Trainee Advanced Critical Care Practitioner Induction Pathway

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Aim

The aims of this Trainee Advanced Critical Care Practitioner (tACCP) induction framework are:

- *To enable effective transition from the individual's base profession to tACCP.*
- *To provide a guideline for both the Clinical and Academic environments to effectively support, inform and guide new tACCPs into their two-year specialist training program.*
- *To support the clinical department to provide a structured induction program which sets out the training expectations and scope of practice of the tACCP.*
- *To support the local HEI to provide a structured induction which sets out the academic expectations and academic pathway of the tACCP.*

Background

This document has been developed by trainee and qualified Advanced Critical Care Practitioners with the support of The Faculty of Intensive Care Medicine ACCP sub-committee (FICMASC), ACCP clinical leads and University representatives. The rationale behind this project was based upon a recognised need to standardise the approach to the induction process. Starting as a tACCP is an incredibly daunting process, regardless of previous base profession. As a working group we recognised that there were key resources and information available which was often not identified until later in training. As a group our intentions are to signpost trainees to these resources early on in their training, standardise the induction process for all tACCPs and provide an adaptable framework for the trainee to navigate their two-year pathway.

Induction framework development

Stage 1 ***Formation of working group***	•Social media was utilised to increase engagement with the project. •An open access document was shared to encouraged tACCPs & qACCPs to contribute their thoughts regarding current induction programs.
Stage 2 ***National consultation***	•Development of a National survey reviewing current induction pathways, HEI inductions and clinical inductions. •The group sought to inform the induction framework with current practice and suggestions from the wider ACCP community.
Stage 3 ***National Consultation Analysis***	•106 responses were obtained from the ACCP community. •Shared responsibility was taken for the data analysis.
Stage 4 ***Induction framework First draft***	•The document was divided into themes which were drawn from the National consultation. •Each member of the working group took individual ownership for developing the concepts into a useable document.
Stage 5 **Peer and *FICMASC review***	•We invited qACCPs, tACCPs, HEI leads and Clinical leads to review the document. •The project was submitted to the FICMASC for review •Changes and formulation of second draft.
Stage 6 ***Final Draft and Ratification***	•Final review of induction framework •Ratified and submitted for wider distribution via FICM September 2021.

National Consultation

A national consultation was undertaken to evaluate current tACCP induction pathways. This consultation was undertaken in the form of a national survey. This survey was designed to invite opinion from the ACCP community to underpin the recommendations made within this framework.

Aims

- *Undertake a national consultation of both trainee and qualified ACCPs to understand current national induction pathways.*
- *Utilise this data set to formulate recommendation for both the clinical and academic environments to ensure effective transition from the individual's base profession to tACCP.*

Methods

- We sought engagement via the ACCPAN network to develop the question set for the HEI induction pathway. We also sought engagement via FICMASC, Critical Care Consultants and the wider ACCP community to develop the question set for the other categories.
- We developed a set of 55 questions which examined professional demographics, current induction pathways, HEI induction pathways specific to ACCPs, technology and study skills, clinical pathway induction and practical skills along with resources for seeking help when struggling.
- We developed the survey utilising a Google Forms platform which was shared via multiple social media platforms.
- The survey ran for two weeks in April 2021, we received a total of 106 respondents.
- We took shared responsibility for the data analysis which has underpinned the recommendations made within this framework.

Results

Professional demographics

Base profession, banding and current place in the ACCP journey.

- All respondents were either tACCPs or qACCPs with 60% of answers received from qualified ACCPs with a large amount from the Midland areas.
- Majority of responders classed themselves as a band 8a with most of the rest banding lower. 1 person stated they were an 8b.
- 88% of responders were nurses with a critical care background with the remainder from AHP backgrounds.

Current Induction program

ACCP induction programs that are already in existence.

- Just over 75% of respondents stated their trust had no current ACCP specific induction program. Those that did have an induction, found generic information (regarding hours, leave and the unit), shadow shifts with the MDT, meeting other ACCPs/medical team and an introduction to the FICM paperwork helpful.
- There was a very mixed response on how long a current induction should be with the most popular answer being 1-2 days.

- We asked whether, as tACCPs and qACCPs in line with FICM recommendations they were easily identifiable from the medical team. Those that were, had either a different uniform and/or lanyard.
- 55% of respondents felt that being distinguishable would be helpful to their role, 22% felt it would not be helpful and a further 22% were unsure. In the comments section there were both positive and negative comments made.

HEI Induction:

Current HEI ACCP specific inductions

- Reasonable geographical spread of HEIs providing ACCP pathways.
- 69% of respondents did not receive an ACCP specific pathway induction.
- 60% of respondents felt they would have found an ACCP specific induction helpful.
- Comments ranging from an overview of the academic pathway, the running of the pathway, academic expectations, and the opportunity to meet other ACCPs who have completed or were in the process of completing their academic pathway would have been helpful.

Information bundles and study skills:

Resources made available prior to starting training. Resources which are currently widely utilised by ACCPs.

- Most people did not receive an induction pack but thought it would have been helpful to receive general hospital information, learning opportunities, when to plan annual leave during the program and how to access ACCP networks.
- A variety of learning resources including notetaking, referencing, educational resources and webinars are being used by current ACCPS. We have provided a summary in Appendix 6
- 75% of respondents felt study skills sessions prior to commencing their academic pathway would be helpful. Several respondents recognised that they had not studied for a long time, and this would have made navigating their academic and clinical pathways easier in terms of academic writing and performing literature searches.

Clinical Pathway Induction:

Current Clinical pathway inductions and FICM requirements

- 85% of respondents were encouraged to start a logbook during their training.
- Only 25% of respondents were provided with a formal overview of how to use the logbook and what information was vital for FICM/ARCP.
- Whilst nearly all respondents were allocated an Educational Supervisor, only 67% were offered an ACCP buddy or mentor.
- Nearly all respondents wanted an electronic logbook with access to examples of completed WPBA and a two-year timetable guiding when to meet with educational supervisors, ARCP deadlines, running dates for university modules and rough timeline of academic deadlines.

Practical Induction:

Scope of practice, clinical skills, and extension of clinical skills

- Only 51% of respondents felt that their scope of practice as a tACCP was clearly outlined from the start of their ACCP pathway.
- Most respondents (94%) felt that an overview of clinical procedures within their scope of practice with clear guidance on formative and summative assessment of competency would be helpful.
- 99% of respondents felt that an early introduction to IRMER and those radiological procedures within their scope of practice to request would be helpful.

- A varied response was gained on what radiological examinations ACCPs could request however the consensus was the majority can request chest X-rays.
- Only 26% of respondents felt that it was clearly outlined when they could independently assess and clear lines, tubes and NGTs on a chest X-ray.
- 96% of respondents felt an introduction to intra and inter hospital transfer setting the expectation of the trainee, making them aware of what supervision is required and when they can undertake these types of transfers independently would be helpful.

Recommendations

From the national consultation we were able to identify some key recommendations, resources and areas for consideration when running an induction pathway for trainee ACCPs. The recommendations are split into themes throughout this document. We have developed several adaptable documents as appendices including a two-year timetable (Appendix 5) and a tACCP passport document (Appendix 3).

HEI Induction & Study Skills

The findings from the consultation highlight the issues that exist surrounding a trainee's understanding of the HEI component required by FICM, and what parts of the HEI content can be used directly in the FICM portfolio. There is a recognised need to be given a full orientation to the HEI pathway and paperwork set out by the HEI, as well as acknowledging the value of the HEI setting in which to meet and network with other trainees and qualified ACCPs. HEI programme leads are recommended to work with the ACCP leads locally as a tripartite relationship to support the trainees in understanding the HEI pathway and associated paperwork requirements.

Recommendations

Overview of HEI Pathway

In response to the national consultation, it is recommended that trainees receive an induction, comprising of HEI specific information to prepare them for their academic pathway, a two-year overview of the academic components of the pathway including assessment information and contact details for the ACCP pathway lead. We recommend the use of a structured academic timetable which can be adapted to meet the local academic requirements, and should include the following;

- *Overview of the HEI ACCP academic pathway*
- *Induction session that is ACCP specific, where possible*
- *Guidance on module content and assessment requirements and how this fits the FICM curriculum*
- *Guidance on academic deadlines*

Below is an example template which can be adapted by the HEI and trainee to meet local module requirements (Appendix 5). It is recognised that the titles of modules, semesters and deadlines will vary nationally.

Year One – HEI		
Semester 1	**Semester 2**	**Semester 3**
Advanced Clinical Assessment and Decision Making *(insert deadline)*		
Clinical Sciences for Advanced Practice *(insert deadline)*		Research for Advanced Practice *(insert deadline)*
Year Two – HEI		
Managing complexities in Advanced Practice *(insert deadline)*		
Non – Medical Prescribing (*insert deadline)*		
Completion of Year 2 – PGDiP and FICM Membership achieved **Optional Year 3 – Completion of MSc**		

(Template from The University of Northumbria – with permission of Sadie Diamond Fox)

Study Skills

Many respondents to the national consultation felt they would have benefitted from study skills sessions. We highly recommend offering study skills sessions to newly appointed trainees who identify a need for this. It is recognised that the role of ACCP will attract individuals looking to progress their career within critical care, and these individuals may not have studied in recent years. We believe a study skills session should consist of.

- *How to complete a literature search including how to formulate the search criteria and use of a variety of databases.*
- *How to critique and assess the quality of the evidence.*
- *Update/introduction on referencing tools such as EndNote*
- *IT skills may also be beneficial to those who identify a need for this.*

Often local healthcare library services can offer the above sessions and we highly recommend engagement with them to provide the above as part of the ongoing development for trainees.

