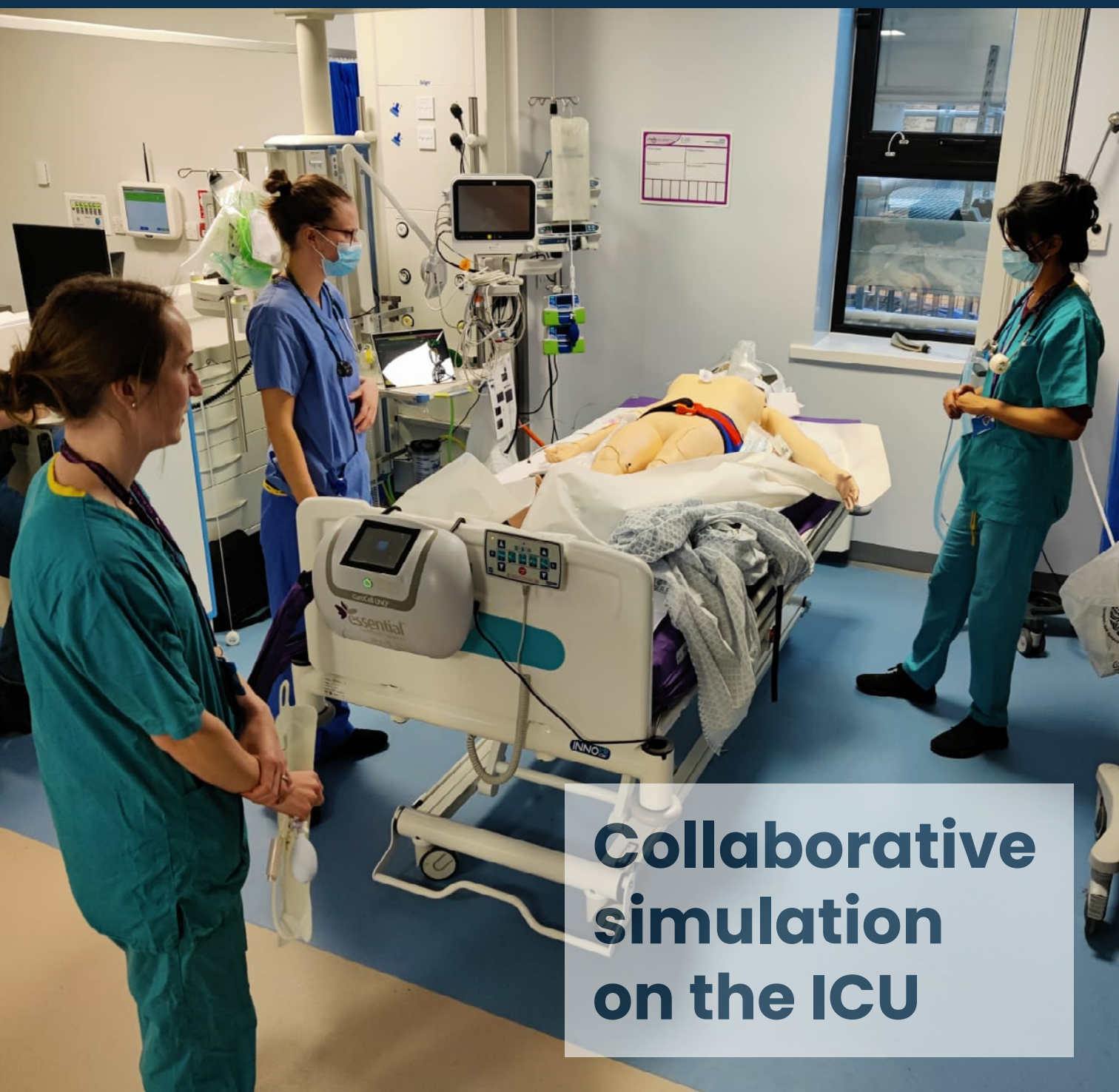
TRAINEE EYE

THE TRAINEE MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

ISSUE 18 | SPRING 2023



Collaborative simulation on the ICU

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The Faculty of Intensive Care Medicine

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Your Lead Trainee Representative

Dr Matt Rowe
FICM Lead Trainee Representative

As I begin my time as Lead Trainee Representative, this year is again proving to be a challenging time for trainees. With the exam review still fresh in our minds and the ongoing junior doctor industrial action taking centre stage, it's important we take stock and look out for one another.

