CRITICAL EYE

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE ISSUE 22 | SUMMER 2022

Simulation resources in critical care

The Faculty of Intensive Care Medicine

In this issue

ANTIMICROBIAL TREATMENT OF SEPSIS

GPICS NEW VERSION 2.1

MEDICAL EXAMINERS

The Faculty of Intensive Care Medicine

Striking the Balance 20 October 2022

Programme*			
Welcome	Dr Sarah Marsh	Women in Surgery	Miss Emma Collins
Women in Intensive Care	Dr Liz Thomas	Returning to work	Dr Victoria McCormack
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Self-preservation	Dr Penny Newman	NIHR Awards Presentation	Dr Alison Pittard
Rotational workshops – Attendees to choose 2 workshops to attend			
Workshop 1:	Work life balance		Dr Rifca LeDieu
Workshop 2:	Coaching		Dr Penny Newman
Workshop 3:	Learning from Experience		Dr David Selwyn

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Face to face

5 CPD points

Coaching

Awards

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- **Fellows & Members:** £205
- **Trainees, Nurses, ACCPs, Pharmacists:** £155
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- **Senior Fellows & Members:** £102.50

UPCOMING EVENTS 2022

@FICMNews

www.ficm.ac.uk/events

Undergraduate Leads Training Day

8 September 2022

FFICM Prep Course

13-14 September 2022

Tier 3 places now SOLD OUT
Please contact us for waiting list

Clinical Leads Conference

29 November 2022

Training & Leadership Annual Meeting

2 Feburary 2023

* Topics may be subject to change

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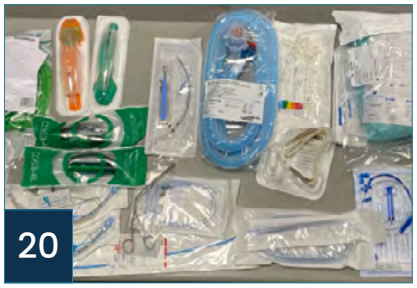

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Mr James Goodwin
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Coordinated by: Ms Lucy Rowan

Dean: Dr Alison Pittard
Vice Dean: Dr Daniele Bryden

WELCOME

Dr John Butler
Clinical Editor

Welcome to this summer edition of *Critical Eye*. I hope you have all enjoyed the warm weather over the last couple of months.

One of several areas of clinical controversy for Intensive Care Medicine over the years has been around the timing of antimicrobial administration to patients with sepsis. In 2019 the Faculty was invited by the Academy of Medical Royal Colleges to review the available guidance on this topic and to issue a consensus statement.

The conclusion of this work, which included input from many other colleges and stakeholders, was published in May 2022 and recommended a risk adaptive approach to patient priorisation using NEWS-2 as part of the risk assessment. Further information on this important piece of work can be found in the article by Professor Julian Bion and colleagues.

Finally in this editorial I would like to take this opportunity to pay tribute to Dr Alison Pittard, who's tenure as FICM Dean is coming to an end. As we are all aware, the last few years have been an extremely challenging period for our speciality dominated by our response to the COVID-19 pandemic. I wanted to thank Alison, on behalf of the Faculty membership, for the leadership, guidance and resilience she has demonstrated during this immensely testing time for our speciality.

As ever, we welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

Message From The Dean

Dr Alison Pittard
Dean

I can't quite believe that my tenure as FICM Dean is almost over. An interesting time to say the least! An opportunity to reflect on the last three years but also a time to look forward. COVID has dominated our lives and so many people have been negatively impacted either directly or indirectly. However, we all came together with a single vision, to care for our patients as best we could but the realisation that we must look after one another is just one of the many positives of the pandemic. Workforce wellbeing now has a much bigger profile and the need to create career pathways that are fulfilling, promote a good work-life balance and create resilience is vital.

Retaining our workforce

Our specialty must be attractive to work in, but we must also be able to retain our workforce too. Portfolio careers are a way forward and this was the focus of one of the presentations at our annual meeting this year. We all have different strengths, different interests and life is too short to be doing things we find unfulfilling. We also need to recognise that the way we work at the beginning of our career is not necessarily sustainable to retirement. Instead of focusing on what individuals do we could look at what the service is, what is needed to deliver it, and then who has the skills to deliver the various aspects of it. In this way we could choose the bits that we feel would be rewarding whilst, at the same time, still contributing as part of the team.

If safe service provision is guaranteed does it really matter if we each do it in a slightly different way? It could help recruitment, retention and resilience!

ICM training posts

We do not have enough ICM training posts to produce the number of consultants needed but we are in a better position than we were, having obtained an extra 100 in 2020 and, more recently, securing an extra 30 posts a year, for five years, from 2022. We continue to have an excellent fill rate and, at some point in our journey, we need to acknowledge the commitment of those who undergo ICM training and

> **"COVID highlighted the health inequalities that exist and the GIRFT report demonstrated unwarranted variation in the way we deliver critical care. We have a responsibility to ensure that our patients receive the right care, at the right time, in the right place and by the right people.**

achieve FFICM by examination. We know that many units find it difficult to recruit consultants with FFICM. I appreciate that our recent statement, requiring that a CCT in ICM becomes an essential criterion for an ICM consultant post, may appear to be counterproductive. Once we have sufficient training numbers this will cease to be an issue but, in the meantime, we hope to be able to influence where additional posts are allocated. HEE made the decision for this year's posts however we want to see more trainees experience of what smaller or remote units have to offer. This will hopefully make consultant posts more attractive and could then promote the training opportunities further.

One size doe not fit all

COVID highlighted the health inequalities that exist and the GIRFT report demonstrated unwarranted variation in the way we deliver critical care. We have a responsibility to ensure that our patients receive the right care, at the right time, in the right place and by the right people. If the pandemic has taught us anything, it is that we can adapt at pace and work in very different ways. Healthcare has been delivered in the same way since the inception of the NHS, but we need to keep patients at the heart of our service and accept that one size does not fit all. Hopefully, Integrated Care Systems will provide the framework to tailor delivery of care on a regional basis, ensuring that the principles of quality and safety remain but, at the same time, accepting that the way it is delivered may be different depending on the needs of the local population.

Transforming how we work

The adoption of digital technology over the last few years has been just amazing. It has transformed the way that we work and facilitated closer working relationships with organisations that may be geographically distant. In 2020, FICM announced its '2020 Vision' collaboration with the College of Intensive Care Medicine in Australia and New Zealand. Our relationship has gone from strength to strength, and we jointly hosted a webinar with the Apollo hospitals, India to promote the possibilities offered by embracing the use of telemedicine. Remote Critical Care means different things to different people but imagine a situation where the consultant intensivist is not physically present on the unit but is providing specialist input virtually. They would still be leading delivery of care but in a novel way. This would reduce variation and possibly help to address some of the health inequalities that exist. It would, however, need organisations to work better together but the opportunities are endless. The webinar can be freely accessed via FICMLearning. Our COVID experience has demonstrated how we can successfully work in different ways, and this is something to build on as we look to the future.

Building foundations

The FICM is now 12 years old. We are still in the very early stages of our journey. I hope the foundations we have built, and the progress we have made in ensuring our specialty receives the recognition it deserves, will ease us slowly into adulthood. We will continue to grow but none of this will happen without the continued, dedicated work of our FICM team who work tirelessly behind the scenes, always at the end of an email or message. I would like to pay tribute to them all and thank them for supporting me through the last three years.

New FICM Dean and Vice Dean

The Faculty is delighted to announce that Dr Daniele Bryden has been elected as the new FICM Dean. We are further pleased to announce that Dr Jack Parry-Jones has been elected as the new FICM Vice Dean. After an open call for nominations from Elected Board members, both stood unopposed. Terms of office will start in October 2022. when the current Dean, Dr Alison Pittard OBE, will step down. Until then, Danny and Jack will continue in their roles as Vice Dean and CRW Chair, respectively.

Dr Daniele Bryden, Dean Elect

Danny has been a consultant in Intensive Care Medicine at Sheffield Teaching Hospitals and Honorary Senior Lecturer at the University of Sheffield since 2001 and have previously been Lead Regional Advisor for the Faculty and Chair of the Careers, Workforce & Recruitment Committee as well as a member of the Legal & Ethical Policy Unit. She has served as FICM Vice Dean since 2019.

Danny says: *"I hope to work with your support and engagement, to build on the respect ICM has as an indispensable medical specialty and in an uncertain time, focus on what is needed to create a stronger future for ourselves and our patients.*

As Dean, I will aim at all times to be an authentic, compassionate and collaborative face of the Faculty and profession."

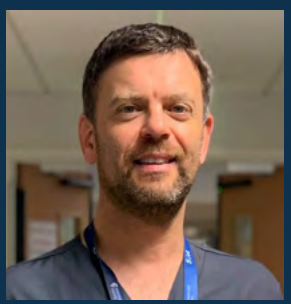
Dr Jack Parry-Jones, Vice Dean Elect

Jack has a postgraduate training background in medicine, anaesthesia and Intensive Care Medicine. Having been a London undergraduate, he then completed training programmes in London and Bristol. He moved from London to South Wales in 2003 and has worked solely as a consultant intensivist ever since. He has been the lead ICM clinician in Aneurin Bevan University Health Board and Cardiff and Vale University Health Boar, as well as Lead Clinician for the South Wales Critical Care and Trauma Network. Jack has an interest in education and was an examiner for the EDIC from 2004-2012, and an examiner for DICM and then FFICM from 2012-2018. He is currently Chair for Careers, Recruitment & Workforce having previously been Workforce Lead.

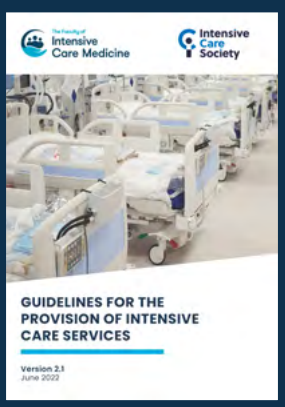
Jack says: *"We face an uncertain future including climate change; we all need to put our own and our environment's sustainability at the forefront of all our work and home lives. As the Faculty we are looking outward to other countries' ICM services for best practice and looking inward, we need to continue to focus on the ICM team's recruitment and retention particularly through education."*

Guidelines for the Provision of Intensive Care Services (GPICS) V2.1

Dr Peter Macnaughton
Co-Editor,
Chair FICMPAS



Dr Paul Dean
Co-Editor, Hon Sec
Intensive Care Society



The latest update to GPICS, Version 2.1, was published recently and builds on the first two editions that were published in 2015 and 2019. The first edition of GPICS was a landmark publication and the result of a continuing partnership between the Faculty and the Intensive Care Society.