All HEIs will offer study skills sessions which can be accessed by all students. These should be clearly signposted to students during induction.

Information Bundles

With significant advances in technology and educational resources there are growing concerns regarding the credibility, quality, and content of some of these purported resources. From the national consultation we have populated the most used resources by both trainee and qualified practitioners.

Over 50 websites, podcasts, webinars, and apps were identified as useful resources within the national consultation. However, the quality and credibility of free online medical education resources can be difficult to ascertain. FICM does not endorse any of the educational resources identified from the national consultation.

An extensive list of resources is available in Appendix 6. We have divided the resources into the following categories.

- *Notetaking*
- *Referencing and scanner resources*
- *Radiology*
- *Clinical Practice*
- *Research and Journals*
- *Medicines and pharmacology*
- *Webinars and podcasts*
- *Professional resources*

Clinical Induction

The clinical induction should be considered separate from the generic trust or unit requirements. Approximately 75% of respondents to the national consultation received no ACCP specific induction.

The aims of the clinical induction are to.

- *To set the clinical expectations and requirements of the training and assessment process.*
- *Identify and allocate a educational supervisor and buddy.*
- *To introduce and explain a chosen logbook and WPBAs which are required to be completed throughout training.*
- *To signpost educational opportunities that can be accessed via training.*

Recommendations

Clinical expectations and assessment process

In response to the national consultation, we have developed a two-year clinical timetable. This timetable can be adapted to meet local needs. It is recognised that the two-year template should include the following.

- *Timetabled induction (ACCP specific)*
- *Guideline to when educational supervisor meetings should occur.*
- *Minimum MSF and Consultant feedback required with guidance on when the trainee should undertake these.*
- *Ongoing assessment of individual development needs using the RAG assessment.*
- *Guidance on when trainees can expect their ARCP.*

Below is an example template which can be adapted by the trainee and supervisor to meet local needs (Appendix 5).

<table>
<tr><th colspan="4">Year One – Clinical</th></tr>
<tr><th>Semester 1</th><th>Semester 2</th><th>Semester 3</th><th>Semester 4</th></tr>
<tr><td>Induction
(Settling in period)</td><td colspan="3">MSF (minimum 1/yr)
Consultant Feedback (Recommended quarterly)</td></tr>
<tr><td>Clinical Supervision Meeting 1
(Complete ACCP educational agreement)</td><td>Clinical Supervision Meeting 2
(Complete ACCP educational agreement)</td><td>Clinical Supervision Meeting 3
(Complete ACCP educational agreement)</td><td>Clinical Supervision Meeting 4
(Complete ACCP educational agreement)</td></tr>
<tr><td colspan="3">RAG Assessment
(update before clinical supervision meetings to help bespoke your development needs)</td><td>ARCP
(See page 18 -19 of assessment systems document)</td></tr>
<tr><th colspan="4">Year Two – Clinical</th></tr>
<tr><td>Clinical Supervision Meeting 5
(Complete ACCP educational agreement)</td><td>Clinical Supervision Meeting 6
(Complete ACCP educational agreement)</td><td>Clinical Supervision Meeting 7
(Complete ACCP educational agreement)</td><td>Clinical Supervision Meeting 8
(Complete ACCP educational agreement)</td></tr>
<tr><td colspan="4">MSF (minimum 1/yr)
Consultant Feedback (Recommended quarterly)</td></tr>
<tr><td colspan="3">RAG Assessment
(update before clinical supervision meetings to help bespoke your development needs)</td><td>ARCP
(See page 18 -19 of assessment systems document)</td></tr>
</table>

Clinical Supervision and Mentorship

For full guidance on clinical supervision please refer to the FICM ACCP handbook

ACCP Curriculum Part I - Handbook v1.1 2019 Revision (ficm.ac.uk)

In response to the national consultation, there was overwhelming opinion that tACCPs would benefit from both an educational supervisor to provide formal support locally and a mentor who is able to provide informal peer support. Below is a summary of both the role of the educational supervisor and the role of the mentor.

Educational Supervisor

All trainees must have a named education supervisor. It is strongly recommended that the trainee should meet with their named educational supervisor during the first two weeks of training. This initial meeting should be used to establish a development plan and ensure the trainee understands what is expected of them.

Formative meetings should occur quarterly throughout training and include.

- *Review of progress and personal development plan*
- *Review of portfolio, HEI progress and WBAs*
- *Review of clinical performance*
- *Structured feedback*
- *Completion of relevant FICM paperwork for each meeting*
- *Plan for next stage of training*

Educational supervisor - Core roles and responsibilities

- To provide support, guidance, and feedback to the trainee for the duration of their training
- In conjunction with the trainee, they should review and contribute to the personal development plan by providing guidance during regular meetings (quarterly).
- To be responsible for the supervision of clinical activity and educational progress during training.
- To identify any trainee in difficulty and manage appropriately alongside Lead ACCP, HEI representative and ACCP local Clinical lead (medical)
- To seek feedback from local consultant body to support trainee development and share this with the trainee.
- Ensure education and training structures are in place locally for the trainee to achieve competence and achieve FICM membership status.
- Ensure the trainee is ARCP ready.

Trainee ACCP- roles and responsibilities

- To be responsible for own learning, seek help and advice for ongoing development needs.
- To understand the training structure and programme and what is required to achieve competence.
- To develop a personal development plan that is discussed and supported by your educational supervisor.

- Responsible for ensuring educational supervisor meetings are planned within an appropriate time frame. Start planning early!
- To collect WPBA and populate logbook to ensure record of clinical practice. This should then be reviewed regularly with your educational supervisor.
- To highlight and seek help if they are getting into difficulty within the training programme.

Identifying a Mentor

The use of a mentor is strongly recommended for each trainee from the national consultation. The mentor may well be an ACCP within the trainee's new team. If this is the first cohort of tACCPs locally we have provided details of ways to identify a mentor nationally. It is recommended that the trainee is supported by their educational supervisor or lead ACCP to identify a mentor.

The mentor should be a qualified ACCP who can perform the following roles.

- *Support the trainee informally throughout their training.*
- *They may be a newly qualified ACCP who has recently undertaken the training programme and will be a useful resource for the new trainee.*
- *They will not be required to fill in the formal FICM documentation or be present at any meetings.*
- *They will provide support and guidance for the new trainees in relation to FICM paperwork, how to achieve competencies, how to use logbook and guidance for meetings, and peer support.*

Routes for identifying a Mentor.

The below are the current ACCP networks that are advertised via the FICM website. Each are advertised with lead contact details. We recommend contacting them to establish either a local or national ACCP mentor.

ACCPNR - Advanced Critical Care Practitioners Northern Region

London ACCP Regional Network

Midland Advanced Critical Care Practitioners Group

NWACCP - Northwest England Advanced Critical Care Practitioners

Scottish Advanced Critical Care Practitioner Network

Southwest ACCP Network

ACCP Network for Wales

Wessex ACCP Network

East of England ACCP Network

https://www.ficm.ac.uk/index.php/careersworkforceaccps/accp-networks

Below are the details of the official national forums for ACCP's. These are an incredible resource for peer support. We recommend posting a message onto the National ACCP Facebook group to identify a mentor.

Official ACCP Facebook Group

You will need to request access and one of the admin team will share access with you.

https://www.facebook.com/groups/957304567684474/?ref=share

Official ACCP Twitter Group

@accpuk

logbook and WPBA requirements

In response to the national consultation, a large proportion of respondents were advised to start a logbook but only a small proportion felt they understood the requirements of the logbook and WPBAs. Below is a summary of the requirements of the logbook and examples of how to populate WPBAs.

Logbook

Most respondents either made their own logbook or they used pre-populated logbooks. All data entry within your chosen logbook should be anonymised. The minimum requirements for the logbook are.

Intubations

- This is a desirable clinical skill currently within the ACCP Curriculum.
- Within your logbook you should provide a summary of both RSI and LMA insertions with clear differentiation between the procedures.
- The insertion of an LMA is an essential clinical skill. The logbook along with relevant WPBAs should demonstrate competence in this procedure.

Transfers

- Within this area you should document transfers which are within your scope of practice.
- It is important to identify whether Intra and Inter hospital transfers are within your scope of practice. It is important to adhere to local policy and procedure. It is important to establish a robust process in assessing competency in undertaking these roles.
- You should differentiate between intra and inter hospital transfers within your logbook if you do undertake these.

Procedures

- Within your logbook you should demonstrate competence with supporting WPBAs in all the **essential procedures** within the FICM curriculum.
  These include.
    - Peripheral venous cannulation
    - Arterial cannulation
    - Central venous cannulation
    - Nasogastric tube insertion
    - Urinary catheterisation
    - Defibrillation in cardiac arrest
    - Laryngeal mask airway insertion
    - Dialysis catheter insertion

- Within your logbook you should also demonstrate competence with supporting WPBAs within locally agreed desirable procedures.
- This procedural log should demonstrate progression and competence.

Noted patients & referrals.

- Within your logbook you should demonstrate your involvement and exposure to a spectrum of clinical conditions, both within the department of critical care and as referrals.
- Along with this area of the logbook you should also demonstrate competence with supporting WPBAs.

Teaching

- You should keep a summary of formal teaching you provide.
- It is recommended that you obtain formal feedback from these sessions.
- This feedback should be presented within your portfolio as supportive evidence at ARCP.

CPD and Training

- You should keep a summary of formal training and CPD activities which are provided in addition to the university modules.
- This can be utilised as supporting evidence for ARCP.

