

JOINT FACULTY OF INTENSIVE CARE MEDICINE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

**GUIDELINES FOR INTENSIVE CARE UNITS SEEKING
ACCREDITATION FOR TRAINING IN INTENSIVE CARE MEDICINE**

1. GENERAL

- 1.1 The Joint Faculty of Intensive Care Medicine classifies intensive care units into a number of categories for the purpose of its Administrative Instructions relating to training in intensive care medicine.
- 1.2 The Joint Faculty of Intensive Care Medicine expects that supervision of vocational trainees will conform to the principles of the Document IC-4 "The Supervision of Vocational Trainees in Intensive Care".
- 1.3 All specialists employed in accredited units have an obligation to teach trainees, as outlined in Document IC-2 "The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care".
- 1.4 Intensive care units accredited for training by the Joint Faculty of Intensive Care Medicine must meet the following criteria:
 - 1.4.1 The unit must fulfil the requirements of either Level III (for C6, C12 and C24 classifications) or Level II (for C6, or occasionally C12, classification) as outlined in Document IC-1 "Minimum Standards for Intensive Care Units".
 - 1.4.2 The unit must offer trainees a wide spectrum of experience with an acceptable case load.
 - 1.4.3 The hospital should provide a comprehensive range of medical and surgical specialties.
 - 1.4.4 There must be access to a wide spectrum of investigations and therapeutic procedures.
 - 1.4.5 Trainees must work adequate hours within the intensive care unit as distinct from high dependency units or other rostered duties. If inadequate hours are worked in intensive care, the Censor may rule that the trainee or trainees must extend the duration of their core training.
 - 1.4.6 Where trainees are involved in routine patient care in a high dependency unit, the high dependency unit should meet the criteria as described in Document IC-13 "Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine".
 - 1.4.7 Unit policies and rosters must ensure that adequate clinical management experience (including performance of procedures) is available to trainees. If excessive numbers of trainees are considered to limit the adequacy of training for individuals,

then the Censor may rule that the trainee or trainees must extend the duration of their core training.

- 1.4.8 Safe working hours for trainees must be maintained and welfare issues addressed.
- 1.4.9 When appointments to the specialist staff are made, the advice of a properly constituted committee capable of evaluating the qualifications of the applicants must be sought. Faculty nominees are available to committees for this purpose.
- 1.4.10 Positions for training in intensive care units accredited by the Joint Faculty of Intensive Care Medicine must be advertised and the unit classification must be indicated in the advertisement. The selection process must conform to Joint Faculty guidelines. Selection panels for the appointment of trainees in intensive care should include a Fellow of the Joint Faculty of Intensive Care Medicine.
- 1.5 A program of education, quality assurance and research must be offered which includes a formal teaching program readily available to trainees.
- 1.6 Adequate intensive care textbooks, journals, management guidelines, protocols or clinical care pathways must be available on site, and the unit should have access to electronic medical information.
- 1.7 The hospital must have a comprehensive continuing education program for its staff and should provide adequate library facilities.
- 1.8 The hospital must be prepared for the Joint Faculty, at intervals determined by the Board, to carry out visits to the unit to assess its suitability for training. Information about caseload, staffing patterns and the rosters must be provided.
- 1.9 The training appointment must be entirely in intensive care, and should include provision for the trainee to take part in out-of-hours rosters in intensive care.
- 1.10 Supervisors of Training are nominated by the Unit and appointed by the Board of the Joint Faculty. The Supervisor is expected to carry out the duties listed in Document IC-6 "The Role of Supervisors of Training in Intensive Care Medicine".
- 1.11 The hospital must agree to notify the Board, through its Supervisor of Training, of any changes that might affect training. Changes such as a reduction in the workload, a significant change in casemix or acuity or a reduction in the number of specialist staff working in the unit are regarded as important.
- 1.12 Applications for a change in classification will be received by the Board, and may necessitate re-inspection of the unit.

