

GUIDANCE FOR TRAINING UNITS IN INTENSIVE CARE MEDICINE

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The Faculty of
Intensive Care Medicine

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This guidance pertains to trainees undertaking blocks in Intensive Care Medicine while pursuing the 2020 standalone curriculum for a CCT in ICM either as a single CCT or within a Dual CCT Training Programme. It is an update of previously issued guidance that has been reviewed in light of the updated curriculum and Guidelines for the Provision of Intensive Care Services v2 2019 (GPICS).

PROGRAMME CONTENT

The ICM curriculum, along with training objectives and competencies for each level and appropriate WPBAs, are available on the Faculty website and will underpin all ICM training programmes. The objective of the training programme is to move from a level of training and ability where an initial diagnosis, resuscitation and stabilisation of a patient is safely undertaken, to a point where the trainee is able to run an intensive care or critical care unit, managing and directing overall patient care plans. As the trainee progresses through each level, the degree of responsibility should increase as should their opportunity to teach and supervise junior colleagues and other staff members. To achieve this certain specific and general aspects of training will be required.

STANDARDS FOR PROGRAMME DELIVERY

1. All training units must have an educational structure in place to allow the recommendations in the 2020 Curriculum for a CCT in Intensive Care Medicine to be delivered. This should include
 - a. A unit induction,
 - b. Named Clinical Supervisor (+/- Educational Supervisor)
 - c. An educational contract, agreeing a bespoke personal development plan (PDP).
 - d. The ability to perform the appropriate workplace based assessments (WPBAs) to facilitate the attainment of all competencies at the relevant level within each designated stage of training.
2. All consultants responsible for the educational supervision of trainees must be recognized by the GMC for this role and there must be sufficient time allocated in the Educational Supervisor's job plan.
3. All module durations are indicative, bearing in mind this is a competency based programme, but must include full day shifts to be spent on the critical care unit to facilitate daytime ICM trainingⁱ and a proportionate degree of experience working at weekends, evenings and nights. Such rosters must be consistent with the new junior doctors contact rules, compliant with the EWTD pattern of working and have an increased presence of Consultants in ICM working in the hospital at these timesⁱⁱ.
4. Training at all stages should be delivered in blocks of a minimum of 3 months duration.
5. Trainee doctors must be given the time and opportunity to achieve the objectives set out in their PDP agreed with Educational Supervisor.

INITIAL PLANNING

Following an appropriate unit inductionⁱⁱⁱ an educational contract and bespoke personal development plan should be agreed between the trainee and Educational Supervisor / Faculty Tutor (FT) as specified by current FICM standards and WPBA will be carried out according to the current recommendations. Trainees must be given the time and opportunity to achieve the objectives set out in this plan. It is good practice for an initial meeting with the FT (and where necessary additional meetings with other facilitators of other relevant aspects of training, such as the regional Training Programme Director or Regional Advisor) to take place well in advance to help plan aspects of training, such as periods of attachment and facilitation of audit or research projects.

TRAINING STANDARDS

1. A weekly programme of teaching should be provided and supervised by a named ICM consultant on a recognised teaching unit^{iv}. Such a programme of education should relate to the literature and practice of ICM as well as relevant applied basic sciences. Time to attend teaching should be incorporated in to the trainees work schedule such that the time is protected. In smaller units teaching may be arranged in collaboration with other units.
2. A postgraduate education programme should be in place within the region for specialty ICM trainees with the aim of facilitating preparation for the written and oral components of the FFICM exam. Training units should contribute to regional programmes by releasing trainees to attend and also by contributions to the design and/or delivery of the programme.
3. Stage 3 trainees should be given enhanced clinical responsibility such as conducting ward rounds with an appropriate level of consultant supervision.
4. There must be regular clinical governance, and morbidity and mortality meetings that are attended by both consultant and non-consultant grade doctors. Stage 3 trainees should be encouraged to attend and participate in regular management meetings. It may also be appropriate for stage 3 trainees to attend the Regional Intensive Care Training Committee meetings.

TRAINING RECOMMENDATIONS

1. Hospitals / Departments should provide access to relevant and up to date Intensive Care Medicine journals and books relevant to the training of all members of the MDT.
2. Critical care units should provide additional access to online clinical resources from within the clinical area relevant to all staff.
3. Study leave, in line with contractual agreements, to attend intensive care-related courses and conferences should be provided where appropriate and reasonable to help meet curriculum and PDP requirements.
4. Where possible, providing “on call” (as opposed to resident) out of hours opportunities for Stage 3 trainees is to be encouraged. It is not appropriate for Stage 3 trainees to be the most junior member of the resident ICM medical team.
5. Departments are encouraged to provide trainees with appropriate access to IT, rest and accommodation facilities as outlined in the FICM Training Handbook^v

CURRICULUM COVERAGE

At each Stage of training, all aspects of the curriculum should be deliverable by each region’s programme. It is recognised that the importance of some areas of practical training will vary with time as medical knowledge advances. However the programme within a region must allow trainees to gain a broad knowledge of intensive care medicine. Specific elements and competencies in the curriculum will only be able to be delivered by placements in units providing specific sub-specialty ICU services (i.e. CICU, PICU, neuro-ICU).