University Modules

- You should keep a summary of all the university modules with module outcomes.
- If you entered the pathway and have APEL credits you should also provide a summary of dates and module outcomes.

Service development

- You should demonstrate activity within Audit, Quality improvement projects and research.
- It is recommended that you discuss QIP and Audit with the local lead.
- You can perform the above with other members of the MDT.
- It is recommended that you discuss with your local research lead, consider completing your GCP qualification and actively recruiting patients to clinical trials where applicable.

Premade Logbook recommendations

These recommendations have been made within the national consultation. Currently as a professional group there is no standardised electronic portfolio. We would suggest that any logbook where a host platform is used is used with caution due to the potential loss of data if said platform closes.

- *Sunderland logbook - www.icceducation.org.uk*
- *Google forms logbook – See Appendix 8*
- *Easilog - www.easilog.com*

WPBA

See Appendix 6 for examples of completed WPBA's.

Whilst the curriculum highlights a minimum standard for WPBAs in terms of numbers completed, it is important to acknowledge these assessments should demonstrate competence. It is likely that you will need more than the minimum to demonstrate clinical proficiency, competency, and clinical scenario exposure.

The key WPBA that you will utilise during training are the following.

- **Direct Observed Procedural Skills (DOPs)**
  - Assessment of practical skills
  - You should have a range of these which include the essential procedures.

- **Case-based Discussion (CBD)**
  - The focus of a CBD is often on patient management.
  - It will often cover a variety of curriculum areas including evidence-based practice, safe practice, teamwork, clinical knowledge, and skills.

- **The ICM Mini Clinical Evaluation Exercise (I-CEX)**
  - This type of assessment involves the assessor directly observing the trainee in a real clinical scenario.
  - It will often cover a variety of curriculum areas including history taking, physical examination, communication skills and clinical judgement.

- **Acute Care Assessment Tool (ACAT)**
  - The role of the ACAT is to assess the trainee's ability to manage the care of multiple patients.
  - It will often cover a variety of curriculum areas including record keeping, time management, team working, leadership and hand over quality.
  - You could consider an ACAT for ward rounds, clinical shifts and off unit activity if you see multiple referrals within a shift.

- **Multi-Source Feedback (MSF)**
  - This type of assessment can be incredibly daunting for trainees. It is designed to collate cross sectional anonymous feedback on the trainee's performance. You should consider asking junior doctors, nursing colleagues, AHPs and other ACCP's for feedback.
  - The forms are generally distributed by the trainee and then handed to and collated by your educational supervisor. Your educational supervisor will then discuss the feedback with you.
  - This assessment should be used to acknowledge areas that you are doing well and build strategies to grow and develop in the areas which need improvement.

- **Consultant Feedback**
  - It is designed to collate feedback on the trainee's performance from the consultant body.
  - Depending on local arrangements you may be asked as the trainee to distribute these, however your educational supervisor may take on this role.
  - Your educational supervisor will then discuss the feedback with you and help you to build strategies to grow and develop.

Training opportunities

During training there are multiple clinical and non-clinical development opportunities. Over 50 responses within the national consultation identified clinics, training courses and academic opportunities for tACCPs. The available opportunities will vary from trust to trust, but the available opportunities should be sign posted for trainees. Below is a summary of potential training opportunities.

Clinical Environment

These are some of the recommended training opportunities within the clinical environment.

- *Critical Care Junior Doctors Induction*
- *Critical Care Nursing training days*
- *Trust study days; IRMER, Cannulation and venepuncture, Male catheterisation*
- *Specialist clinics; cardioversion & arrythmia, vascular access, lumbar puncture, bronchoscopy*
- *Courses – ILS, ALS, CALS, EATLS, ATLS (Consider instructor status).*
- *Simulation training*
- *Transfer training*

MDT Training Opportunities

These are some of the recommended wider MDT training opportunities.

- *Critical Care Consultant led ward rounds.*
- *Specialist ICM registrars; assessment and stabilisation of ward referrals.*
- *Anaesthetics; Theatre placements, shadowing ODPs, working with Anaesthetists, Airway skills*
- *Emergency Department; Consider shadowing RCEM ACPs, physical assessment and history taking skills.*
- *Critical Care Outreach teams*
- *Senior Critical Care Nurses*
- *Cardiac arrest/Medical Emergency teams*
- *Specialists; Critical care physiotherapists, dieticians, SALT, critical care pharmacists, Specialist nurse in organ donation, microbiology ward rounds*
- *Radiology; Cardiac technicians, Radiographer practitioners, Ultrasound clinics*

Non-clinical development opportunities

These are some of the recommended non-clinical development opportunities.

- *Teaching formal and informal.*
- *Publication opportunities; Journals, textbook, national projects*
- *Completing audits.*
- *Quality Improvement meetings and Quality improvement projects.*
- *Poster presentations at regional and national conferences*
- *Journal Club.*
- *Schwartz Rounds.*
- *Morbidity & Mortality (M&M) reviews*
- *Attend regional and national conferences ; National ACCP Conference.*
- E-learning for healthcare modules

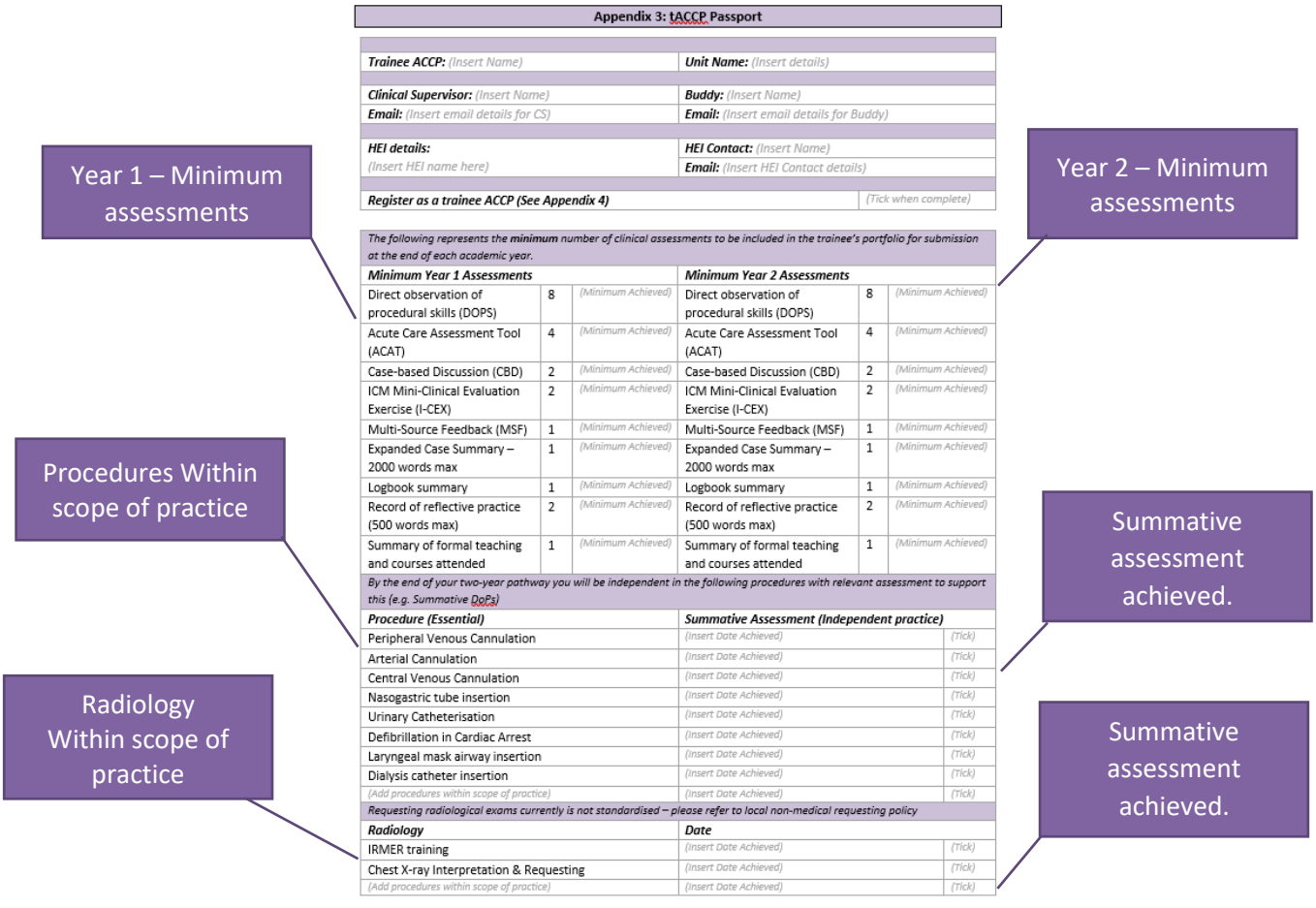
Practical Skills

Commencing the ACCP training pathway with both a clinical and academic component can be daunting. One of the many functions of ACCPs are to perform some of the skills traditionally carried out by a medical professional, therefore the governance behind this needs to be robust. Competence and confidence in performing such skills is evidenced through formative and summative work-based assessments i.e. Direct observations of procedures, clinical examinations, case based discussions.

Understanding scope of practice is essential. From the national consultation only 51% of respondents felt that they had a clear understanding of their scope of practice. Along with this, most respondents felt guidance in terms of which clinical procedures were deemed within their scope of practice, including the essentials from FICM and any desirable skills would be useful. In addition to this, most felt they would have benefitted from guidance on formative and summative assessments to achieve competence.