2. CLASSIFICATION OF UNITS

- 2.1 Subject to criteria being met, the number of training posts in a unit accredited for training is unrestricted and determined by workplace practices in the unit, unless otherwise specified. All accredited units are suitable for core training, elective training and, unless otherwise specified, the intensive care component of anaesthesia training.

2.2 The duration of core training is determined by the classification of the unit as outlined below.

2.2.1 **C24: Unrestricted core training**

This classification is granted only to Level III units and Paediatric Units, where in addition to the Level III status the Board deems it would be appropriate for a trainee to spend the whole of their core training in intensive care. C24 accredited units will be major intensive care units in tertiary referral hospitals and will usually have more than 3 Specialists who are Fellows of the JFICM and who have at least a 50% involvement in the unit. The patients will have a high level of illness severity. The case mix will be diverse, normally including five of the following six specialties: trauma, general medicine, general surgery, cardiac surgery, acute cardiology and neurosurgery. Exposure to burns, spinal injuries and transplant services is desirable. Total case numbers will usually exceed 750 patients per annum with at least a 40% ventilation rate. Trainees are required to spend at least one year of core intensive care training in a unit with a C24 classification.

2.2.2 **C12: Twelve months core training**

This classification is granted to Level III units and Paediatric Units, and occasionally to Level II units, where the caseload and casemix are adequate, but where the Board considers it would be unsuitable for a trainee to spend the whole of their core intensive care training. C12 accredited units will usually have more than 2 Specialists who are Fellows of the JFICM and who have at least a 50% involvement in the unit. The case mix will be diverse including general medicine, and general surgery and may also include, acute cardiology cardiac surgery, trauma and neurosurgery. Total case numbers will usually exceed 500 patients per annum with at least a 40% ventilation rate.

2.2.3 **C6: Six months core training**

This classification is granted to Level II, Level III or Paediatric Units where the case load, case mix, supervision or facilities are limited, such that the period of core training in that unit should be restricted to six months. This is not a reflection on the quality of care in that unit. The C6 classification is also designed to encourage rotations to such units from other units. Normally, not more than one period of C6 training in a given unit is allowed during core intensive care training. A second period of C6 training in another unit requires prior approval of the Censor and will only be granted if specific benefit in training will be achieved.

2.3 **Criteria for determining classification of units**

The determination of a unit's classification will be made with regard to points listed in paragraph 1 above, the unit's case load, case mix, severity of illness of patients, range and frequency of procedures, supervision of trainees and facilities of the unit.

3. **TEACHING AND RESEARCH**

3.1 There must be a formal, documented and demonstrable program of teaching provided for trainees. This teaching will include:

- 3.1.1 Tutorials
- 3.1.2 A bedside review of patients with the intensive care specialist on duty for the unit should occur at least twice daily.
- 3.1.3 Case presentations and review sessions.
- 3.1.4 Mortality and morbidity sessions.
- 3.2 The unit should have an active, documented and demonstrable research program to which trainees are encouraged to contribute in a significant way.
- 3.3 The unit should have adequate clerical, data collection and secretarial support. Trainees are expected to take part in routine unit data collection (eg. patient demographic data, APACHE II scoring data, morbidity and mortality data).
- 3.4 The unit should have active quality assurance (QA) and quality improvement (QI) programs. Trainees are expected to take part in these activities.
- 3.5 Access to an appropriate level of funding for research coordinators to support the active research program. As a minimum, funding to support the full time research coordinator position for a Level III Unit (IC-1), and an appropriate part-time position in smaller units

These guidelines should be interpreted in conjunction with the following Documents of the Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians:

- IC-1 “Minimum Standards for Intensive Care Units”
- IC-2 “The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care”
- IC-4 “The Supervision of Vocational Trainees in Intensive Care”
- IC-6 “The Role of Supervisors of Training in Intensive Care Medicine”
- IC-7 “Secretarial Services to Intensive Care Units”
- IC-8 “Quality Assurance”
- IC-13 “Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine”

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

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

Whilst the Joint Faculty endeavours to ensure that Documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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