GPICS remains the definitive reference source for the planning, commissioning and delivery of adult critical care services in the UK. The GPICS Audit Tool that was released in 2021 provides the definitive method for undertaking local service review.

Learning from the pandemic

GPICS V2.1 is published as we appear to have emerged from the COVID-19 pandemic that placed the provision of intensive care services under extreme pressure. The aim of this latest revision was to incorporate any immediate learning from the response to the COVID-19 pandemic. In addition, authors reviewed their chapters and made amendments to ensure that the guidance and information contained is up to date. No new chapters have been added.

The chapters covering staffing have not been changed in the latest version and remain as published in 2019. Whilst the pandemic forced temporary changes in staffing models to cope with the surge in admissions, these are not viewed as viable long term models for the delivery of critical care. The experiential learning from some of the different models of delivery during the pandemic may inform changes in the future, it was not felt an appropriate time to consider changes in the staffing models whilst we emerge and reflect on its impact. The Faculty of Intensive Care Medicine and the Intensive Care Society, along with our partner organisations, continue to recommend the minimum critical care staffing levels as laid out in the *Guidelines for the Provision of Intensive Care Services* (GPICS) V2.

Continued evolution

GPICS will continue to evolve to reflect the development of Intensive Care Services with the aim to undertake a comprehensive review with the publication of a new edition on a 5 yearly cycle. Planning for version 3 will start shortly!

We are grateful to those chapter authors who have revised their information and to those new authors who have revised existing chapters where previous authors have retired or moved on. We would like to dedicate *Guidelines for the Provision of Intensive Care Services V2.1* to all those who have unfortunately lost loved ones as a result of the pandemic and to all the staff who delivered critical care during a very challenging time.

ZERMATT TO VERBIER 2022

Dr Sarah Clarke
FICMTAQ Dep. Chair

"Are you looking for your next adventure? We are on the hunt to find four ski enthusiasts to join a fearless team and embark on a challenge that will push you to the extreme. If you like high-octane sports, then join us to take on the challenge of a lifetime whilst fundraising for ICS and Doctors in Distress. This is not for the faint-hearted and will require commitment but promises to be life-changing experience." — So read the email which dropped into mine and most of your mailboxes last June...

It was on a hot, sweaty, PPE-adorned shift. Any normal, sane reaction would be to press 'Delete'... But something struck a (deluded) chord, and I pressed 'Reply'.

Joining team ZtoV

Four weeks and an interview later, I was delighted and quite incredulous to be selected for team ZtoV, along with intensivist colleagues Drs Mike Margason and Sarah Sanders. To make up a team of six, we joined Gary (who'd had the idea of a fund-raising mountain challenge after his F2 daughter had worked on ICU during the first wave) and 2 of his colleagues, David and Nick. Soon the enormity of the challenge hit home.

The mission

Our route was the 'Patrouille des Glaciers', a tough all-terrain ski mountaineering challenge, usually undertaken by elite athletes in a biennial race, organised by the Swiss Guard. Teams of 3 sprint their way on skis and crampons crossing high mountain cols, traversing from Zermatt and Verbier in the Swiss Alps. The subtle difference with Team ZtoV was that we were neither elite nor would we be sprinting.

Our mission was two-fold: to complete the route safely in 4 days and to raise money for the Intensive Care Society and Doctors in Distress, to support initiatives across both Societies for the health and well-being of our ICU teams across the UK.

Training

With seven months' notice, training got underway in earnest. Endurance fitness, gym classes and cross-trainers (yawn), uphill sprint sessions, and carrying a loaded rucksack became the norm. Hours spent in the elements, with a headtorch, pounding the local trails. The dog was loving the variety!

But how to walk uphill wearing skis? Ingenious moleskins (or modern synthetic equivalents) make for gravity defying skills and an uphill slide-shuffle is possible. It was clear that this discipline wasn't going to be easily accessed beforehand, and along with COVID disruptions, training was limited. As was our experience with crampons, ice-axes, harness, and avalanche rescue equipment, all of which had to be carried with our personal gear throughout the 4 days. No support crew for Team ZtoV.

Gummy bears and Chocolate

The challenge itself was truly as described in that first email last June. It pushed me to my physical, mental and emotional limits. Blood, sweat and tears, along with the blisters, aching muscles and fatigue. In total we climbed over 4km vertical height and travelled over 60km. I'm so grateful for the support from family and colleagues, who enabled me to complete training schedules and gave me the space and time. And during the expedition itself, knowing there were so many well-wishers back home, it spurred me on through some dark moments on the ice.

How could I not credit Team ZtoV? Having only met once before on a wet, windy Malvern hillside, we worked together, encouraging and cajoling each other when we 'hit the wall', we laughed, and we cried. Gummy Bears and chocolate rule!

On target

Our initial target had been to raise £5,000 each, but as each mile pounded and month passed, I was both overwhelmed and humbled by the support I received from family, friends, colleagues and strangers. The donations continued right into the expedition itself as we had posted updates on our JustGiving pages when mobile phone reception and exhaustion permitted. A phenomenal £80,000 is the current total — just amazing!

So what did I get out of the ZtoV challenge? Being able to fundraise for a cause I firmly believe in was a privilege. The ICU MDT is the best team, and our best resource. We must do all we can to support those who are struggling with emotional and psychological distress, regardless of the cause. Personally, the challenge gave me the time to process my thoughts and experiences of the last 30 months. To think, to reflect, to take stock and to grieve. But also, to take a deep breath and begin to move on. Would I reply to that email again.....?

Thanks to

Sarah, Mike, Gary, Nick & David; Marco (and Alicia) and Will (our long-suffering guides); and our main sponsors: AJN SteelStock, ProPrint Group, TransMec Group and Ardonagh Community Trust.

FICM-led AoMRC guidance on Initial Antimicrobial Treatment of Sepsis

Prof Julian Bion
Independent chair

Dr Matt Inada-Kim
Contributor

Prof Mervyn Singer
Co-chair

Towards the end of 2019, the Academy of Medical Royal Colleges invited the Faculty of Intensive Care Medicine to review current national and international guidance on the initial antimicrobial treatment of adult and paediatric patients with sepsis. The primary aim was to ensure an appropriate balance between timely treatment of individual patients with sepsis, and population-level protection from the growing threat of antimicrobial resistance.

The initiative was stimulated by concerns that mandates to meet a one-hour target for giving broad-spectrum antimicrobials to patients with sepsis were not based on strong scientific evidence, had the potential to cause harm, and encouraged health systems to adopt processes of care which by-passed physician review and hampered patient-centred decision-making. These concerns were shared by professional organisations in other jurisdictions which were adopting an approach which allowed more time for investigation and treatment of lower risk patients with suspected sepsis.

Drafting and consultation

All colleges and faculties were invited to nominate a representative to the working group, which met for the first time in February 2020, and then continued to work virtually through videoconferencing and email exchanges during the pandemic. Initial discussions focused on scoping the problem and developing a framework for testing different approaches which had to be evidence-based, patient-centred, and located in the front line of care. The group used recent systematic reviews to inform their judgements, combined with new data where available.

In the first year consensus on the overall approach was established after five videoconferences and this was then elaborated by a core group in consultation with all members.

During the second year a draft set of proposals was circulated to a stakeholder group of professional organisations and special interest groups for extensive consultation and review. The final statement and the consultation responses were approved and published by the Academy in May 2022.

Recommendations

The working group has recommended that the degree of priority accorded to septic patients is based on severity of illness using the National Early Warning Score version 2 (NEWS2) for adults, and the paediatric early warning score (PEWS) for children. Adult patients with a NEWS2 of 7 or more or shock with a possible, probable or proven infection should receive broad spectrum antimicrobials within one hour of documentation. Patients with a NEWS2 of 5-6 should have received antimicrobials within three hours, and those with a NEWS2

of 1-4 within six hours, if sepsis is suspected, thereby allowing time for refinement of the diagnosis. A similar structure but different time frames and severity bands are proposed for children. PEWS is currently undergoing evaluation and a national working group will produce recommendations shortly. These timeframes are based on evidence from recent studies linking intervals (often referred to as 'delay') in antimicrobial administration to outcomes.

Supporting clinical judgement

In addition to antimicrobials, patients should have been reviewed by a doctor, undergone diagnostic tests, and received other supportive treatments within the same timeframes. The timeframes are maxima, not targets, and the guidelines prioritise the weighting of clinical conviction of infection to reduce inappropriate antimicrobial usage. Clinical assessment and clinical decision-making are accorded primacy: the attending clinician can upgrade the severity and priority band by at least one level if he or she is concerned about the patient's condition, in the setting of severe disease, evidence of organ dysfunction, or immunosuppression. Importantly, consideration must explicitly be given to patient-centred decision-making in terms of the intensity and goals of treatment. The frameworks therefore support, but do not substitute for, clinical judgement.

The working group has chosen NEWS2 and PEWS as the disease-independent generic instruments for detection and prioritisation of urgency for several reasons. NEWS2 is recommended by NHS England as the nationally preferred location-independent tool for assessment, communicating severity and escalating treatment. Its use in sepsis is therefore in line with current national practice. Most importantly, the use of vital signs as the entry point for a sepsis treatment algorithm is entirely consonant with clinical practice: acutely ill patients do not present with labels such as 'sepsis': recognition of sepsis takes time, and is a secondary step in the labelling of a disease process, and it is vital that patients — who are equally unwell — with other pathologies should be managed with equal priority. Patients present with symptoms and signs which we intuitively classify as 'very sick', or 'not very sick' on first acquaintance. We then refine this immediate judgement with an assessment of vital signs — the ABC of acute care.

Warning signs

We will all have experienced situations where a patient does not look particularly ill but whose vital signs tell a different story, and we ignore these warning signs at the patient's expense. This is particularly true of the young (who disguise acute disease) and the elderly (who present with 'atypical' signs). So the first question which NEWS2 and PEWS help answer is 'Is this patient sick?'. The second is 'How sick?' This provides the framework for prioritising supportive treatments before proceeding to deal with the third question — 'Why is this patient sick?' — the diagnosis. It is at this stage that infection — and in the setting or organ dysfunction, sepsis — is considered, and the likelihood of infection as a cause then drives the decision to use antimicrobials.