Recommendations

It is recommended that tACCP's collate achievement of when independent practice is achieved for the essential clinical skills within one centralised document. Below is a screenshot of a tool which can be utilised by trainees and adapted by the clinical ACCP leads ahead of trainees commencing the pathway. This tool can be found in Appendix 3.



Appendix 3: tACCP Passport

Trainee ACCP: *(Insert Name)*	***Unit Name:*** *(Insert details)*
Clinical Supervisor: *(Insert Name)*	***Buddy:*** *(Insert Name)*
Email: *(Insert email details for CS)*	***Email:*** *(Insert email details for Buddy)*
HEI details: *(Insert HEI name here)*	***HEI Contact:*** *(Insert Name)* ***Email:*** *(Insert HEI Contact details)*
Register as a trainee ACCP (See Appendix 4)	*(Tick when complete)*

*The following represents the **minimum** number of clinical assessments to be included in the trainee's portfolio for submission at the end of each academic year.*

Minimum Year 1 Assessments			***Minimum Year 2 Assessments***		
Direct observation of procedural skills (DOPS)	8	*(Minimum Achieved)*	Direct observation of procedural skills (DOPS)	8	*(Minimum Achieved)*
Acute Care Assessment Tool (ACAT)	4	*(Minimum Achieved)*	Acute Care Assessment Tool (ACAT)	4	*(Minimum Achieved)*
Case-based Discussion (CBD)	2	*(Minimum Achieved)*	Case-based Discussion (CBD)	2	*(Minimum Achieved)*
ICM Mini-Clinical Evaluation Exercise (I-CEX)	2	*(Minimum Achieved)*	ICM Mini-Clinical Evaluation Exercise (I-CEX)	2	*(Minimum Achieved)*
Multi-Source Feedback (MSF)	1	*(Minimum Achieved)*	Multi-Source Feedback (MSF)	1	*(Minimum Achieved)*
Expanded Case Summary – 2000 words max	1	*(Minimum Achieved)*	Expanded Case Summary – 2000 words max	1	*(Minimum Achieved)*
Logbook summary	1	*(Minimum Achieved)*	Logbook summary	1	*(Minimum Achieved)*
Record of reflective practice (500 words max)	2	*(Minimum Achieved)*	Record of reflective practice (500 words max)	2	*(Minimum Achieved)*
Summary of formal teaching and courses attended	1	*(Minimum Achieved)*	Summary of formal teaching and courses attended	1	*(Minimum Achieved)*

By the end of your two-year pathway you will be independent in the following procedures with relevant assessment to support this (e.g. Summative DoPs)

Procedure (Essential)	***Summative Assessment (Independent practice)***	
Peripheral Venous Cannulation	*(Insert Date Achieved)*	*(Tick)*
Arterial Cannulation	*(Insert Date Achieved)*	*(Tick)*
Central Venous Cannulation	*(Insert Date Achieved)*	*(Tick)*
Nasogastric tube insertion	*(Insert Date Achieved)*	*(Tick)*
Urinary Catheterisation	*(Insert Date Achieved)*	*(Tick)*
Defibrillation in Cardiac Arrest	*(Insert Date Achieved)*	*(Tick)*
Laryngeal mask airway insertion	*(Insert Date Achieved)*	*(Tick)*
Dialysis catheter insertion	*(Insert Date Achieved)*	*(Tick)*
(Add procedures within scope of practice)	*(Insert Date Achieved)*	*(Tick)*

Requesting radiological exams currently is not standardised – please refer to local non-medical requesting policy

Radiology	***Date***	
IRMER training	*(Insert Date Achieved)*	*(Tick)*
Chest X-ray Interpretation & Requesting	*(Insert Date Achieved)*	*(Tick)*
(Add procedures within scope of practice)	*(Insert Date Achieved)*	*(Tick)*

Assessment of competence

Assessment of competence is on ongoing process and necessitates multiple modes of assessment. Demonstrating procedural progression through multiple assessments is important. Local guidance should be provided to trainees from the outset regarding assessment of competence or independent practice where required.

The assessment process should consist of both formative and then summative assessments (See FICM assessment documents).

Formative

- Work-based assessments particularly Direct Observations of Procedures (DOPs) should be completed in a formative way first e.g., performing a procedure under supervision.
- This assessment can be undertaken by either a Consultant, Qualified ACCP or Registrar
- No limit on number of DOPs completed.
- The more invasive the procedure the more formative evidence is required.
- Local policy will specify the requirements to trigger a Summative assessment.

Summative

- This is recommended to be Consultant supervised.
- This sign off will mean the person is competent to carry out the procedure within their defined scope of practice and local governance structure.

Radiology

An area which is widely varied within the national picture is the ability to request radiological examinations. Along with this only 26% of respondents felt that it was outlined when they could independently assess and clear lines, tubes and NGTs on a chest X-ray.

Something which should be signposted and accessed early is Ionising Radiation (Medical Exposure) Regulations Training (IRMER). If local training is not available trainees should complete the e-learning for healthcare module (https://www.e-lfh.org.uk/programmes/ionising-radiation-medical-exposure-regulations/).

It is essential that the trainee is aware of which radiological tests are within their scope of practice to request and that local governance structures are adhered to. It is recommended that governance structures and local assessment criteria be identified by the ACCP Clinical leads prior to the commencement of any tACCP pathway.

Some of the tests which may be within an ACCP's scope of practice to request are;

- *Chest X-rays*
- *Abdominal X-rays*
- *Limb X-rays*
- *Liver Ultrasound*
- *Renal tract Ultrasound*
- *Dopplers*
- *CT Head/Chest/Abdomen*
- *MRI Brain/Spine*

Assessment of Chest X-rays

A chest X-ray is a commonly requested investigation in critical care following the insertion of central lines, ETT tubes and nasogastric tubes. Assessing the appropriate position, siting and for any complications along with the procedure itself is a skill. It is recommended that a formal process of both formative and summative assessment be undertaken by the trainee in the assessment of chest X-rays.

Local Consideration

Trainees should be provided with a formal teaching session on interpreting chest x-rays in the Critical Care environment. This session should introduce a structured format for image interpretation, but also the criteria for safe clearance of line and nasogastric tubes. Trainees should be introduced to the formative and summative local requirements for assessment of a chest X-ray during the induction period.

Formative process

- This should include a locally agreed number of supervised reviews of chest X-rays.
- These should be supervised by an appropriately trained professional or clinician.
- The review should specifically look at line and NG placement and position, but other pathologies as well.

Summative process

- Completion of trust recommended IRMER training including any additional local governance recommendations.
- Summative DoPs for the assessment of a Chest X-ray.
- This assessment should be undertaken by a Critical Care Consultant.

AHP Background

It is recognised that the diverse blend of base professions eligible to work as ACCPs is undoubtably one of the strengths of the ACCP profession, bringing a broad and extensive range of skills and experiences. With this variation in experience, it has been established that AHPs entering an ACCP training programme could benefit from the initial focus of training and education containing a few key elements. The aims for this section are to highlight the key practice and education considerations to support AHP transition to ACCP training.

Recommendations

Bedside Nursing Experience

One of the great resources of knowledge and experience within every critical care department are the nursing teams. It is highly recommended that time is offered for the trainee to shadow them. By supporting the trainee to have time with the nursing teams they can familiarise themselves with the daily management of patients, common devices, tools, and technology used on the units daily. This is also a good time for practice handling, preparing, and administering drugs.

Critical Care Technology

All Critical Care units will offer local training programs for new starters up to Senior Critical Care nurses. It is worth considering for any non-critical care background and AHPs to attend existing relevant training days. Technology within critical care can be intimidating. It is worth developing a list of commonly used equipment within your critical care department. It is worth considering these before any non-critical care or AHP joins your ACCP team. Below is a list of widely used equipment within Critical care, not all of which will be relevant to every Critical Care.

- *Bedside and transfer monitors (setting alarm limits and adjusting screen settings)*
- *Infusion pumps (How to set up infusions)*
- *Renal Replacement Therapy (modes and machines)*
- *Ventilators (including transport ventilators)*
- *ABG Machines*
- *Arterial/CVP set-up*
- *Targeted Temperature Management devices*
- *PiCCO/LiDCO monitoring*
- *Epidural and Paravertebral block devices*
- *Intra-Abdominal Pressure Monitoring*
- *Train of Four*
- *ICP monitoring*
- *EVDs*
- *PA catheters*
- *Dopplers*
- *Temporary Pacing Wires*
- *ECMO*
- *Intra-Aortic Balloon Pumps*
- *ThromboElastoGram*

Drug handling, preparation, and administration

Education on common drugs, administration routes, rates of infusions, and boluses. Most units will have an induction pack for new Critical Care nurses with this information available. We recommend liaising closely with the practice development teams to access this information. Supervised practical experience on how to prepare and administer IV medications is incredibly useful. This would be an excellent objective for when working with the bedside nursing teams.

AHP Senior Trust Contact

Introduction to local senior AHP matching base registration of the trainee, to maintain base professional relationships and review of yearly objectives is strongly recommended. This meets the conditions set by the HCPC to maintain baseline professional registration. It is recommended these links are established ahead of the trainee commencing the pathway.

AHP ACCP Mentor

If available, having a qualified ACCP mentor that matches the trainee's baseline profession for the first year of training will allow the trainee to have profession-specific insight into the role, including specific educational needs and practice-based learning. If there is no local provision to provide this, it is recommended that the trainee attempt to access a mentor from within the national ACCP group (*page 10*)

Promoting ACCP Wellbeing

With a high proportion of the critical care workforce reported to be experiencing significant burnout [1], emphasis on sustaining and promoting the wellbeing of staff is a priority. Acknowledging that delivering a successful ACCP training programme, is not only determined by the tACCPs ability to manage individual stressors of academic and clinical pressures, but is influenced by external factors such as environment, programme delivery, leadership, engagement, and peer support, is key [2]. By cultivating a positive and safe learning environment, where equality, diversity and inclusion are prioritised, tACCPs are empowered to reach their full potential, improving patient experience and service delivery [3].