As the future of our specialty, it's imperative we feel valued and listened to, but also that we continue to work together with our senior colleagues and healthcare providers in actively shaping our careers for the continued benefit of patients and staff alike.

StR Sub-Committee

I'm pleased to welcome Dr Fraser Waterson as the new Emergency Medicine/ICM trainee representative to the StR Sub-Committee. Following its creation last year, the StR Sub-Committee continues to meet and has provided some incredible new insights into the challenges that trainees face from the wide variety of backgrounds that encompass ICM training.

The committee will be focusing on a number of projects in the coming months including improving training for trainees from all entry routes into ICM and an exciting reverse mentoring project aimed at improving the training experience for those trainees from an ethnic minority background or overseas route of entry.

Welcome to Waqas

A warm welcome also to our newly appointed Deputy Trainee Representative Dr Waqas Akhtar. I'll leave Waqas to introduce himself on the following page, save to say that he comes into the role from a unique perspective and that he has already proven to be an excellent advocate for trainees across the country. I look forward to working with him on a number of exciting projects and ideas over the coming year.

Communication

As always, our doors remain open to any and all feedback, both good and bad. Waqas and I are particularly interested in how we can improve lines of communication between the Faculty, the StR Sub-Committee, the regional representatives and of course the wider trainee cohort.

Our job is to represent your interests within the Faculty and without your feedback we cannot do you justice. I look forward to working with all of you over the coming year.

Your Deputy Trainee Representative

Dr Waqas Akhtar
FICM Deputy Trainee Representative

These are difficult times for the NHS and we stand together with our colleagues across all professions for fair renumeration. Not only is this of justification intrinsically but it will ensure staffing levels to deliver safe patient care into the future. I believe in the founding ideals of the NHS, and Intensive Care Medicine as the pinnacle of care we can provide for our patients at the toughest times of their lives. That is something worth fighting for.

Thank you

As I start in my role I would like to thank you for electing me as your representative and Matt Rowe, Daniele Bryden and the wider FICM team for the warm welcome and introduction. As a bit about myself, I am concurrently training in Intensive Care and Cardiology/ GIM. It is a long story of how it worked out, suffice to say I am keen going forward to make these official partner specialties. I am particularly interested in heart transplantation, mechanical circulatory support and cardiogenic shock.

I stood to become FICM Trainee Representative to improve the aspects of training we all struggle through. Much of this is about respecting trainees as professionals and adapting the system to make training more flexible in order to pursue opportunities, mentoring for career planning and addressing issues within examinations and medical dual training.

Independent Exam Review

The Faculty has now published the results of the independent examinations review with many recommendations to address.

Recommendation 20 in my view is essential, highlighting the correlation between workplace performance and ability to pass the examination. I will work with the Faculty to ensure that the end product is an examination that a clinically well performing trainee, who has adequately prepared should have all the tools necessary to pass first time.