The clock therefore starts ticking not with 'suspicion of sepsis' but with the measurement of vital signs. This approach provides clinical staff and auditors with an unambiguous 'time zero'. By recommending severity-adapted time frames for subsequent actions, for the lower-severity patients clinicians will have more time to think, to investigate and to diagnose more accurately the underlying disease, which will help to reduce inappropriate use of broad-spectrum antimicrobials. For the sickest patients, justification for urgent action and escalation to senior decision-makers is built in, to assure patient safety.

Work in progress

The Academy's statement must be seen as a work in progress. Further modifications will be made as new evidence emerges from clinical research and the development of new diagnostics. The frameworks will be considered by the National Institute for Health and Care Excellence. In the meantime we encourage clinical staff to adopt and audit this new approach, and researchers to consider larger scale evaluations across all settings.

THE STATE OF PLAY: Death, scrutiny certification and coronial issues

Dr Som Sarkar
Consultant in Anaesthesia and ICM, Bank Medical Examiner

Dr Tim Meekings
Consultant in Anaesthesia and ICM, Lead Medical Examiner

Dr Benjamin Lobo
Regional Medical Examiner for the Midlands, Consultant Physician

Although the Shipman Inquiry feels like a distant memory, there have been ongoing concerns in the quality and safety of health/care systems. Mortality review systems have been brought into sharp focus with the national response to the COVID-19 pandemic. Getting the proportionate level of scrutiny of deaths correct has been important to detect problems, to avoid added pressures on healthcare professionals and not delay 'paperwork' (death certification and cremation forms) for bereaved relatives and provide the answers they deserve. From an intensivist perspective, what are the challenges and benefits of implementing a national Medical Examiner (ME) service?

What is a Medical Examiner?

Many intensivists will have had meetings with MEs by now. MEs are senior medical doctors (usually, but not limited to, consultants and GPs) who are contracted for a number of sessions a week to undertake medical examiner duties, in addition to their clinical duties. They are trained in scrutiny of records, death certification and other relevant medico-legal processes, overseen by the Royal College of Pathologists, and undertake annual CPD. They are not medical coroners but work in parallel to the HM Coroners Service reviewing all deaths not requiring 'notification'.

Many local ME services have Consultants in Critical Care working as MEs. MEs are supported by Medical Examiner Officers (MEOs) who oversee the administrative process and interactions with families. Being integral to acute services and having awareness of the whole patient admission, intensivists are often well placed to review the whole patient journey especially treatment escalation or withdrawal decisions, patient/family wishes or concerns. In particular, intensivists are skilled in undertaking challenging conversations including breaking bad news, loss and dealing with familial conflict or complaint.

Intensivists are often aware of cultural and religious needs of patients, organ donation and care after death.

The challenge of scrutiny is be an enhancement and not replacement of the normal governance systems ensuring it is completed in a proportionate and timely manner. MEs do not perform investigations. MEs must remain independent and must not have been involved in the care of the deceased patients for deaths they scrutinise. Care must be taken to actively manage conflicts of interest of any sort.

Scrutiny

Listed below are some clinical examples where critical care teams might have influenced or taken responsibility and may be important areas at ME scrutiny:

- Were critical care teams timely in their response to emergencies?
- Was there clear documentation of advice given by critical care teams? Were safety netting processes established especially for those patients not admitted to critical care?
- Was patient selection for admission to critical care objective and transparent?
- Were there any treatment or care related complications? Were these complications 'expected' and managed accordingly?
- Was there effective communication and decision making with the parent team during the critical care admission and at discharge?
- Was there recognition of the dying patient? Was there an appropriate decision-making process and individualised care plan to care for the dying patient?

Development of ME services

There has been a successful implementation of ME Services across the acute sector of health care and current figures show more than 90% of hospital deaths are now scrutinised. This reflects a significant step forward in the NHS policy to learn from deaths. Approximately 10% of hospital scrutiny triggers some form of review such as a Structured Judgement Review or Significant Event Review. With the Health and Care Act having received Royal Assent on the 28 April 2022,

the national Medical Examiner system is now set to become implemented fully from April 2023. Across England and Wales there are resources for Medical Examiner services to ensure there is sufficient infrastructure in place to be able to scrutinise all deaths in their area. The activity of ME services will double in this next stage of implementation.

The National Medical Examiner has reported progress on the achievements so far:

- the accuracy of the medical certification of the cause of death (MCCD) has improved
- the reduction in the number of rejected MCCD by Registrars
- the detection of significant problems in treatment or care has been effective
- the system of reporting and triggering investigation of deaths where there has been a potential problem has been established with an increase in the appropriate numbers for investigation and a reduction of investigation of cases that do not require this.
- the majority of the bereaved feel supported, appreciate the chance for their questions to be answered and explanations for any subsequent actions that are necessary.

Lead Medical Examiner: An intensivist's view

A working week usually entails 1PA for lead duties with additional sessions for ME work. Lead Medical Examiners take the responsibility for the service in a given Trust, developing good working relationships with the local Coroner's Office, the local Registrar, the acute trust (bereavement office, mortuary and clinical teams) and increasingly primary care whilst maintaining an independent line of accountability to the regional structure of NHS I/E through the regional ME and MEO leads. In addition, the local ME teams are in a unique position to identify and feedback themes and trends emerging in mortality within services to Medical Directors, leads of governance and the Coroner.

One of the key points is developing relationships and an understanding of deaths outside of the acute sector, to establish and support pathways already in place in the community and Primary Care setting to provide positive feedback from bereaved families, investigate and respond to complaints and raise any concerns for further review.

This may involve the need for new pathways and joined up working between primary and secondary care organisations, to ensure there is a robust and sustainable process for escalating any concerns to appropriate organisations for further investigation and action. Actions are being taken to ready new Integrated Care Systems for these changes.

Legal requirement

Finally, and most importantly, the statutory status of the Medical Examiner system will impose a legal requirement for all doctors including General Practitioners working in the community, to now discuss deaths and agree with a Medical Examiner outcomes.

A major role for the Medical Examiner service will be to reassure their colleagues working in Primary Care that the Medical Examiner system will not cause undue delays to the processing of paperwork for bereaved families and will also be a help and not a hindrance. Anecdotal evidence from Medical Examiner services in England and Wales that have already established the scrutiny process for deaths in the community has suggested that General Practitioners have found the ability to discuss a case and the proposed cause of death with an independent and objective colleague to be a supportive and positive experience.

The future

It is hoped that the public will become increasingly aware of national Medical Examiner services and the benefits these bring. It is hoped that the public will trust that any scrutiny will be managed sensitively and remain confidential. Healthcare professionals from any multi-disciplinary background (from any setting whether NHS or private practice) must accept the outcomes and consequences of scrutiny. The implementation of primary legislation and enabling secondary regulations will remove barriers and enable for effective scrutiny and possible remote working.

Further Reading

https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

https://gov.wales/sites/default/files/consultations/2018-06/introduction-of-medical-examiners-in-wales.pdf

https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/

Patient Feedback for Revalidation

Dr Peter Macnaughton
FICMPAS Chair

The Faculty published a position statement regarding patient feedback for the purposes of revalidation in March. Obtaining meaningful patient feedback was challenging before the pandemic, but over the last two years has become even more difficult due to the changes to how many of us work and our reduced direct contact with families.

The Faculty has received a number of communications highlighting difficulties and concerns with obtaining patient feedback. A number have reported inflexibility from responsible officers. The GMC have introduced more flexibility in their guidance *Feedback from Patients* (2020). They key elements are that feedback should be: collected using a formal feedback exercise; collected in a way that is appropriate for your patients and the context in which you work; covers your whole scope of practice across each revalidation cycle.

The following Faculty statement was published to provide support when discussing patient feedback with your local responsible officer. The GMC have confirmed it is in accordance with their latest guidance.

1. The Faculty supports the importance of collecting feedback in order to understand patient experience and encourage reflection and continual improvement.

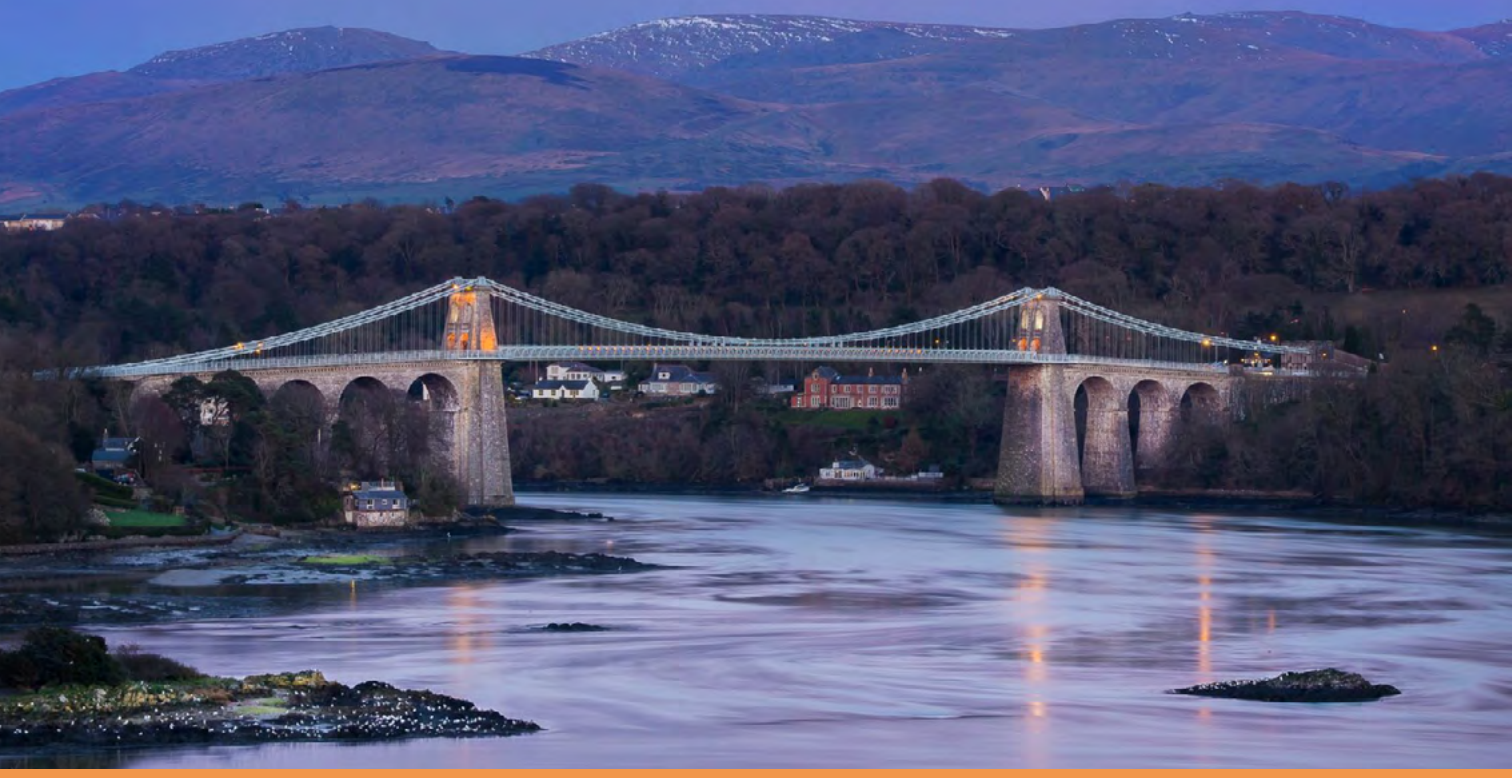
2. The Faculty recognises the challenges in obtaining individual doctor feedback from patients or relatives in intensive care and support alternative approaches.

