



Intercollegiate  
Board for Training  
in Intensive Care  
Medicine

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# Standards for Consultant Staffing of Intensive Care Units

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# STANDARDS AND GUIDELINES

This document has been produced by the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) and the Intensive Care Society. It is not a comprehensive list of all the standards in intensive care, but addresses those issues that the IBTICM and the ICS consider to be the most important at the current time. They are the standards which the professional bodies suggest that PMETB and the Postgraduate Medical Deans adopt as part of the evaluation and accreditation of training units in Intensive Care Medicine. It is recognised that many units will not be able to implement all the standards immediately and a timetable for their implementation is included in the document.

Prepared on behalf of the Council of the Intensive Care Society and the Intercollegiate Board for Training in Intensive Care Medicine by: Dr K Gunning and Dr C Gillbe

## **Standards for Intensive Care Units**

### **A Joint Document for the Intensive Care Society and the Intercollegiate Board for Training in Intensive Care Medicine**

Intensive Care Units treat the sickest patients in a hospital and must provide an appropriate standard of care delivered by fully trained specialists in Intensive Care Medicine.

#### **Summary**

- All newly appointed consultants with programmed activities (PAs) in ICM should have acquired Step 1 competences, or an equivalent level of training.
- All newly appointed consultants with >50% commitment to ICM should have acquired Step 2 competences, a CCT in ICM, or an equivalent.
- All units must have a minimum of 15 PAs of consultant time totally committed to ICM each week per eight Level 3 beds.
- All consultants providing an 'on-call' service to the ICU must have PAs committed to ICM.
- Consultants should not have any other clinical commitment when covering the ICU during daytime hours.
- During working hours the consultant in charge of the ICU should spend the majority of his or her time on the ICU and must always be immediately available on the ICU.
- There must be twenty-four hour cover of the ICU by a named consultant with appropriate experience and competences.
- A consultant in ICM must see all admissions to the ICU within twelve hours.

## Standards for Intensive Care Units

### Background

The question of minimum acceptable standards for staffing of Intensive Care Units (ICUs) has a long history. A committee chaired by John Farman wrote the first UK document, which was published by the ICS in 1984. The practice of intensive care has developed and instead of variable levels of cover by consultant anaesthetists, the majority of ICUs have dedicated medical staff, still largely drawn from anaesthesia, but increasingly from other acute medical specialties. The development of the Joint CCT programme has produced a cohort of well-trained Intensivists who will continue to change the way Intensive Care Medicine is practised in this country. The purpose of this paper is to define the standards that are appropriate for the consultant staffing and management of ICUs.

Clinical academics who work in critical care may have different work plans compared to NHS consultants. The contribution to critical care medicine by such individuals is recognised, and the variation is acceptable, providing clinical care, professional development, unit governance, and trainee supervision are not compromised. Some of the standards apply to the current staffing in intensive care and some are aspirational. A timetable for the implementation of the standards is included in this document. The standards should apply to all patients receiving Level 3 or Level 2 Care at any location in a hospital.

### Consultant Staffing in ICUs

Intensive care is a service that should be delivered by appropriately and fully trained staff. This is not yet possible in the United Kingdom owing to an insufficient number of trained staff. In the light of this deficiency, and whilst the numbers of trained personnel are insufficient to provide a full time service, certain minimum staffing standards should be observed.

1. Training of Consultants
  - a. All newly appointed consultants with programmed activities (PAs) in ICM should have acquired Step 1 competences or equivalent.
  - b. All newly appointed consultants with >50% commitment to ICM should have acquired Step 2 competences or equivalent.
  - c. All newly appointed consultants with >50% commitment to ICM should have a higher qualification in ICM (e.g. DICM UK or EDICM).
  - d. All consultants with ICM responsibilities must provide evidence of Continuing Medical Education in ICM.
  
2. Staffing of Units
  - a. All units must have a named Director of Intensive Care.
  - b. A whole time Director whose job plan is committed to patient care and management of the ICU should be considered for ICUs with more than twenty Level 3 beds.