Below are recommendations adapted from the Intensive Care Society (ICS), National institute for health and care excellence (NICE)guidelines and national ACCP consultation to support establishing an open and transparent learning environment, promote wellbeing and ultimately optimise the experience for tACCPs, critical care workforce and patients.

For additional resources, the Intensive care society has created an excellent wellbeing hub which is free to access and provides information on how to support wellbeing within critical care. You can access this by clicking here . In addition the association of anaesthetics has some excellent tips and resource's on recognising and managing fatigue that can be accessed by Clicking here .

Laying foundations

When implementing an ACCP training program the expectations of the tACCPs and vision of the qualified ACCP team should be introduced to the wider CCU work force prior to the tACCPs starting [3]. This promotes a team culture, setting the scene for strategic change and encourages engagement of key stakeholders including critical care nurses, AHPs, junior doctors, registrars, and teams which tACCPs trainees will meet regularly [3] [7]. This invites opportunity to raise concern and address barriers associated with a changing workforce [6]. By actively engaging and educating the CCU team, embedding tACCPs into the workforce becomes a collective decision with shared ownership, reducing anxiety and positively promoting the value of transformational change [7]. On arrival tACCPs should be given an induction to the unit, team, operational and managerial structure, outlining where they fit into the organisation and vision, giving value and context to the role, identifying their contribution in driving the service forward.

Role of line managers and supervisors

On induction tACCPs should be introduced to their line manager, clinical/educational and academic supervisors. The roles and responsibilities of each should be clearly outlined including expectation of how often they would meet with trainees and how/who best to communicate with and scheduled meetings.

Fostering a supportive, open, transparent, and trusting relationship between these triumvirates promotes a safe learning environment where the tACCPs should feel empowered to raise concerns, provide feedback and feel their contribution is valued [8]. Regular check ins which promote open dialogue regarding mental health and acknowledging triggering factors should be normalised, encouraging tACCPs to consider their own mental health and risk of burnout [9].

Emphasis on shared values, equality, diversity, and inclusion should be embedded within the culture of the team, giving opportunity for all trainees to meet their full potential [7, 9]. Building resilience within the workforce by promoting collective debriefs, reflective practice, learning from incidents and embracing new

strategies to overcome adversity, supports retention by driving a collective sense of responsibility and belonging. [3].

Lastly, it's important to acknowledge and promote wellbeing within your role as manager. Providing clinical, emotional and professional support can be burdensome and can take its toll. It is important to lead by example, prioritising your own wellbeing by ensuring you take regular leave, seek peer support, and implement boundaries around communication and availability.[3, 7]

Setting expectations

From the outset a structured job description and learning agreement should be put in place and agreed by all parties. This should clearly define the expectation of the trainee, educational supervisor, and educational supervisor and reinforce the core purpose of training and how this feeds into the future development of service (3). Flexible working should be considered to reflect the needs of both the trainee and service, to encourage autonomy and ownership of continued development [1, 8, 3].

Educational opportunities and training should be protected, maintaining a 2-year supernumerary period. This should be embedded in the training programme, so both tACCPs and the wider team clearly understand the boundaries of their trainee post and the burden of service delivery is reduced especially during the early transition into post. During this supernumerary period tACCPs should be prepared for working out of hours independently including weekend and night shifts , by shadowing senior colleagues. Ideally this should be introduced in year two and scheduled as part of their clinical learning experience.

If for any reason a break in training is needed the FICM guidelines should be followed, training should be postponed and the tACCPs should be informed and supported during this period. Prior to recommencing training a local faculty meeting should be held to identify any specific educational, clinical or psychological needs that may need to be met before of during reinstating tACCP training programme.

Meeting basic needs

A unit culture should be embraced which supports self-care, regular breaks and encourages full annual leave entitlement to be taken. On site facilities should be adequate providing dedicated/shared workspaces, rest rooms and informal spaces to socialise as a team or have meetings [11]. Direction towards where to find and access staff benefits should be given as part of the introduction pack.
tACCPs should be integrated into the team and regular huddles with the whole MDT CCU team are encouraged to reflect on experiences and learn from shared experiences [9].

Sign posting

ACCP training is demanding both for trainees and trainers and can test the most resilient of individuals. Often it is not the training itself but an accumulation of factors which renders people feeling overwhelmed and/or stressed. Often an opportunity to talk this through over a coffee is enough reassurance to help people realign themselves, for others more formal support may be required. Regardless of the reason, giving opportunity to understand the individual's situation ,providing reassurance and supporting them to seek support should be encouraged. Below is a list of useful resources trainees can be signposted too. In addition, trust resources and how to access them should be provided. These include but are not exclusive too:

- Staff councillor
- Pastoral care
- Occupational health
- Internal staff communications
- Freedom to speak up champion.

Mentorship and Peer support

Informal mentorship and peer support is vital to both trainees and trainers alike and can be sought through external organisations or within hospital trusts. Below are some recommended resources.

- *Hospital Trust LGBTQ+ Networks*
- *NHS Muslim Women's Network muslim.women@nhs.net @NHSMuslimwomen*
- *Filipino Nurses Association https://www.fnauk.org.uk/ @filipinonurseuk*
- *Intensive Care Society (ICS) Equality Diversity & inclusion working group*
- *Dr Jen Warren Intensivist and Co-Chair of the Disabled Doctors Network @drjen_warren drjenwarren@gmail.com*
- *National Association of Advanced Critical Care Practitioners accpuk@gmail.com*
- *NHS Black & Minority Ethnic (BME) Network*
- *NHS Women's Development Network*
- *NHS Lesbian Gay Bisexual Transgender (LGBT+) Network*
- *NHS Disability & Wellbeing Network (DAWN)*
- *Nurse Life Line @Nurse_lifeline 0808 801 0455*
- *Rachel Moses British Thoracic Society president elect, Chartered Society of Physiotherapists council @NHSLeader*

Appendix 1: Abbreviations

The below is a list of abbreviations commonly used throughout the induction framework document

Abbreviation	Term
ACCP	Advanced Critical Care Practitioner
tACCP	Trainee Advanced Critical Care Practitioner
qACCP	Qualified Advanced Critical Care Practitioner
FICM	Faculty of Intensive Care Medicine
FICMASC	Faculty of Intensive Care Medicine ACCP Subcommittee
HEI	Higher Education Institute
WPBA	Workplace based Assessments
APEL	Accreditation of Prior Experiential Learning
ARCP	Annual Review of Competency Progression
MDT	Multidisciplinary Team
IRMER	Ionising Radiation (Medical Exposure) Regulations
NGT	Nasogastric Tube
MSF	Multi-source Feedback
RSI	Rapid Sequence Induction
LMA	Laryngeal Mask Airway
GCP	Good Clinical Practice
DOPS	Direct Observation of Procedure
CBD	Case Based Discussion
I-CEX	ICM Mini Clinical Evaluation Exercise
ACAT	Acute Care Assessment Tool
ILS	Immediate Life Support
ALS	Advanced Life Support
CALS	Cardiac Advanced Life Support
ATLS	Advanced Trauma Life Support
ODP	Operating Department Practitioner
RCEM	Roya College of Emergency Medicine
SALT	Speech and Language Therapy
ETT	Endotracheal Tube
NICE	National Institute for Health and Care Excellence
ICS	Intensive Care Society
PiCCO	Pulse Contour Cardiac Output
LiDCO	Lithium Dilution Cardiac Output
ICP	Intracranial Pressure
EVD	Extra Ventricular Drain
AHP	Allied Health Professional
ECMO	Extracorporeal Membrane Oxygenation
HCPC	Health and Care Professions Council

Appendix 2: Induction Framework Working Group

We wanted to take a moment to acknowledge the efforts of the following contributors in the creation of this framework:

Working Group	
Lucy Halpin	*Advanced Critical Care Practitioner* *Advanced Critical Care Practice Pathway Director Thames Valley*
Natalie Gardner	*Advanced Critical Care Practitioner*
Anita Jones	*Advanced Critical Care Practitioner*
Kate McCormick	*Advanced Critical Care Practitioner*
Jo-Anne Gilroy	*Advanced Critical Care Practitioner* *Advanced Critical Care Practice Pathway Director London*
Caroline McCrea	*Advanced Critical Care Practitioner*
Louise Houslip	*Trainee Advanced Critical Care Practitioner*
Ali Hopkins	*Trainee Advanced Critical Care Practitioner*
Stevie Park	*Trainee Advanced Critical Care Practitioner*
Ashton Burden-Selvaraj	*Trainee Advanced Critical Care Practitioner*