3. The Faculty support the use of appropriate team-based feedback in lieu of individual doctor feedback which should be supported by the responsible officer as it is within the latest GMC guidance. Sources of feedback could include:

- Friends and family feedback for the intensive care unit (We Share or similar) as used by a number of units
- Team feedback from intensive care follow-up clinics
- Online or app-based feedback sought after hospital visits or telephone consultation
- Service user data collected for CQC
- External peer review data (Network review and the like)
- Feedback from teams within the hospital following patient discharge from intensive care.

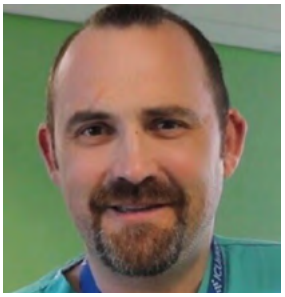
Employers should support a more flexible approach to obtaining patient feedback that is appropriate for doctors in intensive care and have mechanisms in place to support its collection. The GMC requirements for collecting patient feedback include that the patients or their representatives are not selected by the doctor, must know the purpose of the feedback, systems used should minimise bias, responses should be anonymised, and the doctor must be able to reflect on the responses and how they will impact on practice.

The full statement is available on the website: www.ficm.ac.uk/standardssafetyguidelines clinicalquality/patient-feedback-for-revalidation.



CRITICAL EYE *Spotlight:*

The Welsh Intensive Care Society Cymdeithas Gofal Dwys Cymru



Dr Richard Pugh
Chair, Welsh Intensive Care Society

In 2022, the Welsh Intensive Care Society (WICS) celebrates its thirtieth anniversary. The Society's foundation owes much to the efforts of its inaugural Chair, Dr Ed Major, an intensive care consultant based in Swansea and past President of the (UK) Intensive Care Society.

Welsh Intensive Care Society
Cymdeithas Gofal Dwys Cymru

Throughout this time, the Society's main objectives have been consistent:

- to advance critical care in Wales through education, training and the coordination of audit and research
- to define and promote standards for critical care in Wales
- to engage with national professional bodies and authorities in relation to critical care
- to promote collaboration between health organisations involved in the provision of critical care.

Multi-professional

WICS is a multi-professional society and is represented on Council by every Welsh Health Board that provides a critical care service, and by medical, nursing, Advanced Critical Care Practitioner, Allied Health Professional, and trainee members.

WICS works closely with the Intensive Care Medicine Specialist Training Committee through the Welsh Regional Advisor. It also supports an annual 'Advanced Update' meeting intended for non-medical clinical staff, and a 'Welsh Intensivists in Training Society' meeting, as well as the main Summer Scientific Meeting.

Collaborative research

The Society facilitates all Wales audit and research, and pre-pandemic has coordinated studies on wide-ranging topics including healthcare-associated infection, impact of alcohol, critical care follow-up, frailty assessment, and the experience and attitudes of nurses and AHPs to research in critical care. Close working with the Health and Care Research Wales specialty lead for Critical Care has also led to the development of a collaborative Welsh critical care research network, sharing successes and providing peer support for study participation.

Links with others

Importantly, WICS has strengthened its links with the wider UK critical care community in recent years, as Strategic Partner to the Intensive Care Society (and providing representation on ICS Standards and Guidelines Committee), as UK Critical Care Research Group sponsor, supporting professional guidance in relation to organ donation, and most recently developing a formal relationship with the FICM Executive Board and leads for the intensive care societies of the other devolved nations.

Reconfiguration

As a devolved administration, Welsh Government is responsible for overseeing healthcare in Wales. There are fundamental differences in commissioning, delivery and accountability between NHS England and Wales, and Welsh critical care capacity has unfortunately remained largely static over the last decade.

Welsh clinical networks reconfigured in 2015 as the Wales Critical Care and Trauma Network (WCCTN) — and despite capacity constraints the network has demonstrated an outstanding response to the pandemic and its aftermath.

Effective representation

WICS, WCCTN and FICM have been in a strong position to collaborate which pre-dates the pandemic and enabled collective engagement with Welsh Government and NHS Wales (leading, for example, to 2019's Welsh Government Task and Finish Group Report on Critical Care).

As healthcare policy and service priorities readjust post-pandemic, this collaboration and the effective representation of our critical care community remain vitally important.

Find out more about WICS at www.welshics.org.

Getting 'Crative' in the time of COVID

The Royal Free Hospital in London was one of the first UK hospitals to become overwhelmed with COVID-19 patients. From March-May 2020, 156 COVID-19 positive patients were admitted to the ICU, with 136 mechanically ventilated[1]. In March 2020, to streamline and standardise hospital-wide intubations, the anaesthetic, ICU, and emergency department clinicians joined forces and developed a standardised operating procedure and 'COVID crates' to safely secure the airway of patients in extremis.

Dr Lucy L. Yang

Dr Adrian Perera

Dr James Cronin

Dr Sarah Bigham

DrJane Lowery

Dr Rebecca Flower

Intubation teams (Fig. 1) underwent in-situ simulation training to drill down the minimum equipment necessary for remote videolaryngoscope-guided intubations, lines, and maintenance of anaesthesia[2]the World Health Organization (WHO. In a designated preparation room, anaesthetists prepared emergency and anaesthetic drug packs, and ensured the ventilator and monitoring equipment were ready. Medical student volunteers were supervised to pack the 'COVID crates' utilising a checklist (Fig. 2). The crates were packed according to this checklist with equipment divided into airway, infusions, and lines grab bags, as well as some loose items (Fig. 3).

Crate contents

Each crate contained three grab bags: airway, lines, and infusions (Fig. 4), and was closed with a pharmacy-approved breakable seal. Thus, for emergency intubations, the team could quickly attend to the patients fully equipped (Fig. 5).

Fig. 1 **The intubation team with the complete equipment before attending to an emergency COVID-19 intubation.** *The intubation team included a consultant anaesthetist (left), an experienced operating department practitioner (middle), and an anaesthetic registrar (right). They attended emergency intubations with drug packs, walkie-talkies, and a trolley containing the 'COVID crate', ventilator, monitoring equipment, and oxygen.*

'COVID Crate' checklist

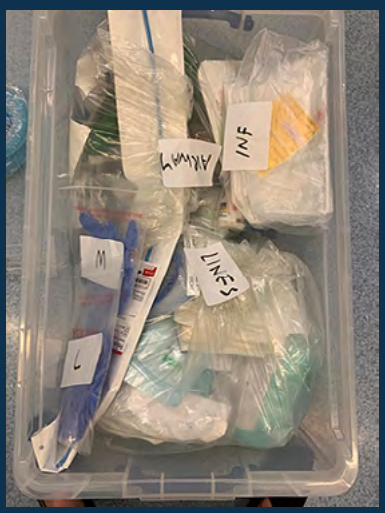
Item	Quantity	Checked	Item	Quantity	Checked
Airway Bag			***Infusions Bag***		
Mapleson C circuit (Water's circuit)	1		50ml syringes	2	
Anaesthetic face mask 4 (Green)	1		Syringe infusion lines	2	
Anaesthetic face mask 5 (Orange)	1		Yellow infusion drugs stickers	2	
Standard catheter mount with HME	1		Drawing up needles	2	
Guedel airway (Green)	1		1% Propofol 100ml bottle (or 2 x 50ml bottles 1% Propofol)	1	
Guedel airway (Orange)	1		Metaraminol 2.5mg/5ml – 10 Vials	1	
Guedel airway (Red)	1				
Mac 4 disposable laryngoscope	1		***Lines Bag***		
Disposable videolaryngoscope	1		Arterial line pack (includes 2-0 silk suture)	1	
ETT - Size 6 – SACETT	1		Double transducer	1	
ETT - Size 7 – SACETT	1		0.9% saline 500ml bag	1	
ETT - Size 8 – SACETT	1		1L pressure bag	1	
OptiLube	2		Stitch cutter	1	
20ml syringe	1		Central venous line pack	1	
AnchorFast or similar ETT fastener	1		16cm Quad-lumen central line	1	
Tube tie	1		Double lumen IV attachments	4	
iGel Size 4	1		0.9% saline 100ml bag	1	
iGel Size 5	1		2-0 silk suture (straight needle)	1	
Yankauer sucker	1		Central venous line BioPatch	1	
Suction tubing (Male-Female)	1		Sterile gloves – Size 7	1	
Suction tubing (Female-Female)	1		Sterile gloves – Size 8	1	
NG feeding tube	1		Sterile gloves – Size 9	1	
Magills forceps	1				
Scalpel Size 10 blade	1		***Loose Items***		
Closed suction 54cm 12G	1		Hamilton ventilator circuit	1	
Microstream filterline (EtCO, adaptor	1		Medium non-sterile gloves	4	
Tube clamp	1		Large non-sterile gloves	4	
Bougie/Frova intubation catheter	1		Emergency COVID-19/HCID intubation checklist, observations chart, pen	1	
			Donning & doffing poster - laminate	1	