- c. The Director must have sufficient time for administration of the ICU; a minimum of one PA each week is recommended.
- d. There must be appropriate information technology and secretarial support, office space and equipment.
- e. There must be twenty-four hour cover of the ICU by named consultants with appropriate experience and competences to manage the patients in that unit.
- f. All units must have a minimum of 15 PAs of consultant time totally committed to ICM each week per eight Level 3 beds.
- g. Consultants should not be rostered for any other clinical commitment when covering the ICU during daytime hours.
- h. During daytime hours the consultant in charge of the ICU should spend the majority of his or her time on the ICU and must always be immediately available on the ICU.
- i. An increase in the total PAs dedicated to ICUs with more than eight Level 3 beds is strongly recommended during the normal working week.
- j. Daytime PAs in ICM at the weekends and on public holidays should be routine for all level 3 units.
- k. All consultants providing an 'on-call' service to the ICU must have PAs committed to ICM.
- l. Consultants with a daytime commitment to ICM must have a minimum of two PAs devoted to ICM; and four is desirable.

### 3. Clinical Management

- a. A medical practitioner of appropriate experience and training must normally be present on the unit at all times.
- b. There should be a minimum of two, and preferably three, ICU rounds every day at which a consultant is present; the only exception is when the round has been specifically delegated to a senior trainee for training purposes.
- c. There must be continuity of care in the consultant cover of the ICU. This may be best achieved by a consultant managing the unit for a period of several days at a time. Where a group of consultants have a significant overlapping commitment to ICU, then a single day working pattern is acceptable, but adequate time must be provided for a full clinical handover of patient care.
- d. A handover must occur between the consultants in charge of the ICU whenever there is transfer of responsibility for the unit. Sufficient time must be allowed in the job plans for an effective handover between consultants. This will depend on the size of the ICU
- e. The maximum number of beds managed by one consultant must be carefully considered and will depend on the number of other partly qualified staff available.
- f. All admissions and refused admissions must be discussed with the duty ICU consultant and a management plan drawn up.
- g. A consultant in ICM must see all patients admitted to the ICU within twelve hours of admission.

## Standards other than consultant staffing

Other standards that need to be considered are:

### 1. Structure

- This should follow HBN 57 for all new builds or refurbishment.  
[http://www.sykehusplan.org/data/critical\\_care\\_20040629170135.pdf](http://www.sykehusplan.org/data/critical_care_20040629170135.pdf)
- Should move towards 100% single bedded rooms.
- The ICU must have sufficient space and equipment for training and education.

### 2. Management

- There must be a clear line of leadership in line with the Trust clinical management structure.  
<http://www.ics.ac.uk/icmprof/downloads/ICSstandards4302.pdf>
- Intensivists should be responsible for the overall management of patients in the ICU and consult with the medical team responsible for other parts of the Integrated Care Pathway when appropriate.

### 3. Operational Policies must include:

- Admission, discharge and referral.
- Futility (Do not escalate treatment and Do not resuscitate policies).  
<http://www.ics.ac.uk/icmprof/downloads/LimitTreatGuidelines2003.pdf>
- Clinical Management.
- Infection control.
- Clinical governance; there must be a structure in place that integrates with the Trust Clinical Governance structure including regular incident monitoring.  
<http://www.ics.ac.uk/icmprof/downloads/icsincidentreporting.pdf>
- Multidisciplinary audit.
- Review of outcomes against national outcome data.

### 4. Training

- A documented induction programme for new staff must take place in protected time.
- There should be explicit mandatory training and assessment with dedicated time allocated to this:
  - i. At Trust level
  - ii. At ICU level for equipment and procedures
- There must be access to online resources and e-learning packages on the ICU.

- We would welcome comments on this document and suggestions for other standards in intensive care.
- Please send comments to:  
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e mail; [ehayes@rcoa.org](mailto:ehayes@rcoa.org)
- Implementation date: May 2007
- Review date: May 2010

**Timetable for Implementation of Standards**

Standard	Implementation date
1a	End of 2008
1b	End of 2009
1c	End of 2009
1d	End of 2007
2a	End of 2007
2b	End of 2007
2c	End of 2007
2d	End of 2007
2e	End of 2007
2f	End of 2009
2g	End of 2007
2h	End of 2007
2i	End of 2007
2j	End of 2008
2k	End of 2008
2l	End of 2008
3a	End of 2008
3b	End of 2007
3c	End of 2007
3d	End of 2007
3e	End of 2007
3f	End of 2007
3g	End of 2007

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