TRAINING CAPACITY AND ROSTERING

Foundation Trainees

Foundation Trainees form a valuable part of the Critical Care team. Rostering of this group varies between units but care should be taken that there are sufficient training opportunities for all the trainees allocated to the unit at any one time.

Stage 1 and Stage 2 trainees

Trainees should have sufficient patient contact to provide enough clinical experience. The case mix and numbers presenting to the unit is the main determinant of this; however as a general rule an Intensive Care Medicine trainee at this level should look after a minimum of 3 level 3 patients or 6 level 2 patients and a maximum of 8 level 3 or 16 level 2 or a combination during daytime hours. Local considerations, such as the frequency of nocturnal admissions and the degree of instability of the patients will determine appropriate ratios at night. Interaction with other grades influences the ratio: for example more junior grades such as Foundation programme and CT Medicine trainees may be present on the unit in varying numbers. The tutor needs to ensure that interaction between these groups is productive, with the ICM trainee developing a supportive and supervisory role.

Stage 3 trainees

Units of eight level 3 or fewer beds should have only one Stage 3 trainee rostered to be on duty at any one time, excluding handovers. Stage 3 trainees may be rostered to be on-call from home. This may allow additional opportunities for training appropriate to this level of trainee but it is recognised that it is increasingly common for ICM to be delivered by consultants who are resident themselves.

ADDITIONAL CONSIDERATIONS

It is recognised that some units are critical care units i.e. a flexible mix of ICU and HDU patients. In these situations the average level 3 occupancy should be related to bed numbers. Similarly many units have adjacent ICU and HDU facilities, covered by the same medical staff. Here a similar calculation could be applied. Geographically separate units, for example separated by several floors or considerable horizontal distance of more than a few yards should not be normally regarded as one unit.

As a general principle, consideration should be given to the needs of trainees on units where other Allied Health Professionals (eg ACCPs) work in a medical role or are being trained. ACCPs may contribute to supporting the education of trainees new to ICM, eg Foundation doctors, but units may need to be mindful of the similar needs of trainee ACCPs and junior doctors in some areas of ICM practice and so should plan their rotas and work patterns accordingly.

Minor overlaps in trainee medical and trainee ACCP rostering should be at the discretion of the RA for ICM to consider if the training needs of both groups are able to be met.

For stage 2 single CCT trainees who are completing their 'specialist skill' module, the requirement for being rostered only to a critical care unit does not apply. They should be rostered as appropriate for acquisition of their specialist skill. However, these trainees must be rostered to clinical work to help maintain critical care skills during this year; each Special Skills Year stipulates the recommended minimum proportion of time this should be.

Where dual CCT trainees gain competences and training time towards the ICM programme while in their partner specialty, care should be taken to ensure they have adequate exposure within the overall programme to meet the required ICM competency.

GENERAL GUIDANCE FOR ROSTERING

All trainees must spend at least half of their working time (over a 24-hour period) during periods when consultants are rostered to be on site. If consultants have programmed activities on the Intensive Care Unit at other than usual office hours, these times may be counted towards the trainees' normal daytime hours, as direct consultant supervision is the deciding factor.

It is important that a minimum proportionate degree of training time is spent at night and weekends since the nature of experience at night is qualitatively different from that during the day. This minimum proportion should be 12.5% for the hours 2200-0700hrs.

It is accepted that there will be a need, particularly in smaller intensive care units, for the first line of call at night to be drawn from a pool of resident doctors comprised of trainees and non-trainees, not all of whom may be attached to intensive care during the day. Local arrangements must be made in these circumstances to ensure that appropriate induction and lines of reporting are in place, that the cover is provided by those with adequate competencies and that an appropriate skill mix is always available. Within the limits of the EWTD there is no requirement for a working day to be of any particular duration.

More formal lecture and tutorial based teaching may be most effectively organised in larger blocks of perhaps 4 hours to be held when none of the trainees are scheduled to be present on the intensive care unit. Trainees should be expected to come to work solely to attend such organised teaching, so long as it forms part of a work programme compatible with EWTD and the relevant junior doctor contract.

ADDITIONAL REQUIREMENTS FOR STAGE 3 TRAINING

Training in additional areas of expertise has been a common feature of ICM training programmes, such as the acquisition of experience in echocardiography, bronchoscopy or gastroscopy. These types of activities encourage new developments on intensive care units and should be strongly encouraged. The acquisition of relevant experience by attachment to other areas such as microbiology or radiology should be allowed and should count towards intensive care training. This should not normally exceed 1 half day per week. However, pure service attachments outside intensive care will not be permitted during any time of day or night^{vi}.

The opportunity to be involved in research, quality improvement and service review should be provided. However, it may be difficult for non-academic trainees to do original research and that "research awareness" may be easiest to obtain via an established research programme. Therefore, this should be part of an existing programme of research rather than individual projects specifically developed for trainees, and should be identified as early as possible. An ICM consultant with responsibility for coordinating trainee allocation to these projects should be identified. It is possible that this coordinator could be the Faculty Tutor or another individual; whatever the arrangement, close liaison should occur between the Tutor and coordinator/researcher at an early stage to avoid delays and missed opportunities.