Date Assembled ___/___/_____ Assembled By _____

PLEASE NOW SEAL BOX

Fig. 2 **'COVID crate' checklist** *Abbreviations: EtCO2, end-tidal carbon dioxide; ETT, endotracheal tube; HCID high consequence infectious disease; HME, heat and moisture exchange filter; IV, intravenous; NG, nasogastric; SACETT, suction above cuff endotracheal tube.*

Fig. 3, 4 & 5 **Equipment, grab bags, and the completed 'COVID crate'.** *Lines, infusion, airway equipment, ventilator tubing, and gloves were packaged into grab bags and placed into 'COVID crates', which could be wiped clean after use. Abbreviations: Inf, infusions; L, large; M, medium.*



Improved intubations

In May 2020, a departmental survey revealed that the 'COVID crates' were used in ED, ICU, the ward, and interventional radiology for >80% of emergency intubations. Feedback on the drug packs and 'COVID crates' was unanimously positive; 100% team members would recommend using both and 97.5% confirmed that 'COVID crates' improved intubations. Specific comments included: "a brilliant resource that made life much easier and less stressful", "impressive how quickly it was put together". Throughout the pandemic peaks, the 'COVID crates' faculty met weekly to consolidate feedback, and the intubation SOP was updated on a COVID-19 website[3]. The 'COVID crates' became cemented into the Royal Free Hospital's COVID-19 response. Their production and utilisation flattened hierarchy and enhanced communication, teamwork, and collaboration between multidisciplinary team members during a challenging time.

Acknowledgements

We thank the operating department practitioners and medical students for facilitating the 'COVID crates' project. We also thank the participants of our survey.

References

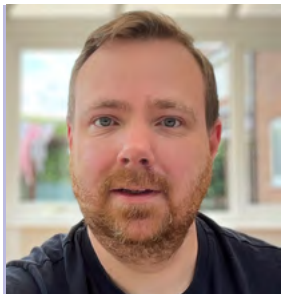
1. Thomson RJ, Hunter J, Dutton J, et al. Clinical characteristics and outcomes of critically ill patients with COVID-19 admitted to an intensive care unit in London: A prospective observational cohort study. PloS One 2020; 15: e0243710.

2. Fregene TE, Nadarajah P, Buckley JF, et al. Use of in situ simulation to evaluate the operational readiness of a high-consequence infectious disease intensive care unit. Anaesthesia 2020; 75: 733–738.

3. rfanaesthesia.org; Yang LL, Stevens JL, Campbell MJ. An Online Educational Platform in the COVID-19 Pandemic. Anesthesiology 2020; 133: 485–486.

Acute Care Echo Club

Dr Euan Mackay,
Consultant in intensive care and anaesthesia



Dr Ephraim O'Dea,
Registrar in intensive care and anaesthesia

This article describes a focused ultrasound in intensive care (FUSIC) departmental meeting which has been easy to implement and is of value for education and quality assurance.

Background

Critically ill patients benefit from having access to doctors who can use ultrasound to accurately and rapidly diagnose life threatening pathologies. However, the magnitude of the challenge for the ICM workforce to achieve FUSIC competency is reflected by its absence from the required capabilities in the ICM curriculum.

GPICS states that there should be regular ultrasound meetings, quality improvement and peer-reviewed activity. The following recipe outlines how we organise a two-hour meeting for a diverse audience.

Ingredients

- 1 registrar to administer the club.
- 1 expert guest such as a BSE accredited echocardiography technician.
- 6-10 FUSIC scans and cases for discussion.
- Enthusiastic audience from critical care, emergency medicine and acute medicine.

Recipe

- **0-30 minutes, introduction**
  A summary of the four FUSIC heart windows and basic anatomy. This is essential to orientate novices when viewing scans.
- **30-90 minutes, case presentations**
  Each case starts with a one slide clinical summary to set the scene and pose the question to be answered by the scan. The scans are displayed and interpreted. There is an emphasis on integrating the findings with the clinical context and the subsequent clinical management. Audience discussion is encouraged alongside insights from the expert guest.
- The educational benefits include allowing the audience to recognise the role of FUSIC in guiding management. It also promotes an appreciation of the limitations of FUSIC in terms of subjectivity and recognising inadequate scans which should be disregarded.
- **90-120 minutes, miscellaneous**
  Additional time for journal presentations, a detailed review of scans from an interesting case by the expert guest or education on other FUSIC protocols such as lung/abdomen/vascular.

Training, Assessment and Quality (FICMTAQ)

Dr Chris Thorpe
FICM TAQ Chair

Following on from the unexpected FFICM OSCE results, we had a strong steer from trainees that there needed to be more information and guidance for candidates. A working group was therefore put together to completely revamp the resources available to FFICM candidates and trainers on the FICM website.

The working group was comprised of incredibly focused and enthusiastic consultants and trainees, supported by the Faculty team and a huge amount of material was developed and put together in a short time frame.

Thanks very much to all involved! If you are sitting an exam, or are a trainer it really is well worth while exploring what is available, and please let us know if you think there is anything else that might be helpful: www.ficm.ac.uk/trainingexamsexaminations/resources-for-candidates. Our new StR Sub-Committee will be taking forward further review of the layout and flow of resources and the Faculty is open to feedback on this.

Outcomes-based

We have now changed to an outcomes-based curriculum. This fundamentally changes the way in which we assess a trainee's progress. Previously it was time-based, with a little bit of flexibility for those trainees able to achieve competencies (now capabilities) in a quicker timescale. Queries about a trainee's progress — whether the trainee has done enough time in cardiothoracic ICM for example — would come to the TAQ committee for a decision. We would look at the time in post, and make an allowance but we will no longer be doing this as a routine. The onus will be on the regional and local trainers to assess whether the trainee has met the required outcome in terms of capabilities, and trainees will vary in how long it takes to achieve this.

Innate variation

In addition to the innate variation in individuals, external factors may affect this: for example different rotas, clinical time and responsibility undertaken. In addition, trainees may have undertaken extra training time in ICM. All of this means that training has the potential to be much more individualised, and that the regional training body, via the ARCP process, will have more authority in adjusting training.

Accumulation

We do however have some guidance as to how long each section of training would be expected to take. I think it's important to understand that even if a trainee is brilliant the gradual accumulation of skills and knowledge is an important aspect of medical training. Some of this is not an easy to test for, and demands observation and assessment over a period of time.

It is also important to realise that a training programme has many moving parts, and for it to function well the time element is very important. We would anticipate that any time changes outside of the guidance would be easier planned in advance on the oncoming year, and that in any event most trainees would complete their blocks in the guided time.

FFICM Examinations

Dr Victoria Robson
Chair of Examiners

The eighteenth sitting of FFICM was held in January and April 2022. Having transferred to on-line delivery during the pandemic, April saw the return to face-to-face delivery at Churchill House in in London.

MCQ

The MCQ continues to be delivered online. 91% of 161 candidates passed. This is the last multiple choice exam which will contain true/false questions. From June 2022, all questions will be of the single best answer type; this gradual change from all true/false questions to all SBA has been made at the request of GMC.

Oral examinations

213 candidates appeared for one or more of the oral components over four days, the largest number ever of oral FFICM candidates; with the increase in ICM trainee numbers, so have examination candidate numbers. All eligible applicants were accommodated, with none deferred. The examiners are rightly proud that by providing additional examination days, no candidates have ever been deferred due to insufficient capacity in FFICM.

72% of 166 SOE candidates passed the structured oral exam, which has eight questions, each marked by two examiners. The pass mark (determined using borderline regression with cross-check by Hofstee method) was 27/32.

A further large-scale trial of a proposed new marking scheme for the SOE was undertaken. This scheme awards marks individually for each of the five stems in each SOE question, rather than marking the question as a whole. The data from this will be analysed before any decision to change the mark scheme is taken, and candidates will be informed on any such proposed change via the FICM website. The proposed marking scheme will not change the candidates' exam experience.

74% of 208 OSCE candidates passed the OSCE, which has twelve stations plus a test station. The pass marks (set using the Angoff method) were 167, 166, 166, 167.

Following the low pass rate of the October OSCE, additional candidate resources have been put on the FICM web site to assist candidates to prepare, such as additional sample questions with answers, videos of borderline and good passes, and guidance articles on particular questions. Overall, of the 213 oral exam candidates, 65% have now passed both components so are to be congratulated on achieving the Fellowship qualification.

Seven visitors, including ICM consultants and a lay visitor observed the oral exam. They commented on the overall fairness of the exam, wide range of questions and that the standards of questions were as they expected. They saw some very well-prepared candidates and some less so.

Thanks

My thanks as ever go to the examiners who work hard both examining candidates and writing and revising exam questions, as well as the RCoA Exams Team who administer this exam.

Specialty Registrar Update

Dr Cat Felderhof
FICM StR Rep

By looking around at my colleagues, by the communications I have with the UK network and through my involvement in the ICM Recruitment process over the last 18 months, I have become increasingly aware of the wide-ranging abilities and exceptional achievements amongst doctors in ICM training.

To call them 'talented' does them a disservice as this implies an innate ability rather than acknowledging the hours of (sometimes literal) blood, sweat and tears that have been required to achieve these successes. I have developed a determination to shine a light where we can on these diverse accomplishments and skillsets.

I strongly believe that our Specialty Registrar (StR) community have much to contribute to ICM development and training and finding an avenue through which we can facilitate this happening would be beneficial to all.

StR Sub-Committee

At the beginning of 2022 the FICM Board agreed that a priority for the year would be the founding of a new FICM StR Sub-Committee to supplement our existing links to the Regional StR Representatives Group. One of the objectives of this new committee is to increase the range of representation from the StRs, both on a geographical and training background basis with improved links to relevant societies. Therefore, the structure includes co-opted members from the intensive care societies in all four nations and appointed members from all the single and dual CCT programmes including academia whilst also ensuring representation from those training less-than-full-time.

