



**College of Intensive Care Medicine**  
 of Australia and New Zealand  
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## **GUIDELINES ON INTENSIVE CARE SPECIALIST PRACTICE IN HOSPITALS ACCREDITED FOR TRAINING IN INTENSIVE CARE MEDICINE**

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### **1. PURPOSE**

These guidelines have been developed to outline the expectations of the College of Intensive Care Medicine with regard to specialist practice in Intensive Care Units accredited for training. They should be read in conjunction with other College documents and regulations.

### **2. THE DUTIES OF AN INTENSIVE CARE SPECIALIST**

#### **2.1 *Clinical Duties include:***

2.1.1 Providing care and assuming responsibility for patients in the intensive care unit and, where appropriate, a co-located high dependency unit.

2.1.2 Supervising medical staff including trainees in the intensive care unit and, where appropriate, in a co-located high dependency unit.

2.1.3 Being available to medical colleagues for consultation and liaison as appropriate regarding patient care.

2.1.4 Being immediately available for urgent consultation and assistance in the resuscitation and subsequent management of critically ill or injured patients.

*The intensive care specialist may also be responsible for providing or facilitating:*

2.1.5 Acute resuscitation in the context of cardiac arrest, trauma and other emergency responses such as rapid response teams.

2.1.6 Assessment, management and review of patients outside the intensive care unit in 'follow up' and related initiatives

2.1.7 Transport of critically ill patients.

2.1.8 Parenteral nutrition and/or venous access services to patients in other areas of the hospital.

2.1.9 Advice to hospital management and to other bodies outside the hospital (e.g. professional and regulatory bodies) on clinical and other matters relevant to intensive care medicine.

## 2.2 *Administrative and Educational Duties include:*

2.2.1 Ensuring that administrative duties relating to the proper functioning of the unit and the hospital are carried out.

2.2.2 Providing and participating in appropriate educational activities for:

- Trainee specialists.
- Interns, resident medical officers and registrars.
- Postgraduate nurses.
- Medical students.
- Undergraduate nurses.
- Paramedical staff.

2.2.3 Preparing material to be used for teaching.

2.2.4 Ensuring and reviewing quality of patient care by participating in audit, peer review and quality assurance programs as outlined in Document IC-8 *Quality Improvement*.

2.2.5 Maintaining personal knowledge and skills by participating in continuing education and continuing professional development activities and programs.

2.2.6 Contributing to hospital committees and the committees of health authorities and other organisations.

2.2.7 Contributing to the activities of the College and other professional organisations. This may include acting as Supervisor of Training (refer Document IC-10 *The Role of Supervisors of Training in Intensive Care Medicine*).

## 2.3 *Research Activities*

Participating in or supporting research and assisting trainees in undertaking research and in understanding research methodology and processes.

## 2.4 *General*

Striving to achieve the highest standards and quality of health care through excellence in the CanMEDS core competencies of medical expert, communicator, collaborator, manager, health advocate, scholar and professional.

## **3. THE APPORTIONING OF TIME BETWEEN CLINICAL AND NON-CLINICAL DUTIES**

By its nature, intensive care practice involves a great deal of 'out-of-hours' commitment. This document does not address the industrial issues related to weekend and night-time practice but some consideration of these is relevant. Non-clinical time allocation in this document refers to sessions undertaken during the course of the normal Monday to Friday (five day) week ('daytime').

### 3.1 *The Intensive Care Staff Specialist*

All intensive care staff specialists, part-time or full time, must have sufficient exposure to clinical practice to maintain their clinical skills. They must also have a commitment to personal continuing education, administration, audit, quality assurance and other educational activities such as a Continuing Professional Development Program. Sufficient time must be allocated for these activities. For the non-clinical duties of an intensive care staff specialist, on average, three days per fortnight should be allocated. A greater allocation may be required for specialists with a major commitment to research or professional affairs.