Contributors	
Sadie Diamond Fox	*ACCPAN Co-Lead* *Senior Lecturer in Advanced Critical Care Practice* *Advanced Critical Care Practitioner*
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Stuart Cox	*Advanced Critical Care Practitioner*
Allison Keegan	*Advanced Critical Care Practitioner*
Kate Mayes	*Lead Advanced Critical Care Practitioner*
Dr Jonathon Coates	*Emergency medicine and Critical Care Consultant, ACCP Clinical Lead*
Dr Jonathan Paige	*Critical Care Consultant, ACCP Clinical Lead*
Dr Mathew Williams	*Anaesthetics and Critical Care Consultant, ACCP Clinical Lead*
Joe Wood	*Advanced Critical Care Practitioner*
Heather Baker	*Advanced Critical Care Practitioner*
David Cartlidge	*Advanced Critical Care Practitioner*
Eoin McNamee	*Trainee Advanced Critical Care Practitioner*
Stuart Fraser	*Advanced Critical Care Practitioner*
Ashley Harris	*Advanced Critical Care Practitioner*
Rachel Melbourne	*Trainee Advanced Critical Care Practitioner*
Alice Hodgson	*Trainee Advanced Critical Care Practitioner*
Hannah Conway	*Advanced Critical Care Practitioner* *Assistant Professor of Advanced Clinical Practice, University of Nottingham*
James Sherwin	*Advanced Critical Care Practitioner*

Appendix 3: tACCP Passport

Trainee ACCP: *(Insert Name)*	***Unit Name:*** *(Insert details)*
Educational Supervisor: *(Insert Name)*	***Mentor:*** *(Insert Name)*
Email: *(Insert email details for CS)*	***Email:*** *(Insert email details for Mentor)*
HEI details: *(Insert HEI name here)*	***HEI Contact:*** *(Insert Name)* ***Email:*** *(Insert HEI Contact details)*
Register as a trainee ACCP (See Appendix 4)	*(Tick when complete)*

*The following represents the **minimum** number of clinical assessments to be included in the trainee's portfolio for submission at the end of each academic year.*					
Minimum Year 1 Assessments			***Minimum Year 2 Assessments***		
Direct observation of procedural skills (DOPS)	8	*(Minimum Achieved)*	Direct observation of procedural skills (DOPS)	8	*(Minimum Achieved)*
Acute Care Assessment Tool (ACAT)	4	*(Minimum Achieved)*	Acute Care Assessment Tool (ACAT)	4	*(Minimum Achieved)*
Case-based Discussion (CBD)	2	*(Minimum Achieved)*	Case-based Discussion (CBD)	2	*(Minimum Achieved)*
ICM Mini-Clinical Evaluation Exercise (I-CEX)	2	*(Minimum Achieved)*	ICM Mini-Clinical Evaluation Exercise (I-CEX)	2	*(Minimum Achieved)*
Multi-Source Feedback (MSF)	1	*(Minimum Achieved)*	Multi-Source Feedback (MSF)	1	*(Minimum Achieved)*
Expanded Case Summary – 2000 words max	1	*(Minimum Achieved)*	Expanded Case Summary – 2000 words max	1	*(Minimum Achieved)*
Logbook summary	1	*(Minimum Achieved)*	Logbook summary	1	*(Minimum Achieved)*
Record of reflective practice (500 words max)	2	*(Minimum Achieved)*	Record of reflective practice (500 words max)	2	*(Minimum Achieved)*
Summary of formal teaching and courses attended	1	*(Minimum Achieved)*	Summary of formal teaching and courses attended	1	*(Minimum Achieved)*

By the end of your two-year pathway, you will be independent in the following procedures.		
Procedure (Essential)	***Summative Assessment (Independent practice)***	
Peripheral Venous Cannulation	*(Insert Date Achieved)*	*(Tick)*
Arterial Cannulation	*(Insert Date Achieved)*	*(Tick)*
Central Venous Cannulation	*(Insert Date Achieved)*	*(Tick)*
Nasogastric tube insertion	*(Insert Date Achieved)*	*(Tick)*
Urinary Catheterisation	*(Insert Date Achieved)*	*(Tick)*
Defibrillation in Cardiac Arrest	*(Insert Date Achieved)*	*(Tick)*
Laryngeal mask airway insertion	*(Insert Date Achieved)*	*(Tick)*
Dialysis catheter insertion	*(Insert Date Achieved)*	*(Tick)*
(Add procedures within scope of practice)	*(Insert Date Achieved)*	*(Tick)*
Requesting radiological exams currently is not standardised – please refer to local non-medical requesting policy		
Radiology	***Date***	
IRMER training	*(Insert Date Achieved)*	*(Tick)*
Chest X-ray Interpretation & Requesting	*(Insert Date Achieved)*	*(Tick)*
(Add procedures within scope of practice)	*(Insert Date Achieved)*	*(Tick)*

The Faculty of
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ACCP Trainee Registration Form

This form is ONLY for use by practitioners employed in the United Kingdom in a substantive training post who are undertaking Higher and/or ACCP training. This form **must** be counter-signed by the local clinical lead for ACCP training and the ACCP programme director.

This form must be completed in full using the Word version of the document. All information must be submitted electronically. Electronic signatures are accepted. Please **do not** alter the format.

Please submit your completed form to contact@ficm.ac.uk. Submission is acknowledged via email.

Part 1 Personal Details

1.1 Title:

1.2 First name(s):

1.3 Last name:

1.4 Permanent address and Postcode:

1.5 Telephone No: (*Home*)

1.6 Telephone No: (*Work*)

1.7 Gender:

1.8 Date of Birth:

1.9 Email address:

1.10 Base profession:

1.11 NMC/HCPC No:

1.12 Expiry date:

Part 2 Training

2.1 Higher Education Institute:

2.2 HEI Programme Title:

2.2 Module lead:

2.5 Email address:

2.4 Training Centre:

2.5 Training start date:

2.6 Expected completion date:

Part 3 Trainee Declaration

I wish to register as an ACCP Trainee with the Faculty of Intensive Care Medicine and understand to give the Faculty notice of any change in this training programme.

I confirm that, to the best of my knowledged, all of the information I have provided in this application represents a true and accurate statement.

Under the Data Protection Act, I accept that the information provided on this form may be processed and passed to the ACCP Advisory Group, employers etc for legitimate purposes connected with my training.

3.1 Trainee Signature

3.2 Date

Part 4 Supporting Signatures

Clinical Lead

I can confirm that the above named trainee is undertaking an ACCP training programme in line with the 2015 ACCP Curriculum.

4.1 Signature:

4.2 Date:

4.3 Clinical Lead Name:

4.4 Hospital:

ACCP Programme Director

I can confirm that the above named trainee employed in a designated ACCP training post and is registered on a PGDip level ACCP programme which meets the requirements of the FICM ACCP Curriclum 2015.

4.5 Signature:

4.6 Date:

4.7 Please print

Appendix 5: Trainee ACCP Planner

Below is an example of a Two-year HEI & Clinical planner

Year One – HEI		
Semester 1	**Semester 2**	**Semester 3**
Advanced Clinical Assessment and Decision Making (Deadline TBC)		
Clinical Sciences for Advanced Practice (Deadline TBC)		Research for Advanced Practice (Deadline TBC)
Year Two – HEI		
Managing complexities in Advanced Practice (Deadline TBC)		
Non – Medical Prescribing (Deadline TBC)		
Optional Year 3 – Completion of MSc		

Year One – Clinical			
Semester 1	**Semester 2**	**Semester 3**	**Semester 4**
Induction	MSF (minimum 1/yr) Consultant Feedback (Recommended quarterly)		
Clinical Supervision Meeting 1 (Complete ACCP educational agreement)	Clinical Supervision Meeting 2 (Complete ACCP educational agreement)	Clinical Supervision Meeting 3 (Complete ACCP educational agreement)	Clinical Supervision Meeting 4 (Complete ACCP educational agreement)
RAG Assessment (update before clinical supervision meetings to help bespoke your development needs)			ARCP (See page 18 -19 of assessment systems document)
Year Two – Clinical			
Clinical Supervision Meeting 5 (Complete ACCP educational agreement)	Clinical Supervision Meeting 6 (Complete ACCP educational agreement)	Clinical Supervision Meeting 7 (Complete ACCP educational agreement)	Clinical Supervision Meeting 8 (Complete ACCP educational agreement)
MSF (minimum 1/yr) Consultant Feedback (Recommended quarterly)			
RAG Assessment (update before clinical supervision meetings to help bespoke your development needs)			ARCP (See page 18 -19 of assessment systems document)

All paperwork can be located within the Curriculum for training for Advanced Critical Care Practitioners – Assessment System.

https://www.ficm.ac.uk/index.php/careersworkforceaccps/accp-curriculum

Appendix 6: Resources

These resources have been recommended by practising ACCP's, they are not endorsed by FICM.