College of ICM

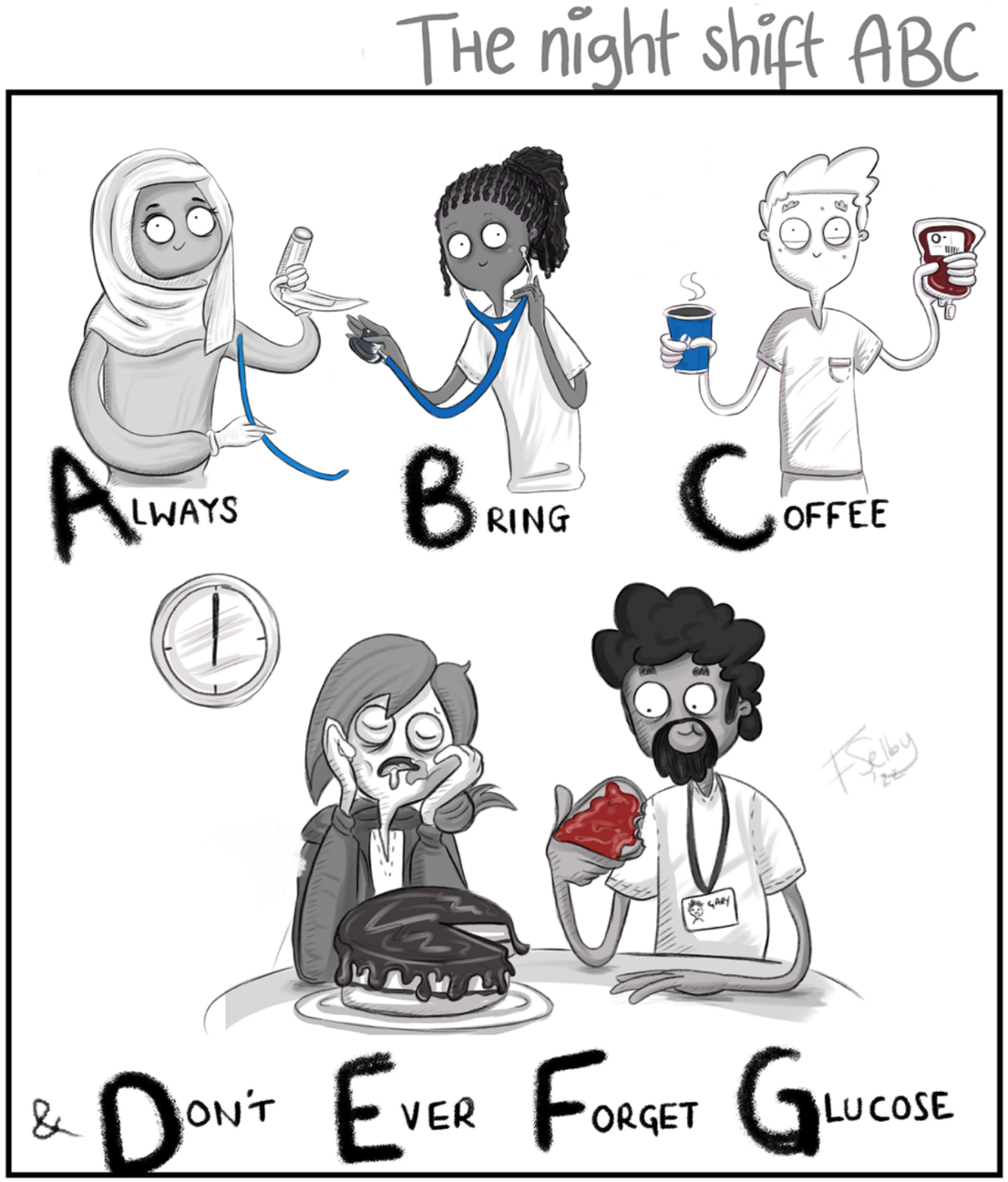
The Faculty has also rightly set itself a path for becoming a College. In view of the wider climate this is essential to the future of ICM in the UK. We need to be able to lobby at a high level to ensure adequate staffing and training numbers, to maintain minimum standards of care and to drive a vision of intensive care forward.

Having demonstrated during the pandemic the importance and capability of our specialty, the time is now to harness that reputation and make College status a reality. As with many things in life, its unfortunately not so much about your ability or skill but perception that is key in the fight for resources and rights.

Identity

There is also the question of identity. Intensive care has always been an open body partnering with many medical specialties. This has only strengthened the specialty and its status, however, the vision is yet to be completed. Many issues remain around consultant job planning to recognise both dual medical and single specialty posts in the job market. It is important that FICM, or CICM to be, is seen as a home by all its members whose differing skills are all respected.

I hope I can help deliver some effectual change and look forward working with you all.



My name is Faye Selby, and I am an Oxfordshire-based single specialty Intensive Care Medicine (background in Core Medicine) trainee. I'm just finishing Stage 1, and have a keen interest in doodling about some of the more whimsical bits of training and working in the NHS.

Shaping your future:

Job plans in ICM with a defined partner specialty

Dr Matt Rowe
FICM Lead Trainee Representative

It has long been my suspicion that intensivists training towards a dual or triple CCT with a "defined partner specialty" encounter a specific range of challenges not experienced by those seeking to dual CCT with anaesthetics. I suspect this may also be true for our single specialty ICM colleagues to an extent. As a dual anaesthetic/ICM trainee I have very little personal lived experience of this issue.

After hearing countless colleagues describe some of the difficulties they have experienced, both during and at the end of their training, it has become a personal and professional ambition of mine to start a process in which this situation can be improved.

As the Faculty begins working towards achieving an independent College status for our specialty, I believe we have a duty to further strengthen our commitment to supporting and developing intensivists from all backgrounds. After all, the multi-disciplinary nature of ICM and the multi-professional teams we have built are what makes our specialty both unique and great.