After asking for applications for the five posts for appointment we were delighted to receive a remarkable thirty-nine applications giving an average competition ratio of nearly 8:1 for each post. The applications were anonymised, scored and ranked. During this process I had my suspicions regarding the broad skillset and experience of ICM StRs confirmed beyond my highest expectations and I am confident we have acquired an excellent group with expansive training backgrounds and stages.

Planning priorities

Our first meeting was online at the start of June and will be followed by an in-person meeting in September. At these meetings we will be planning our own priorities and projects for the future and we will be linking in with existing committees and sub-committees to see how we can assist with existing workstreams.

Having been part of the Exam Resources Short Life Working Group earlier this year I was pleased to see what was produced in a fairly short period of time. I hope we can continue this work alongside the Education Sub-Committee.

Enthusiasm and experience

In short, if the enthusiasm and experience of the doctors in ICM training is anything to go by, the future of ICM is looking exceedingly bright. I'm proud to be able to be part of this new venture and look forward to seeing where this takes us.

Dr David Melia
FICM Education Sub-Committee Sim Lead

New FICMLearning Simulation Resources

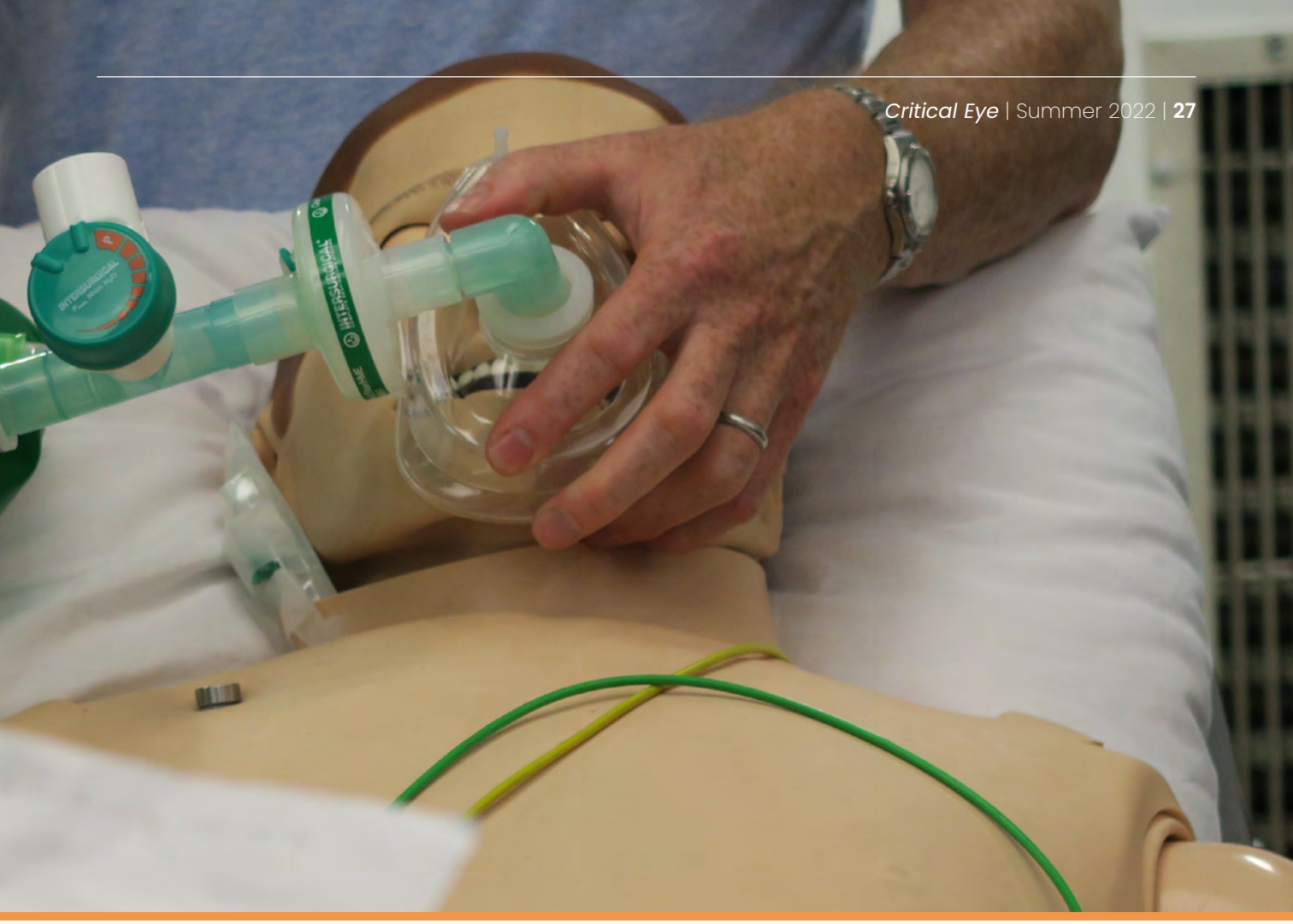
In the last two decades the use of simulation in healthcare has mushroomed[1], with anaesthesia being pioneers in the medical field[2]. Its use in Intensive Care Medicine has accelerated, with both in-situ simulation, and high-fidelity, high-technology, courses becoming more commonplace[3]. The fact that 11 of 14 High Level Learning Outcomes (HiLLOs) now reference simulation as part of training or assessment in the 2021 ICM curriculum[4] is testament to its benefit to postgraduate training.

Unquestionable value

Trainees and trainers are much more simulation-savvy than in years gone by, experiencing simulation during their undergraduate education, Foundation training, and beyond, much more frequently. Both approaches to simulation training have unquestionable value; in-situ simulation improving team performance[5] and patient outcomes[6], and centre-based training improving junior doctors' learning and performance on the ICU.[7]

New resources

We have now launched the new simulation resources on FICMLearning. This is by no means a complete resource, but the start of something we can grow as a Faculty. We hope to curate rather than



create this resource, as I know there is so much phenomenal simulation occurring up and down the UK already, with excellent resources already in existence. Initial pages include a *Getting Started* guide, a template on which to develop simulation scenarios/curriculum, multiple debriefing templates, and links to other resources I've found useful in the past.

We've also published a handful of scenarios that can be used or adapted as needed either in-situ or in-centre, and as the library grows, we will subdivide these into areas of special interest/themes. Hopefully, in time, this will become your one-stop shop for all your simulation needs.

Whether you have a complex in-situ scenario on the management of neuroleptic malignant syndrome, or someone's favourite homemade 'blood' recipe that can be knocked together on the fly, we would like to hear about it. If you'd like to submit something, please contact me on DavidJohn.Melia@nhs.net and let's share the great work that's being done from Dundee to Dover!

Visit www.ficm.ac.uk/ficmlearning/simulation for more.

References

1. Herrera-Aliaga E et al. *Trends and Innovations of Simulation for Twenty First Century Medical Education*. Front Public Health 2022;10:619769
2. Higham H et al. 'To err is human: use of simulation to enhance training and patient safety in anaesthesia' BJA 2017. 119 (S1):i106-i114
3. Seam N et al. 'Simulation Training in the ICU' Chest. 2019;156(6):1223-1233
4. Faculty of Intensive Care Medicine. *ICM Curriculum: Supporting Excellence for a CCT in Intensive Care Medicine*. Version 1.2. August 2021.
5. Manggala SK et al. 'In situ simulation training for a better interprofessional team performance in transferring critically ill patients with COVID-19: a prospective randomised control trial' Postgrad Med J. 2022;0:1-5
6. Josey K et al. 'Hospitals with more-active participation in conducting standardized in-situ mock codes have improved survival after in-hospital cardiopulmonary arrest' Resuscitation. 2018 Dec ;133:47-52
7. Schroedl CJ et al. 'Use of simulation-based education to improve resident learning and patient care in the medical intensive care unit: a randomized trial' J Crit Care. 2012;27(2):219

THANK YOU!

Over the past two years FICMLearning has been steadily growing. We now have an amazing bank of fantastic Podcasts, Cases of the Month, Midnight Laws, FICM and WICM Blogs and we've recently launched our Simulation resources and guides. The Education Sub-Committee works hard to maintain the FICMLearning resource and it simply would not be possible to have FICMLearning without all the contributions of the the amazing people listed here. We want to thank everyone here and encourage you to check out the brilliant content provided. If you fancy contributing to this amazing resource, please do get in touch at contact@ficm.ac.uk.

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www.ficm.ac.uk/ficmlearning

Smaller and Specialist Units Advisory Group (SSUAG): Future training

Dr Chris Thorpe
FICMSSUAG Chair

There has been a change in the approach towards smaller, remote and rural units over the last ten years, allowing sensible forward planning. Forward planning is one thing but obtaining the resources to deliver that plan is quite another, and although we have made inroads into ICM delivery there is no doubt that this is still patchy across the UK. One of the aspects that is difficult to achieve is adequate medical staffing.

Deprivation in coastal areas

Recent work by Health Education England has shown that, across the UK, deprivation is most commonly close to coastal areas and away from urban centres, and this is accompanied by worse healthcare outcomes in a number of areas. Within this work there is a further look at the consultant staffing available per head of population, and once again in some areas this is found to be noticeably worse.

Experiencing medicine in smaller hospitals

One part of the solution is to ensure that trainees get the opportunity to experience medicine in smaller hospitals, and it would be a positive step to ensure that there is a better distribution between regions to reflect the workforce needs. While on paper this looks like a good solution— we know that trainees rotating through a given hospital are more likely to return there as a consultant — there are some interesting aspects of the new outcome-based training scheme which could affect implementation.

Changes in training, and the new outcomes-based curriculum have the potential for trainees to complete clinical fellow jobs or other attachments outside of a training rotation and to have them counted towards a specialist qualification. This means that trainees may potentially create their own bespoke training scheme, at least in part, and thereby dictate where they live and work. At present this is not really an issue, but it is something to keep an eye on.

Where you train

There is potential for trainees to have a greater say in where they train, and many may feel that they want to stay close to where they live — a rotation that takes them to an attachment that is far away may be less attractive. It is therefore important to make sure that attachments in your unit are top quality. This means that the educational structure is right, that all consultants (and other staff) buy into the training ethos and that trainees are very well supported. In addition, it is not just the training but other aspects that will make a year enjoyable — for example with good accommodation, a social calendar and flexibility in working.

