation Committee.

### 2.5 Affiliated ICU Accreditation Guidelines

It is possible for trainees to undertake a rotation from an approved general training ICU to a nearby affiliated ICU, that is not separately approved for training. The affiliated ICU will be prospectively assessed and approved by the Hospital Accreditation Committee. These ICUs are not accredited for training in their own right but are approved as an adjunct to the 'parent' ICU.

The affiliated ICU will be reviewed by the Accreditation Team, ideally on the same day as the accreditation visit to the 'parent' ICU. Physical facilities must meet the standards required of training ICUs. Information on caseload, case mix and staffing within the affiliated ICU will be separated from the dataset for the main ICU, to facilitate assessment of compliance with College standards.

The ICUs should be close to each other – this is not simply defined by a specific distance but rather by the relationship. As an example, the two ICUs should share specialist staff, Supervisors of Training. and teaching arrangements, If the two ICUs share resources for trainee teaching, supervision, and mentoring, then their proximity must enable this sharing. Affiliate ICU staffing should allow a trainee to attend relevant online and in-person teaching sessions.

#### 2.5.1 Considerations for Trainee Rotations to Affiliated ICUs

2.5.1.1 The rotation may only be undertaken where the 'parent' unit is accredited for unlimited general training and when the rotation is undertaken during an approved 12-month period of training.

2.5.1.2 The rotation should add to the trainee experience for example, subspecialty exposure, different case mix, or exposure to private hospital medical practice.

2.5.1.3 The duration of trainee rotation to the affiliated unit cannot exceed 16 weeks (four months) in any 12-month period. This may be undertaken in a single block or may be spread over the year in shorter blocks so that the affiliated unit may effectively function as a pod of the parent unit.

2.5.1.4 The rotation may be undertaken only once during an individual trainee's core training time although the Censor has discretion to potentially approve a second period if a specific benefit to the trainee can be demonstrated.

## 3. APPROVAL OF CORE INTENSIVE CARE TRAINING IN OVERSEAS ICUs

The College is very supportive of the potential benefits of rotations to overseas ICUs for College trainees. Three options exist for consideration of approval for training time spent overseas ICUs.

### 3.1 Accredited ICUs

Overseas ICUs may seek General or Limited General accreditation. They are required to meet the same standards as ICUs in Australia, Aotearoa New Zealand, or Hong Kong. These are described in detail in the documents *IC-1 Minimum Standards for Intensive Care Units* and *IC-3 Minimum Standards of Intensive Care Units Seeking Accreditation.*

### 3.2 Approved ICUs for Training

3.2.1 It is possible that 12 months of core training may be approved in an overseas ICU that is not accredited by the College, provided that the following conditions are met:

3.2.1.1 The proposal must be considered prospectively by the Censor.

3.2.1.2 The 12 months must be continuous and be in a single ICU.

3.2.1.3 The trainee occupies a role consistent with that in an accredited General Training ICU.

3.2.1.4 There is an appropriate Supervisor of Training appointed consistent with the role described in *T-10 The Role of Supervisors of Training in Intensive Care Medicine.*

3.2.1.5 An In-Training Evaluation Report (ITER) is completed for each six-month term of approved training. See *T-10 The Role of Supervisors of Training in Intensive Care Medicine.*

3.2.1.6 The remaining 12 months of core ICU training must be continuous and in a General Training (C24) ICU in Australia, Aotearoa New Zealand, or Hong Kong conforming to conditions set out in *the Regulations, section 5*.

3.2.2 These ICUs would generally fulfil the following conditions:

3.2.2.1 The ICU must be fully established and operational and have a Director who is an FCICM or who has a specialist qualification acceptable to the relevant national intensive care training body.

3.2.2.2 The ICU has been accredited for intensive care training by the relevant national training body.

3.2.2.3 Trainees must be exposed to at least four specialists who are either FCICMs or who have a specialist qualification acceptable to the relevant national intensive care training body AND who have a minimum of 50 per cent involvement in the ICU.

3.2.2.4 In all other respects the ICU should comply with the requirements for General Training accreditation outlined in this document.

3.2.2.5 A Hospital Data Sheet is completed and submitted to the Censor or Hospital Accreditation Committee to be reviewed and assessed using the criteria outlined in section 2.2 of this document.

3.2.2.6 When a trainee has submitted a successful application for training in such an ICU, the Censor may, for the subsequent three years, approve 12 months of core training for other trainees based only on a prospective training application. Such ICUs would be considered as 'approved for training' rather than accredited for training.

### 3.3 Censor Consideration

Additional situations where time in an overseas unit may be counted as approved training time can be individually considered by the Censor such as when shorter six-month rotations are being proposed.

**References and sources**

IC-1 Minimum Standards for Intensive Care Units
IC-2 Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine
IC-4 Guidelines on the Supervision of Vocational Trainees in Intensive Care Medicine
IC-33 Minimum Criteria for Hospitals Seeking Accreditation for Foundation Training for Intensive Care
T-10 The Role of Supervisors of Training in Intensive Care Medicine

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Hospital Accreditation Committee

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| 2021 | Affiliated unit addition. Out of ICU roles. |

**Further Reading**

IC-7 Guidelines on Administrative Services to Intensive Care Units
IC-8 Guidelines on Quality Improvement
IC-13 Guidelines on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine

## Publishing Statement

Published by CICM: April 2022. This Professional Document has been prepared with 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. The college's Professional Documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure the current version has been obtained. Professional Documents have been prepared according to the information available at the time of their publication, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently. Whilst the college endeavours to ensure its Professional Documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.
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