Challenges for dual and triple CCT trainees

Tales of trainees being asked "Why are you doing that? There's no job at the end of it", "Didn't you get the anaesthetic job then?" and "Are you sure you don't want to change to anaesthetics?" are all too common around the country. There are reports of trainees being placed on different rotas, not being given on-call commitments/opportunities, and of some educational/clinical supervisors having a very poor understanding of the needs and expectations of this trainee group. As if this wasn't enough to deal with, anecdotally, many trainees report having to choose between their specialties when applying for consultant posts.

Trainees endure many additional sacrifices in obtaining dual or triple CCTs; additional exams and clinical workload, portfolio nightmares, curriculum changes and transitions as well as the significant effect on your work-life balance to name but a few. It is heartbreaking to hear of people having to drop one specialty simply because of difficulties developing a job plan that encompasses them both.

Job plans

Clearly, there are multiple challenges in developing dual ICM job plans with other specialties, and creating a fair job plan requires total commitment from both divisions in order to work. Traditionally, this has been easier with Anaesthetics as they operate on a largely session-based framework and often fall under the same trust directorate. Often specialties advertise for a whole person contribution to service provision, unless the specific departmental lead has enough forward vision in their workforce planning.

Dual jobs also tend to require there to be a vacancy in both specialties simultaneously and there is often disagreement between clinicians wishing to advertise for posts and what individual trusts/directorates are willing to fund. The sticking point is often the on-call commitments, and it is very difficult to be able to perform on-calls in both specialties. In essence, the issues come down to funding, and to there being few established dual job plans in place with the onus very much on the individual to convince employers to cooperate.

Shaping careers

The FICM cannot instruct employers directly, nor does it have the ability to shape job plans in individual trusts, but I believe we can demonstrate what dual ICM job plans might look like. Enlightening employers and their respective HR/medical workforce departments as to how these patterns of working can be accommodated is the first step in improving the process for the future.

Together with the fantastic precedents set by our colleagues already in post, I hope that over time we can make it as easy as possible for future intensivists to shape their careers as intended. To this end, this issue of **Trainee Eye** has a focus on example job plans for direct clinical commitment time in both ICM and a partner specialty. Several consultants from around the country have kindly outlined their experiences and current job plans to help achieve this goal.

Acute Medicine and ICM job plan

Dr Andrew Achilleos
Consultant in ICM & Acute Medicine

Fancy dualling with a specialty that allows for rest and recuperation, free from the demanding reality of critical care? Well look away now, this is acute medicine! Of course I am joking. And besides if you are contemplating this, the chances are that you are already a committed medic. We don't go into medicine on a whim and despite its problems, medicine at its peak is rich with diagnostic conundra and complex problem solving that is rarely paralleled, and as a medical registrar you are rightly revered. But what does it mean to be a consultant in both specialties?

The good news is that, with regards to your job plan at least, this should be largely dictated by you. I am fortunate to work in a Trust, and with departmental leads, that are supportive of my dual role and encourage flexibility. My feeling of control over non-work time is far superior to my experience as a trainee. I choose to rarely work consecutive clinical weeks, set my own clinical split (approximately two thirds ICM) and my SPA time is almost exclusively in ICM where I have been encouraged to develop my interest in medical education as Faculty Tutor. As a result I do not find myself overwhelmed with governance responsibilities in two specialties.

My acute medicine PAs are Monday to Friday in-hours where I am scheduled for a week at a time of either AMU, morning post-take rounds or Same Day Emergency Care (SDEC), which offers some salvation from the ward. In the ICU, I work between two and seven days consecutively, and this time, (and whether nights are covered by a colleague) is negotiable.

I take satisfaction in what I can offer as an intensivist in AMU, and as a medic in ICU. With junior colleagues on AMU I discuss physiology, shock phenotypes or dispel myths and demystify critical care. I have helped aspiring intensivists to join us for taster weeks. For patients I can anticipate trajectories and make considered approaches to ICM colleagues, whilst providing support for patients and families when that is not an option. For both departments, I promote collaboration and understanding. Ultimately I believe that a plurality of experiences and clinical backgrounds benefits patients, trainees and the wider clinical environment.

There are, of course, challenges. Where dual-practising colleagues in other specialties assure me (variably) that their non-ICU work affords some respite, I cannot do the same. AMU is always busy and the turnover is staggering. No two days are the same, which is part of the attraction, but the mind can get overwhelmed, and increasingly comorbid patients with multi-system disease and frailty add to the complexity. As an intensivist I am committed to confronting treatment escalation at the front door, but at times these discussions wear me down.