Start now

If you are working in a smaller unit, start working on this now — there may be an opportunity to take on trainees in the near future, and you need a strong submission to push your case forward.

For more information on Smaller and Specialist Units, take a look at the Faculty website.

Advanced Critical Care Practitioners (ACCPs)

Carole Boulanger
ACCP Sub-Comittee
Co-Chair

It's safe to say it has been another busy period for the FICM ACCP Sub-Committee. As you will be aware, in December 2021, FICM polled the ACCP community (fully trained, registered, and ACCPs in training, as well as the wider ACCP community via the National Association of ACCPs) around the future direction for the role.

Survey results

77% of respondents clearly supported the feeling that active involvement in the [Medical Associate Professionals] MAP agenda has become increasingly less applicable for ACCPs. This tallied with the view of the FICM ACCP Sub-Committee and the MAP Oversight Board. This feedback has led to the ACCP community to formally align with the HEE Centre for Advanced Practice and away from the Medical Associate Professionals group and agenda.

It is important to say this was a mutual arrangement and that we remain committed to supporting and advising on any workforce issue relating to critical care. Going forwards we wish the MAP group and our AA colleagues every success going forwards.

This news has been received very positively by the ACCP community who felt strongly this was the correct place now the landscape and national agenda around advanced practice has changed so significantly from when we first became involved, coupled with increased engagement from base regulators. This change is timely in relation to the update currently in progress of the FICM ACCP curriculum as this will emphasise elements reflecting our new alignment.

The Centre for Advanced practice has welcomed our transition and are supportive of no dilution to the FICM training process for ACCPs. We continue to lobby at all available opportunities for the legal restrictions on non-medical prescribing to be addressed, which limits our ODP colleagues from entering ACCP training.

Optional Skills Framework

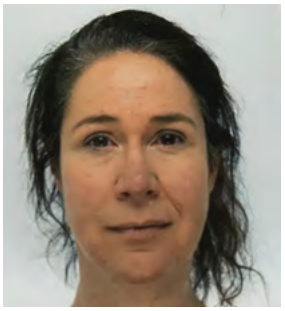
Our Optional skills Framework [OSF] for Advanced airway skills has been well received. Importantly experienced ACCPs for whom this has been a long-standing skill set are registering with FICM under the prior learning route. The OSF for critical care transfers for ACCPs is out soon and will have the same arrangement for experienced ACCPs in recognition of skills and competencies being used in clinical practice already.

Key for all the OSFs is the governance section to provide clear arrangements to protect both patients and ACCPs alike. It is also key that employers provide the CPD arrangements to facilitate maintaining additional skills for ACCPs in clinical practice. These are issues that the ACCP groups have raised which we have hopefully gone a long way to address.

2022 ACCP Conference

The FICM ACCP conference held face to face in June in Newcastle was sold out again which keeps the record of this event since it commenced. The number of ACCPs holding FICM membership continues to rise which is a reflection on how valued this is to ACCPs and employing ICUs.

Mentoring: Supporting people to maximise opportunities



Dr Aoife Quinn
WICM Member

A couple of years ago I went through a negative patch at work — a tricky patient death lingered on my mind, more exams were on the horizon with confidence shattering pass rates, second, third and fourth thoughts about career choice. I simultaneously had that niggling unquashable voice that I wasn't quite good enough and also a fiercely held belief that I wanted to make everything work out. Despite being in an incredibly supportive department, I felt totally stuck and unable to make progress.

I stumbled across mentoring at this point and it was like a switch got flipped back on and flooded the shadowy spaces with light.

Mentoring means different things to everyone — for me it is a process and most helpful to consider what good mentoring looks like. Ideally there is a working partnership where a trained mentor brings expertise on the process of mentoring, and an engaged mentee brings expertise on their life, specifically on issues or challenges that need to be untangled. Training is important and there is a range of offerings to choose from, including hour long sessions via on line platform to formal qualifications. A systematic approach allows to share perspectives, check for blind spots, and explore all avenues, particularly ones not considered previously.

What Mentoring provides

Mentoring allows a platform to practice difficult conversations, and a space to explore mental blocks hindering us from seizing opportunities.

Initially I saw mentoring as a way of dealing with problems, but after learning more and doing some training I came to see the many benefits particularly with supporting people to maximise opportunities. Personally, I love being involved with mentoring, it has been a way to explore new ideas and perspectives, and allowed me to loosen up in my own outlook so that I can see other points of view more readily. It has helped me build communication tools and communication is the bedrock of all we do in intensive care. I have used skills honed from mentoring in so many facets of my professional life as a clinician, trainer, and problem solving in general.

Seeing both sides

I am both a mentee and a mentor and I get massive benefit from both. I get real joy in my mentor role helping a person to unpick a topic and figure out a personalised way to deal with the issue. I am constantly humbled by the insights volunteered. As part of the WICMEL programme I work with a mentor and these sessions have been a wonderful environment to broaden my horizons, vocalise concepts important to me and put structure on my career development.

The FICM Thrive Mentoring is an important programme to be involved with. It is a means of supporting new consultant colleagues as they start careers. It also provides an opportunity to talk about and normalise mentoring. As a speciality we are emerging from an incredibly challenging time. We should use all available resources to refocus and reset and have robust means of supporting each other throughout the arc of our careers. Mentoring offers a mutually beneficial, supportive and collaborate way to achieve this. Find out more about FICM Thrive at www.ficm.ac.uk/careersworkforce/ficm-thrive.

Dr Jack Parry-Jones
FICMCRW Chair

FICM Thrive NEEDS YOU!

Most of us reach a certain point in our careers and work relationships when, given the chance we would have done things differently. The Richard Curtis film *About Time* explores this theme with the protagonist able to time travel to change his life and relationships for the better. The feeling of déjà vu sometimes feels like time travel. This is especially the case working in the NHS and critical care. I love the NHS for many reasons but you can get the feeling that you have been here before; I love working in critical care but we do have a habit of revisiting the same questions in a five to ten year cycle.

What would I do differently?

What would I have done differently if I had better understood how things work earlier in my career, and if I could go back in time what would I change? We can't time travel, but we can ask the questions of those who have been there — our guides or mentors.

This is why mentoring can be so important; to help those early on in their careers avoid the same potholes that we bumped our way through, to take a different road or to at least better understand the nature of those potholes. Smoothing the careers of those who follow in our footsteps may help them go one step further than we have and without some of the headaches, frustrations and difficulties.

The Thrive mentoring scheme needs more mentors. I urge those of you in the later part of your careers to volunteer for this. The scheme's training is quick and easy, and matches you up with a mentee. The commitment over the next 12 months is not onerous. The interesting thing is how much you can benefit from being the mentor. 'Reverse mentoring' is an emerging idea of those who are more senior and consequently may be out of touch with modern trends, being mentored by someone younger in order to gain understanding. I think the Thrive mentorship scheme provides for this.

Not a one way process

The mentor/mentee relationship is not a one way process and I have already gained from my mentee by reflecting on what has been said. There are new difficulties, new potholes in the road which we did not face before, which are good for those of us later on in our careers to understand and better appreciate. To leave something behind for those that follow in our footsteps is good for us as well as good for them — please give it a go if you haven't already: www.ficm.ac.uk/careersworkforce/ficm-thrive.

Careers, Recruitment and Workforce (FICMCRW)

Dr Jack Parry-Jones
FICMCRW Chair

The adult UK population is currently around 54 million, with projected demographic increases in age and frailty. Ten critical care beds per 100,000 population would help meet existing demand but requires at least 5,400 staffed critical care beds; we currently have around 4,000.

It is against this backdrop that the Faculty seeks to increase ICM National Training Numbers (NTNs), and also facilitate those seeking an alternative CESR pathway into an ICM consultant career. CRW now has a team, led by Dr Shashi Chandrashekaraiah working on helping those work their way through the CESR process. CRW now has a team, led by Dr Shashi Chandrashekaraiah working on helping those work their way through the CESR process.

Substantive appointments to ICM consultant posts

The Faculty put out a position statement in March 2022 on substantive appointments to ICM consultant posts. The care of the critically ill should be led and directed by doctors fully trained in ICM wherever possible. Adverts for ICM consultant posts, including essential criteria and post sign off by Regional Advisors should reflect this. It is very important that doctors trained as single, dual or triple ICM CCTs are seen as equally deserving of consideration for ICM consultant appointment with the ICM CCT being fundamental.

Recruitment 2022

Recruitment into ICM in 2022 has been expertly managed again by Dr Tim Meekings, and the teams from the Faculty and Health Education England. Demand to enter the specialty remains high with more than 2 applicants for every training place. Increases in NTNs and where people train are very important in matching supply to demand including to small, specialist, remote and rural hospitals.

Portfolio careers

ICM careers are increasingly diverse. Drs Ascanio Tridente and Ken McGrattan jointly lead our Career section and seek to reflect the modern portfolio nature of ICM careers, from entry through to retirement.

The census

The annual Faculty census, led by Dr Richard Porter should help match regional supply to demand and also looked into differential attainment based on protected characteristics. The specialty still needs a Women in Intensive Care Medicine (WICM) group, chaired by Dr Liz Thomas. Expert panels, editorial boards, research grants, and ICM consultants etc are in general still predominantly male gender. This needs rectifying. The census results should be available soon. COVID highlighted issues that existed for our specialty before the pandemic and will still exist afterwards.

Critical Staffing

The last in the Faculty's *Critical Staffing* series seeks to address 'Return to work.' Any of us may, or possibly already have required time away from work for a variety of reasons including mental and physical ill health, bereavement, caring for loved ones, referral to the General Medical Council, and parental leave. We hope this will help delineate, with ICM doctors personal experiences, what our employing organisations should be doing to help us return safely and well to the workplace.

ICM National Recruitment

Dr Tim Meekings
Recruitment Lead

At the time of writing this, the 2022 ICM recruitment process has recently come to a close, with training posts having been offered on the 21st April and the deadline for holding or upgrading posts passing in the first few days of May. We look forwards to welcoming our new colleagues to their training posts later this year, as they continue their journey towards a career in ICM. For the first time since 2019, we were able to hold an interview process for ICM recruitment in addition to the portfolio assessment.

Although this was held online, it still gave the Consultant Intensivist interviewers the opportunity to meet the applicants and assess their suitability for joining the ICM training scheme, whilst also finding a bit more about them and their reasons for wanting to join our dynamic, challenging and rewarding specialty.