Notetaking		
Google Docs	https://www.google.co.uk/docs/about/	
Notability	https://www.gingerlabs.com/	
Goodnotes	https://www.goodnotes.com/	GoodNotes
Evernote	https://evernote.com/	

Referencing & Scanner		
EndNote	https://endnote.com/	
Cite this for Me	https://www.citethisforme.com/	Cite This For Me
Ref Works	https://refworks.proquest.com/	RefWorks
Tiny Scanner	*Available for both Apple and Android*	

Radiology		
Radiopaedia	https://radiopaedia.org/articles/image-preparation?lang=gb	Radiopaedia
Radiology Masterclass	https://www.radiologymasterclass.co.uk/gallery/galleries	RADIOLOGY masterclass
Pocus 101	https://www.pocus101.com/	POCUS 101
Core Ultrasound	https://www.coreultrasound.com/	CORE ULTRASOUND LEARN · EXPLORE · SHARE

Clinical Practice		
Up to Date	https://www.uptodate.com/login	
BMJ Best Practice	https://www.bmj.com/company/hee/	
E-learning for Healthcare	https://www.e-lfh.org.uk/	
Geeky Medics	https://geekymedics.com/	
The Internet Book of Critical Care	https://emcrit.org/ibcc/toc/	
Zero to Finals	https://zerotofinals.com/	
Deranged Physiology	https://derangedphysiology.com/main/home	
ESICM E-Learning	https://www.esicm.org/education/academy/	
Life in the fast lane	https://litfl.com/	

Research & Journals		
Critical Care Reviews	https://criticalcarereviews.com/	
The Bottom Line	https://www.thebottomline.org.uk/	
Cochrane Library	https://www.cochranelibrary.com/	

Medicines & Pharmacology		
BNF	https://bnf.nice.org.uk/	
EMC Online	https://www.medicines.org.uk/emc#gref	
Microguide	*Available via the Induction App*	
Toxbase	https://www.toxbase.org/	

Webinars & Podcasts		
Critical Care Practitioner Webinars	https://www.criticalcarepractitioner.co.uk/	
Resus Room	https://www.theresusroom.co.uk/	
EMCrit Project	https://emcrit.org/about/	
Dr Podcast	https://drpodcast.co.uk/	

Professional Resources		
FICM: ACCP Curriculum	https://www.ficm.ac.uk/index.php/careersworkforceaccps/accp-curriculum	
Health Education England (HEE) Advanced Practice	https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf	
The Intensive Care Society	https://www.ics.ac.uk/	

Appendix 7: Example WPBA's

The Faculty of Intensive Care Medicine

Direct Observation of Procedural Skills (DOPS) Assessment Form

Please complete this form in BLOCK CAPITALS and BLACK ink

Trainee's Surname	[redacted]
Trainee's Forename(s)	[redacted]
GMC Number	[redacted] GMC NUMBER MUST BE COMPLETED

Procedure	INSERTION OF PERIPHERAL CANNULA
Code Number	

Observed by	[redacted]
GMC Number	[redacted] GMC NUMBER MUST BE COMPLETED
Date	[redacted]
Signature of observing doctor	[redacted]

Assessment:

Practice was satisfactory	X	[redacted]
Practice was unsatisfactory		

Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given.

Example of good practice were:

[redacted] prepared adequately for the procedure – she ensured all the equipment was ready.

Although the patient was sedated, she made sure she explained to him what she was going to do and completed the procedure in his best interests.

[redacted] inserted the cannula on the first try using ANTT, flushed and dressed the line.

She then handed over to the nurse and documented in the patients notes.

Areas of practice requiring improvement were:

Nil.

Further learning and experience should focus on:

Nil.

ICM DOPS Assessment

If you have rated the performance unsatisfactory, you **MUST** indicate which elements were unsatisfactory:

Performance	YES	NO	Comments
Understands **indications** and **contraindications** for the procedure	X	Tick	Comments
Explained procedure to patient	X	Tick	Comments
Understands relevant **anatomy**	X	Tick	Comments
Satisfactory **preparation** for procedure	X	Tick	Comments
Communicated appropriately with patient and staff	X	Tick	Comments
Full **aseptic** technique	X	Tick	Comments
Satisfactory **technical** performance of procedure	X	Tick	Comments
Adapted to unexpected problems during procedure	X	Tick	Comments
Demonstrated adequate **skill** and **practical fluency**	X	Tick	Comments
Maintained **Safe** practice	X	Tick	Comments
Completed procedure	X	Tick	Comments
Satisfactory **documentation** of procedure	X	Tick	Comments
Issued clear **post-procedure instructions** to patient and staff	X	Tick	Comments
Maintained **professional** demeanour throughout procedure	X	Tick	Comments

Curriculum Competency Level Descriptors

The following Competency Level Descriptors are excerpted from Part II of *The CCT in Intensive Care Medicine* and are presented here for ease of reference when completing the 'Competencies Assessed' section (over).

Level	Task orientated competence	Knowledge orientated competence	Patient management competence
1	Performs task under direct supervision.	Very limited knowledge; requires considerable guidance to solve a problem within the area.	Can take history, examine and arrange investigations for straight forward case (limited differential diagnosis). Can initiate emergency management and continue a management plan, recognising acute divergences from the plan. Will need help to deal with these.
2	Performs task in straightforward circumstances, requires help for more difficult situations. Understands indications and complications of task.	Sound basic knowledge; requires some guidance to solve a problem within the area. Will have knowledge of appropriate guidelines and protocols.	Can take history, examine and arrange investigations in a more complicated case. Can initiate emergency management. In a straightforward case, can plan management and manage any divergences in short term. Will need help with more complicated cases.
3	Performs task in most circumstances, will need some guidance in complex situations. Can manage most complications, has a good understanding of contraindications and alternatives.	Advanced knowledge and understanding; only requires occasional advice and assistance to solve a problem. Will be able to assess evidence critically.	Can take history, examine and arrange investigations in a more complex case in a focused manner. Can initiate emergency management. In a most cases, can plan management and manage any divergences. May need specialist help for some cases.
4	Independent (consultant) practice.	Expert level of knowledge.	Specialist.

The Faculty of Intensive Care Medicine

Case-based Discussion (CbD) Assessment Form

Please complete this form in BLOCK CAPITALS and BLACK ink

Trainee's Surname	[redacted]
Trainee's Forename(s)	[redacted]
GMC Number	[redacted] GMC NUMBER MUST BE COMPLETED

Code Number or Description of Case	Discussion around ventilator associated pneumonia (VAP).

Observed by	[redacted]
GMC Number	[redacted] GMC NUMBER MUST BE COMPLETED
Date	[redacted]
Signature of supervising doctor	

Clinical Setting:

ICU X HDU ☐ ED ☐ Ward ☐ Transfer ☐ Other ☐

Assessment:

Practice was satisfactory	X	
Practice was unsatisfactory	Tick one	Assessor's signature

Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given.

Discussion around VAP:

- Pathophysiology (how patients get VAP, different bacteria)
- Causes/risks (type of patients that get VAP)
- Diagnosis & Investigations (temperature, secretions, clinical picture & differentials)
- Management and prevention (starting ABX, cultures, PPE).
- VAP care bundle (weaning from ventilator/use of NIV, stress ulcer prophylaxis, routine cuff pressures and micro aspiration, subglottic suctioning and routine mouth care/chlorhexidine).

Special focus of discussion:
Discussion around VAP, its causes, management and possible preventative measures that can be taken. Importance of VAP to prolonged ITU stay and increased number of ventilator days recognised and therefore the importance of recognition and prompt treatment.

ICM CbD Assessment

Please grade the following areas: (Descriptors included with each section)	Satisfactory	Unsatisfactory
1. History taking and information gathering		
Did the trainee take an adequate history and gather enough information from relatives, staff, notes or other colleagues to help decision making?	X	Tick
2. Assessment and differential diagnosis		
The focus here is on a targeted clinical examination that, combined with domain 1, allows full assessment and the assimilation of a differential diagnosis. It is important that more than one diagnosis is considered, but the most likely diagnosis should also be highlighted.	X	Tick
3. Immediate management and stabilisation		
Having made a full assessment, was the immediate management appropriate? Did the patient require urgent action? Was that action taken? Was it effective? Was appropriate help sought?	X	Tick
4. Further management and clinical judgement		
Once patient was stable, were further management decisions appropriate? Were appropriate drugs given? Were relevant tests ordered? Was the patient **managed/admitted** to the appropriate clinical area?	X	Tick
5. Identification of potential problems and difficulties		
Did the trainee identify potential problems?	X	Tick
6. Communication with patient, staff and colleagues		
How was communication dealt with by the trainee? Were intervention options discussed with the patient? Was there good communication with patient's relatives, staff and other colleagues?	X	Tick
7. Record keeping		
The records should be legible, signed, dated and timed. All necessary records should be completed in full.	X	Tick
8. Overall clinical care		
The case records and the trainee's discussion should demonstrate that this episode of clinical care was conducted in accordance with good practice and to a good overall standard.	X	Tick
9. Understanding of the issues surrounding the clinical focus chosen by the assessor		
The clinical focus must be one of the topics identified in the assessment schedule. The trainee should show an understanding ***appropriate to their experience.***	X	Tick

Case-based Discussion (CbD) – Intensive Care Medicine

Case-based discussion is designed to evaluate trainee clinical practice, decision-making and the interpretation and application of evidence, by reviewing their record of practice. Its primary purpose is to enable a conversation between trainee and assessor about the presentation and management of a critically ill patient. It is not intended as a test of knowledge, nor as an oral or clinical examination. It is intended to assess the clinical decision-making process and the way in which the trainee used medical knowledge when managing a single case.

The evaluation should be according to the trainee's level of training. A satisfactory assessment will indicate that the trainee's performance is what is expected from a trainee at their level of training. Please refer to the ICM curriculum.

The trainee should bring to their assessment a copy of the notes of three critically ill patients they have dealt with independently. The assessor will select one case. The trainee should be asked how they proceeded with management. In particular questions should be directed towards asking them to explain and justify the decisions they made. It is important to ask questions that bear directly upon the thought processes of the trainee during the case being discussed and not to digress into a long exploration of their knowledge of theory.

The assessor should also identify one particular issue that should have influenced the trainee's decision making in

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ICM Mini Clinical Evaluation Exercise (ICM-CEX) Assessment Form

Please complete this form in BLOCK CAPITALS and BLACK ink

Trainee's Surname	[redacted]	
Trainee's Forename(s)	[redacted]	
GMC Number	[redacted]	GMC NUMBER MUST BE COMPLETED

Observation	CRITICAL CARE ADMISSION & CLERKING
Code Number	

Observed by	[redacted]	
GMC Number	[redacted]	GMC NUMBER MUST BE COMPLETED
Date	[redacted]	
Signature of supervising doctor		

Clinical Setting:

ICU X HDU ☐ ED ☐ Ward ☐ Transfer ☐ Other ☐

Assessment:

	Practice was satisfactory	X	
	Practice was unsatisfactory		

Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given.