Dual accreditation opens many doors. You are in a unique (and highly employable) position from which to negotiate your job plan. Ensure that your Trust encourages and can support **your** plans. Departmental culture and your relationship with colleagues will help you through harder times, so get to know your proposed place of work. In time you may even learn to love the inevitable query, 'are you medics or ICU today?' Perhaps I need to colour code my scrubs.

Acute Medicine and ICM: Less Than Full Time (LTFT) job plan

Dr Kay Protheroe
Consultant in Acute Medicine & ICM

I took up my Consultant Post in September 2022 on an annualised contract to be delivered over 42 weeks of the year (excluding leave). I trained LTFT at 60% from ST5 onwards and have two young children and so after interview and offer, I requested to start at 8.5PAs per week to maintain a manageable work life balance.

I am full time on a 1 in 10 on call rota for ICM (2.5PA/week). I provide five weeks of day time critical care a year and in between work one to two days of clinical acute medicine a week. My educational supervision time is delivered for AIM and I supervise three ACCS trainees currently — SPA time of 1.5 PA plus 0.5 PA for ES work. I am a FAMUS and FICE mentor and have recently added two hours (0.5PA) a week to my job plan to mentor and teach ultrasound within the acute medicine department to enable our trust to fulfil this key new component of the AIM curriculum.

Don't despair if you are a senior registrar and feel clueless about this stuff. Consultant job plans seemed a bit of a mystery right up until you find yourself negotiating them! As a dual trainee outside of anaesthetics, you first need to explore the priorities of both departments in any potential trusts that you wish to work, and how your job or elements of the job plan will be funded. You may be applying to job adverts which may or may not be tailored to suit you or as a dual trainee, it may need to be bespoke for you (mine was).

With many medicine business units moving towards seven-day working, acute medicine may ask you to contribute to out of hours work, as will the intensive care department. The feeling of not wanting to disappoint either team will become very familiar to you and is, unfortunately, the biggest negative of dual working. However, with more non-anaesthetic dual trainees gaining CCT than ever before, I am sure flexibility in the way you can split out of hours will follow if that is required.

I chose my trust because I knew there would be scope to be flexible within my job plan, allowing me to start less than full time and not mandate pre-determined numbers of weeks in critical care (2 in 10 often required on a 1 in 10 rota). At 8.5PA, this would have left little time for acute medicine. I feel at present my job plan works well for me, but it may not be the one you want, so I hope this has helped any dual trainee to start to think about what would work for you and your chosen hospital, as you start your search for the right job, in the right place, with the right teams for you.

Cross-trust working

Dr Amit Adlakha
Consultant in Respiratory, General Internal Medicine and Intensive Care Medicine

Having triple accredited in Intensive Care Medicine, Respiratory Medicine, and General Internal Medicine, I have a cross-trust post that enables split working between intensive care and lung transplant medicine. Cross-trust working is not everyone's cup of tea. From the perplexed looks I occasionally get when describing my working life, some clearly prefer the familiarity and routine that comes with traditional single-site working. For me, variety is important and change (of working pattern, specialty, *and* hospital) is as good as a break.

Extending one's tentacles outside the employing trust would normally start with tactful inquiry to your (hopefully open-minded) line manager. Such an arrangement is easier to square if there is an obvious mutual benefit to the trust in terms of either bringing back externally-gained expertise or building relations between centres. This isn't necessarily a key advantage of my arrangement, but obstetric medicine, cardiac anaesthesia, and long term weaning (for example) are add-ons that would understandably be viewed positively.

Flexibility

I started as an ICU consultant in 2018 and added in lung transplant medicine when an opportunity arose a year later. Getting the arrangement off the ground was ultimately testament to the flexibility of the two respective departments/clinical leads, and was achieved after a few weeks of amicable negotiations. An overly demanding approach never seems to help these conversations, and recognising the duty to contribute to both departments over and above the usual direct clinical care is helpful. As an example, I have clinical lead roles for morbidity and mortality in the ICU and organ utilisation (albeit NHSBT-funded) in the transplant department. Teaching, quality improvement work and clinical time is also equally divided.