Trainees are expected to complete smaller worthwhile quality improvement projects as well as contribute to programmes with a longer timescale for completion and dissemination.

DEFINING AN APPROPRIATE TRAINING ENVIRONMENT

In order for training in Intensive Care Medicine (ICM) to be recognised and approved, the Faculty of Intensive Care Medicine (FICM) have issued guidance to assist in the maintenance and development of training programmes by Deaneries, Regional Advisors (RAs) and Faculty Tutors (FTs).

Regions vary in the arrangement of training units and the Regional Advisor is best placed to maximise the training opportunities within their region's resources. In making this decision, the RA will take into account the ability of the unit to deliver the curriculum. Emphasis will be placed on the ethos of training within the

unit, in particular consultant support for training and the ability of the department to engage with the current training requirements. To ensure the quality of training there must be an appropriate case mix, case numbers and adequate consultant supervision.

Consistently poor feedback from the GMC or ICM training survey should prompt the RA to review training attachments.

The use of smaller units as part of the training scheme is to be encouraged. The duration of attachments and supervisory structure may need to be addressed on an individual basis. FFICM eligible consultants should staff the unit during daytime hours, and appropriate consultant support at all times as detailed in the GPICS V2 chapter on smaller remote and rural units. Again the ethos and enthusiasm of the unit to embrace training is of paramount importance.

While a mix of Intensive Care Units is essential for a broad training programme, care should be taken to ensure an appropriate environment for the trainee at a given stage of ICM training. The Regional Advisor and Training Programme Director will tailor the training programme to best suit the trainee's requirements. Stage 3 trainees should be based in units with a comprehensive teaching capability. Stage 3 trainees may be seconded to more than one unit so as to ensure a broad complimentary exposure to the needs of this Stage of training, and as befits their training needs and career preferences.

SUMMARY

It is vital that broad coverage of the curriculum is achieved at all levels of ICM training and training programmes must accommodate this. The overall running and structure of the programme should be determined by the TPD and RA taking local knowledge of hospital and service structures into account to ensure that the curriculum is fully covered by each trainee.

The objective of the training programme is to produce high quality patient-centred doctors skilled in ICM with appropriate knowledge, skills and attitudes to enable them to practise independently at consultant level.

Dual CCTs may only be acquired jointly with a recognised partner specialty. All aspects of training should be geared to enhancing the skills and abilities trainees will need as consultants. Therefore service provision for other specialties will not be permitted. Planning of training appropriate to the individual should take place at an early stage.

NOTES

ⁱ An element of flexibility may be accepted but should not average more than 1 half day every 2 weeks of training time for duties outside of Critical Care unless for specific ICM training purposes.

ⁱⁱ Within a conventional 1 in 8 trainee rota pattern this would equate to at least 12.5% out of hours' experience. Immediate cover for emergencies outside Critical Care may be acceptable but there should be arrangements in place to ensure that Critical Care cover is not compromised; for example Senior ICM trainees may be one of the more senior resident doctors in a hospital and may be in a position to deal with emergencies outside of the ICU, but during ICM training this should only be to deal with life/limb threatening time critical emergencies pending the arrival of another appropriate member of staff (usually a consultant)

ⁱⁱⁱ Formal, consultant-led departmental induction to the unit must include

- a. Instructions on how to raise patient safety concerns.
- b. Instructions on how to raise issues of bullying and undermining.
- c. Introduction to key members of medical, nursing, allied professional and operational support staff.
- d. Highlighting key departmental guidelines and how to access all departmental guidelines.
- e. Explanation and distribution of the doctor's rostered work pattern, and their roles and responsibilities when rostered to work both during the daytime and out of hours.
- f. Arrangements for access to all IT systems, including passwords, provision of identification badges and tutorials on the use of any clinical IT systems on the day of induction. Assigning each doctor an Educational Supervisor.

^{iv} Trainees at Stage 2 should participate in the delivery of this teaching and advanced Stage 3 trainees should be encouraged to take an active part in their design.

^v FICM Training Handbook, page 30

- a. Adequate accommodation for trainers and teachers in which to prepare their work.
- b. A private area where confidential activities such as assessment, appraisal, counseling and mentoring can occur.
- c. A secure storage facility for confidential training records.
- d. A reference library where trainees have ready access to bench books (or an electronic equivalent) and where they can access information at any time.
- e. Access for trainees to IT equipment such that they can carry out basic tasks on a computer, including the preparation of audio-visual presentations; access to the internet is recognised as an essential adjunct to learning.
- f. A suitably equipped teaching area and a private study area.
- g. An appropriate rest area whilst on shift.

^{vi} For example a trainee with an anaesthesia background will not be permitted to be involved in anaesthesia daytime or out of hours provision, or a trainee from a medicine background will not be permitted to conduct clinics or out of hours provision.