Examples of good practice were:

- Good communication with patient.
- Acceptable examination of patient (PC: SOB – COVID-19) and made plan (self-proning, CPAP, insert arterial line, stop antibiotics).
- Good record keeping.
- Identified limitations (unsure about management of pneumomediastinum) and ensured that this was followed up and sought advice regarding this. This self-awareness is critical to everyone in healthcare to ensure patients are the centre of care.

Areas of practice requiring improvement were:

- History Taking – key questions were asked however this was not structured and requires a vast amount of improvement.
- Arterial lines – able to insert and get flash back but when a-line pushed in further lost artery.
- CXR – again need to be more structured and keep practising.
- Later in the shift, it was handed over from the respiratory team that patient had a pneumomediastinum. I was unsure how to proceed with this and needed to discuss it with the SPR. She advised speaking to radiology SPR to see if patient warranted a CT scan however the radiology SPR wanted to discuss it with a doctor and not myself and I was unsure how to handle the situation as it was me 'looking after' that patient.
- I also did not identify that the patient needed Toclizumab prescribing.

Further learning and experience should focus on:

- History taking – go to wards such as AMU and A&E and practice. Present these back to the ITU consultant and summarise each patient. Ideally by going ahead of consultant / registrar to see referrals.
- Continue to gain exposure on reading and presenting CXR's.
- Continue inserting arterial lines.

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Direct Observation of Procedural Skills (DOPS) Assessment Form

Please complete this form in BLOCK CAPITALS and BLACK ink

Trainee's Surname	[redacted]	
Trainee's Forename(s)	[redacted]	
GMC Number	[redacted]	GMC NUMBER MUST BE COMPLETED

Procedure	INSERTION OF VASCATH
Code Number	

Observed by	[redacted]	
GMC Number	[redacted]	GMC NUMBER MUST BE COMPLETED
Date	[redacted]	
Signature of observing doctor		

Assessment:

	Practice was satisfactory	X	
	Practice was unsatisfactory	Tick one	Assessor's signature

Expand on areas of good practice. You **MUST** expand on areas for improvement for each unsatisfactory score given.

Example of good practice were:

Vascath inserted to an acceptable standard on a patient with platelets of 52.

More confident in troubleshooting why guide wire would not initially go in. I also did not dilate enough originally, this was due to me being nervous because of the platelets but I felt more confident in my ability to fix the problem.

Areas of practice requiring improvement were:

Ensuring all equipment is available and ready before scrubbing.

Further learning and experience should focus on:

Continue to gain experience in inserting vascath's to increase confidence and ensure more fluent in procedure.

If you have rated the performance unsatisfactory, you **MUST** indicate which elements were unsatisfactory:

Performance	YES	NO	Comments
Understands **indications** and **contraindications** for the procedure	X	Tick	Comments
Explained procedure to patient	X	Tick	Comments
Understands relevant **anatomy**	X	Tick	Comments
Satisfactory **preparation** for procedure	X	Tick	Comments
Communicated appropriately with patient and staff	X	Tick	Comments
Full **aseptic** technique	X	Tick	Comments
Satisfactory **technical** performance of procedure	X	Tick	Comments
Adapted to unexpected problems during procedure	X	Tick	Comments
Demonstrated adequate **skill** and **practical fluency**	X	Tick	Comments
Maintained **Safe** practice	X	Tick	Comments
Completed procedure	X	Tick	Comments
Satisfactory **documentation** of procedure	X	Tick	Comments
Issued clear **post-procedure instructions** to patient and staff	X	Tick	Comments
Maintained **professional** demeanour throughout procedure	X	Tick	Comments

Curriculum Competency Level Descriptors

The following Competency Level Descriptors are excerpted from Part II of *The CCT in Intensive Care Medicine* and are presented here for ease of reference when completing the 'Competencies Assessed' section (over).

Level	Task orientated competence	Knowledge orientated competence	Patient management competence
1	Performs task under direct supervision.	Very limited knowledge; requires considerable guidance to solve a problem within the area.	Can take history, examine and arrange investigations for straight forward case (limited differential diagnosis). Can initiate emergency management and continue a management plan, recognising acute divergences from the plan. Will need help to deal with these.
2	Performs task in straightforward circumstances, requires help for more difficult situations. Understands indications and complications of task.	Sound basic knowledge; requires some guidance to solve a problem within the area. Will have knowledge of appropriate guidelines and protocols.	Can take history, examine and arrange investigations in a more complicated case. Can initiate emergency management. In a straightforward case, can plan management and manage any divergences in short term. Will need help with more complicated cases.
3	Performs task in most circumstances, will need some guidance in complex situations. Can manage most complications, has a good understanding of contraindications and alternatives.	Advanced knowledge and understanding; only requires occasional advice and assistance to solve a problem. Will be able to assess evidence critically.	Can take history, examine and arrange investigations in a more complex case in a focused manner. Can initiate emergency management. In a most cases, can plan management and manage any divergences. May need specialist help for some cases.

Appendix 8: Logbook

the Google form logbooks is open source so anyone can access them and use them as they wish. This was developed by Natalie Gardner (ACCP – Kings College London).

The only risk with this is if people don't follow the instructions below and don't make their own copy, then the master will have people's data on.

So PLEASE follow the instructions below, and enjoy!

Note these instructions are for Apple devices as that's all I have but it should be a similar process for android

1. Ensure you have a Google account

2. Using a laptop, click the link

https://drive.google.com/.../1qNE0z69K47UfDb1ivqPbnwNSbI7...

3. Click on one of the copies of the forms

4. Click on the three dots in the top right corner, and click 'make a copy'

5. Name this how you wish it to be seen on your phone

6. Have your phone open, unlocked, and to hand.

7. On *your personal copy* (not the original copy in the link), click send in the top right corner

8. Click the 'link' button, then 'copy'

9. On your iPhone open safari, click the search bar twice until the option to 'paste' comes up. Click paste and the link from your MacBook will copy across.

10. When the page loads click the 'share' button then 'add to home screen'

11. Your form will appear somewhere between all your apps

12. You can create a logbook folder and add this form to that folder

13. Repeat this process with all forms

14. You then have all your forms on your home screen

Feel free to personalise your own copies as you see fit, or even make your own. Please do not use the original forms as they are master copies. Note you can export your data at the end of each year to excel, and the forms will create their own summary pages which are useful at ARCP and appraisal.

Any issues please post onto the National ACCP Facebook group for support.

Appendix 9: References

1. Dall'Ora, C., Ball, J., Reinius, M. *et al.* Burnout in nursing: a theoretical review. *Hum Resour Health* 18, 41 (2020). Available from :https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-020-00469-9 Accessed 24/06/21
2. Bates, A., Ottaway, J., Rushbrook, S., Moyses, H., et al .(2020). Psychological impact of caring for critically ill patients during the COVID-19 pandemic: recommendations for staff support. Journal of the Intensive Care Society. Available from : https://journals.sagepub.com/doi/pdf/10.1177/1751143720965109. Accessed from:24/6/21
3. Highfield,J. Burren, A. Baldwin , A,et al. (2021) Intensive care as a positive place to work: Workforce wellbeing best practice framework. Intensive Care Society. Available from: file:///C:/Users/gilroyj/Downloads/Workforce%20Wellbeing%20Best%20Practice%20Framework%20-%20Fina%20(2).pdf Accessed 24/6/21
4. Hidde H, Zegers M,Vanmol M & Boogaard M. (2021) The impact of the first COVID-19 surge on the mental well-being of ICU nurses: A nationwide survey study. Available from: https://pubmed.ncbi.nlm.nih.gov/33863609/. Accessed 24/6/21
5. Kannampallil T, Goss C, Evanoff B, et al. (2020). Exposure to COVID-19 patients increases physician trainee stress and burnout. Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0237301. Accessed 24/06/21
6. Lee G, Gilroy J, Ritchie A, Gruber P and Grover V. (2017). Advanced Critical Care Practitioners – Practical experience of implementing the Advanced Critical Care Practitioner Faculty of Intensive Care Medicine Curriculum in a London Critical Care Unit. Available from https://journals.sagepub.com/doi/full/10.1177/1751143717740019 Accessed 24/06/21
7. Mind. (2021). How to promote wellbeing and tackle the causes of work-related mental health problems. Available from: https://www.mind.org.uk/media-a/4808/how-to-promote-wellbeing-and-tackle-the-causes-of-work-related-mh-problems_walesv2.pdf Accessed 24/6/21
8. NICE (2015). Workplace health: management practices , (NG13) . Available from: https://www.nice.org.uk/guidance/ng13 Accessed 24/06/21
9. Sharp M & Burkat M. (2017). Trainee Wellness: Why It Matters, and How to Promote It. Annals of American thoracic society. Available from: https://www.atsjournals.org/doi/pdf/10.1513/AnnalsATS.201612-1006PS. Accessed 24/06/21
10. Vincent, L., Brindley, P. Highfield, J., Innes, R., Greig, P. & Suntharalingam, G. (2019). A National Survey of Burnout in UK Intensive Care Staff. Journal of the Intensive Care Society . Available from:https://journals.sagepub.com/doi/pdf/10.1177/1751143719860391
11. Warren J, Plunkett E, Rudge J, et al .(2021) Trainee doctors' experiences of learning and well-being while working in intensive care during the COVID-19 pandemic: a qualitative study using appreciative inquiry. BMJ Open. Available from: *https://bmjopen.bmj.com/content/11/5/e049437* Accessed 24/6/21