### 3.2 *The Director of Intensive Care*

It is the primary responsibility of the Director to ensure that the intensive care service functions effectively and efficiently. Administrative responsibilities constitute a significant workload. A minimum of three days per fortnight should be allocated for these administrative and related activities in addition to the general specialist allocation.

3.2.1 In larger units (greater than 20 beds and 750 annual admissions requiring more than one specialist on duty per day) a Deputy Director should be appointed to assist the Director in its administration with a non-clinical allocation of at least two days per fortnight.

3.2.2 If the Director is not a full time appointee, appropriate time must be provided for administrative duties and personal continuing educational needs.

### 3.3 *Supervisor of Training*

The Supervisor of Training has a very important role in the co-ordination of all aspects of the training of CICM and other specialty trainees. Specific non-clinical time should be allocated to enable the Supervisor to fulfil this role. The required time commitment will vary with the number of trainees but one non-clinical day per fortnight will usually be required.

### 3.4 *The Visiting Intensive Care Specialist*

Visiting intensive care specialists have similar needs to intensive care staff specialists and proportional provision should be made for administrative and educational duties.

## 4. **GUIDELINES ON CLINICAL AND TRAINEE SUPERVISION**

These guidelines are based on a practice norm in which the major decisions related to patient care are determined during at least twice daily ward rounds undertaken by the intensive care team during 'daytime' hours. The intensive care team consists of specialists and more junior medical officers (who may or may not be undertaking vocational training in intensive care medicine), working with other intensive care staff and primary and consulting medical teams. Outside routine ward rounds, trainee supervision is undertaken on an 'as needs' basis (see IC-4 *The Supervision of Vocational Trainees in Intensive Care Medicine*), and applies to the assessment and management of new patients as well as changes in the condition of existing patients. This supervision must occur at all times although most formal teaching and related training activities take place during regular weekday hours.

For the purposes of these guidelines, a single ICU is one with a single administrative structure with a single administrative head and reporting responsibilities. Many ICUs include high dependency (HDU) or "step down" patients with a lower level of nursing acuity. Large ICUs should be divided into pods for the purposes of clinical management.

The maximum number of patients whose care can be satisfactorily supervised by a single intensive care specialist at any given time has not been established categorically. However the evidence suggests that this number is 8 to 15 during 'daytime' hours, when the direction-setting, ward round component of intensive care practice occurs. This dictates that a number of intensive care specialists will be required for clinical management in large ICUs with multiple pods. For the 'out of hours' on call component of intensive care specialist practice it is reasonable for one specialist to manage more than this number of patients, providing backup is available from a 'second-on call' specialist.

It is expected that there will be sufficient specialist staff appointed to ensure appropriate levels of specialist cover at all times with due consideration to safe practice principles. It is also expected that rostering and administrative practices will ensure adequate handover amongst specialists together with initiatives to maximise continuity of care.

- 4.1 During regular weekday 'daytime' hours, the supervising specialist should be predominantly present within the ICU or pod. This specialist should be required to manage no more than 8-15 patients. This requirement precludes service provision in two separate units during regular hours even if the two units are co-located on a single campus.
- 4.2 Outside regular, weekday hours, the supervising specialist may be simultaneously rostered to more than 8-15 patients providing another specialist is rostered to be 'second on call'. This specialist may be rostered to cover more than one ICU or pod, but only if they are on a single, geographical campus.
- 4.3 The supervising specialist must be exclusively rostered and immediately available to attend patients within the ICU. Other clinical and non-clinical commitments which might preclude immediate availability may only be undertaken when another suitable specialist is immediately available and formal cover arrangements have been made.

These guidelines should be interpreted in conjunction with the following documents of the College of Intensive Care Medicine:

IC-1 *Minimum Standards for Intensive Care Units*  
 IC-4 *The Supervision of Vocational Trainees in Intensive Care Medicine*  
 IC-8 *Quality Improvement*  
 IC-10 *The Role of Supervisors of Training in Intensive Care Medicine*

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