Online interviews

Overall, the online interview process ran smoothly and all applicants that attended for interview were able to have a 30 minute interview with a pair of interviewers with no major technical issues.

As always, there is room for improvement in terms of the interview questions and scoring systems and we have gathered feedback from the applicants themselves, interviewers and observers of the process to see how we can continue to evolve and improve the process to make sure it is as fair as possible, whilst also enabling us to assess each applicant in a range of domains.

2023

What about next year? HEE have already released a statement that recruitment for all specialties will continue to be run virtually next year and there will be no face-to-face interviews in 2023. The reasons cited for this include the environmental and cost benefits to running the process online, along with the lack of evidence to prove that either online or face-to-face is the fairest method of recruitment.

Digital Platform

As the digital platforms continue to be improved and enhanced, there is the possibility that ICM recruitment next year may involve more than one station and the opportunity for the applicant to be assessed by more than one pair of interviewers. We will continue to engage with this process to see what may be possible.

Looking ahead

The portfolio self-assessment with verification by trained consultant intensivist assessors will continue to form an important part of ICM recruitment, but the importance of adding the opportunity to meet the applicant in an interview, albeit a virtual one, remains a vital part of ensuring we continue to recruit a high-quality workforce to join our specialty in the future.

Year	Applications for ICM speciality training	NTNs
2019	305	170
2020	430	289
2021	553	203
2022	470	194

Women in Intensive Care Medicine (WICM)

Dr Liz Thomas
FICMWICM Chair

Women in Intensive Care Medicine is a sub-committee of FICM and we aim to promote ICM as a career for all. Fifty-five percent of medical school graduate are women, but only 21% of ICM consultants are women. We are looking forward to seeing the results of the 2022 FICM census but we understand that these changes are slow to show results. The key aims of the sub-committee are to:

- **Educate:** To recruit — raise the profile of ICM at undergraduate and postgraduate level
- **Support:** To retain — be an advocate for female doctors in training and in consultant posts
- **Explore:** To remove barriers — identify and address reasons for gender inequality
- **Network:** To create a community — be part of something critical in the development of ICM in the UK.

Wider WICM

The sub-committee is made up of ten consultant members and two StR members. Members are appointed for a 3-year term. We also have the WICM Wider Group (WWG). A lot of our social media content has been written by WWG members. If you would like to be part of WWG then please email wicm@ficm.ac.uk and we will add you to the group.

FICM Thrive

Thrive — FICM's mentoring scheme for consultants in the first 5-years of their consultant post, launched 12 months ago and the first pairings are coming to a close. We only have informal feedback at present, but the scheme has been very well received by mentees and mentors. Most mentors I have spoken with have been surprised about how much they have got out of the pairings. We are always looking for more mentors — the eLearning only takes an hour or so, and the requirement is for four meetings in a year, so the time constraint is very small but being a mentor can be invaluable for the person being mentored.

Striking the Balance

Following the very well received face-to-face meeting held back in November 2019 and the virtual meeting held last year, we are delighted to announce we will be having an in person meeting on Thursday 20 October 2022. The programme will cover some difficult and thought provoking topics but being balanced with workshops and positivity. I would love to meet as many of you as possible there! WICM is keen to promote ICM for all – so people of any gender are welcomed at our meeting. You do not have to be a woman to attend!

Medical students

We have also held a workshop with some medical students from across the UK to help us promoting ICM as a career to people earlier on in their medical career. Our aim is to increase ICM visibility for medical students and provide resources to aid this. If you would like to help in this endeavour, please get in touch.

WICM Blogs

We believe in talking about the excellent bits of our jobs, whilst acknowledging that it can be a difficult and stressful work environment. We have a monthly WICM Blog, a Twitter feed, and other outputs; for example, I have recently done a FICM podcast. You can follow us on Twitter via @womenICM and our blogs are hosted on the FICMLearning pages.

Professional Affairs and Safety (FICMPAS)

Dr Peter Macnaughton
FICMPAS Chair

This will be my last update as chair of PAS as I leave the board in October having completed my second term. I am delighted that Dale Gardiner will be taking over as the new chair and I am confident that the future of the committee is in very safe hands. I must thank Prof Gary Mills for his hard work on the fifth edition of the Safety Bulletin, in analysing all the incidents involving critical care reported on the national reporting system and summarising the lessons.

Arterial line flush

The Health Care Safety Investigation Branch (HSIB) has been conducting an investigation into the wrong arterial line flush line fluid following a further tragic death from hypoglycaemia due to the inadvertent use of glucose containing fluid. The committee has provided feedback into the draft report and recommendations which should be published in the near future. This investigation highlights the continuing risk to patients of using the wrong flush fluid, the current lack of robust barriers in terms of design solutions and the need for all staff to be vigilant in prevention.

GPICS V2 Audit Toolkit

We have received data from 49 units that completed the GPICS V2 audit toolkit and submitted their responses. After some teething problems, the data is being analysed and we are discussing with the Intensive Care Society the best format to share the results. Thanks to all the units that completed the audit and hope that they found the exercise helpful in identifying areas for development of their local service. The audit toolkit remains available on the website. GPICS V2.1 is out now and discussed elsewhere in this issue.

Neurological criteria

Dale Gardiner has been representing the Faculty on a working group to develop guidance on ancillary testing to support the clinical diagnosis of death using neurological criteria. A draft consensus protocol using CT Angiography has been produced and endorsed by PAS. Once endorsed by all the other contributing organisations, it should be published in the next few months. This and other developments, including the addition of red flags, has highlighted the need for an update to the 2008 Academy Code of Practice. The Faculty is represented on an Academy working party chaired by Alex Manara which is undertaking a review of the current guidance.

Thank you

I would like to thank all the committee members and FICM secretariat for their hard work in supporting the committee. A particular thanks to Peter Shirley and Chris Bassford who completed their terms of office in June.

Safety Incidents in Critical Care: Themes from the Safety Bulletin

Prof Gary Mills
Safety Lead

The Safety Bulletin is developing. The plan to circulate to critical care nurses and allied health professionals as well as doctors has been implemented from the fourth edition onwards and we now have editorial involvement from nursing, critical care pharmacists, ACCPs and physiotherapists. The aim from here is to expand the sources of the incident reporting.

The pattern of recurring incidents across the first five bulletins unfortunately continues. This recurrence is one area we are analysing and will publicise in more depth in the future, as it may lend itself to intervention. It may be possible to establish a current top ten of incidents across all organ systems and forms of treatment, to publicise these problems and reduce them, focussing on those that cause more morbidity and even mortality and considering which lend themselves best to intervention.

Much of our data is submitted 'voluntarily' via the national reporting systems and received anonymously and so is not truly quantitative. However, it could also be argued that most surveys are also not fully representative, because not all data will be submitted. So even with our limitations and the inevitable lack of a denominator of successful actions in the same area of care that went well, the incidents included in the bulletin represent important individual cases, which could potentially be reduced or avoided with the right resources and determination. Awareness of common or even less common but serious incidents is the first step to reducing safety incidents.

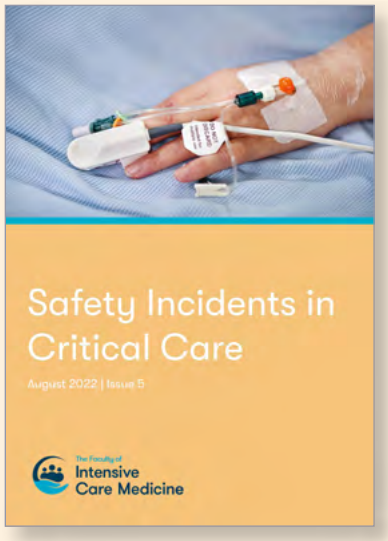
The latest bulletin (Issue 5) features important lessons, a few of these are briefly summarised here:

Airway

We know the airway is a hazardous area from previous bulletins, together with the specific airway studies of NAP4[1] and the international experience published by Russotto[2]. Key points in Issue 5 include laryngeal oedema after prolonged intubation and therefore the need to consider assessment for this by visual methods and the endotracheal tube cuff deflation leak test.

Tracheostomy

Tracheostomies form a major proportion of airway incidents on ICU and their management has been greatly helped by the work of McGrath and colleagues[3]. Displacement and the need for urgent and potentially difficult intubation is illustrated. In one episode, surgical emphysema of the chest and face ensued, emphasising the need for immediately accessible



full difficult intubation equipment, continuous capnography and resuscitation equipment.

Lines

Failure to transduce CVC lines at insertion and during subsequent care was once again a feature of late diagnosis of accidental intra-arterial placement.

Nasogastric tube

Problems with placement arose when a separate fine bore feeding NG tube was used at the same time as a standard NG tube causing confusion with ECG leads and a missed lung placement on chest Xray.

Chest drain

Recording of chest drain negative suction pressures was omitted leading to confusion over the correct level of suction.

Dosing incidents

Despite correct prescriptions administration errors occurred with anticoagulants. In one example a heparin infusion infused and in a separate case a heparin infusion was stopped, regular low molecular weight heparin was not given at the prescribed time, resulting in clotting.

Pressure ulcers and tissue injury

Tension in nasogastric tubes or pressure effects worsened by the means of attachment are a common source of injury. Similarly, tension in urinary catheters, possible more commonly in proned patients could potentially be reduced.

Delays in treatment, admission or the reporting of results featured strongly. Many potentially being due to overload of work or limited staffing. The need for consultant involvement of all the relevant teams, including the referring team was illustrated in some complex cases.

Overall, the theme of recurrence of many issues or types of incident across all aspects of critical care, is a topic we will focus on and investigate further. The aim will be to assess their incidence and causative factors and to introduce a campaign to reduce their occurrence in the coming year.

The *Safety Incidents in Critical Care* Bulletin can be accessed via this link: https://www.ficm.ac.uk/standardssafetyguidelines/safety.

References

1. T M Cook 2011. Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 2: intensive care and emergency departments. British Journal of Anaesthesia 106 (5): 632–42 (2011). doi:10.1093/bja/aer059

2. V Russotto, 2021. JAMA. 2021;325(12):1164-1172. doi:10.1001/jama.2021.1727

3. https://www.tracheostomy.org.uk/

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