On-call commitment

Competing needs for weekend cover can be a stumbling block with structuring a bespoke rota; though if there is sufficient flex for weekends to be allocated, pro rata between the specialties, this might not materially alter the weekend frequency. Yes, it may affect the on-call supplement by shifting up or down a category, but the effect on pay is usually marginal.

For medical specialties in particular, where there are outpatient responsibilities in addition to inpatient work, then redundancy and CNS support are extremely advantageous. Cross cover with another consultant colleague allows clinics to continue seamlessly in the face of interruptions for ICU work or leave, and clinical nurse specialists are invaluable in providing clinical admin support.

Contracts

The contractual status can be arranged in a number of ways. Ad hoc locum shifts at the second workplace may be flexible and financially advantageous, but not provide the desired level of long-term security.

Many clinical academics have had a memorandum of understanding, mainly with the academic institution as the principle employer. Two part time contracts via competitive appointment may be laborious to achieve and add complexity to tax (two p60s per year!) and pensions — a route I was heavily dissuaded from taking, primarily to avoid a complicated tax return!

A service level agreement (SLA), appears to offer a reasonable solution, whereby Trust A is fully responsible for salary, but bills Trust B proportionally for the number of PAs taken via the SLA, whilst also building in a notice period of mutually agreed length and equivalent employer responsibilities, except for appraisal and revalidation which are not duplicated. This works well for me, though many intensivists reach happy agreements with external employers for their split roles (transfer services, HEMS etc) using any of these frameworks.

Job satisfaction

Flexibility is becoming a core aspect of job satisfaction, and employers and clinical leads appear increasingly amenable to making such arrangements possible, so if you have cross-site working in mind, don't hesitate to ask around. Good luck!

Job Profiles

Dr. Kayode Adeniji | ICM and Respiratory Medicine Consultant | Portsmouth

K is a consultant in Critical Care and Respiratory Medicine at the Queen Alexandra Hospital in Portsmouth. His job plan consists of 10 PAs total DCC with two PAs of this in Respiratory Medicine, paid for by critical care. His two PAs in Respiratory Medicine are done as a job share with a less than full-time (LTFT) colleague to cover 17-18 weeks respiratory wards, incorporating time in outpatient clinics and his respiratory special interests (the Home/Chronic Respiratory Failure service and Respiratory High Care services).

All of his out of hours-time is in ICU as annualisation means he can't do Resp Med or GIM on-calls. K makes the point that annualisation is key in terms of spreading your on-call commitments/time between specialties and that it is essential to ensure that you have appropriate SPA time to deal with two specialties.

Dr. Richard Porter | ICM and ECMO Consultant | Leicester

Richard is an ECMO specialist working at The Glenfield Hospital in Leicester, he is a dual specialty qualified intensivist with anaesthesia. He stopped anaesthetic work to become a Medical Examiner as he felt the frequency of anaesthetic sessions he was doing was too low and it was difficult to maintain CPD across multiple specialties. His current job plan is 12 PAs with seven PAs of ECMO and ICM, 1 PA for Medical Examiner work, 2.5 for Deputy Clinical Director work and 1.5 for SPA.

He says he enjoys the non-clinical challenges presented by his other roles and finds the seven PAs good from a clinical perspective as it is enough to allow ongoing skill maintenance and development, but not too onerous.

Dr. Dushi Ahilanadan | ICM and Respiratory Medicine | Southampton

Dushi is a Consultant in at the University Hospital Southampton NHS Foundation Trust. He is dual accredited in ICM and Respiratory Medicine but has chosen to no longer work in Respiratory Medicine, having taken on more research responsibilities. His initial Job plan was a 50:50 split with a relatively desired job plan (including leading PH service, NIV clinic, RHDU, etc). This incorporated eight PAs Direct Clinical Care — four DCC from respiratory (clinics/wards/RHDU) and four DCC from ICM, all of his on-call commitments were for ICM. He also incorporated two SPAs into his job plan, one each for ICM and Respiratory Medicine respectively.

Dushi is a vocal advocate for reducing the challenges that Intensivists face in procuring jobs with DCC in ICM and a partner specialty. He cites the currently inflexible nature of the divisional workforce as being a major barrier to overcome, but despite the challenges faced, advised it is still possible to get a dual job, and before getting the UHS job, was offered a similar job plan by two other hospitals.

FFICM Prep Course

SAVE THE DATE

Day 1

Online lectures

Monday 11 September 2023

Day 2

In-person mock OSCE/SOE

Tuesday 19 September 2023

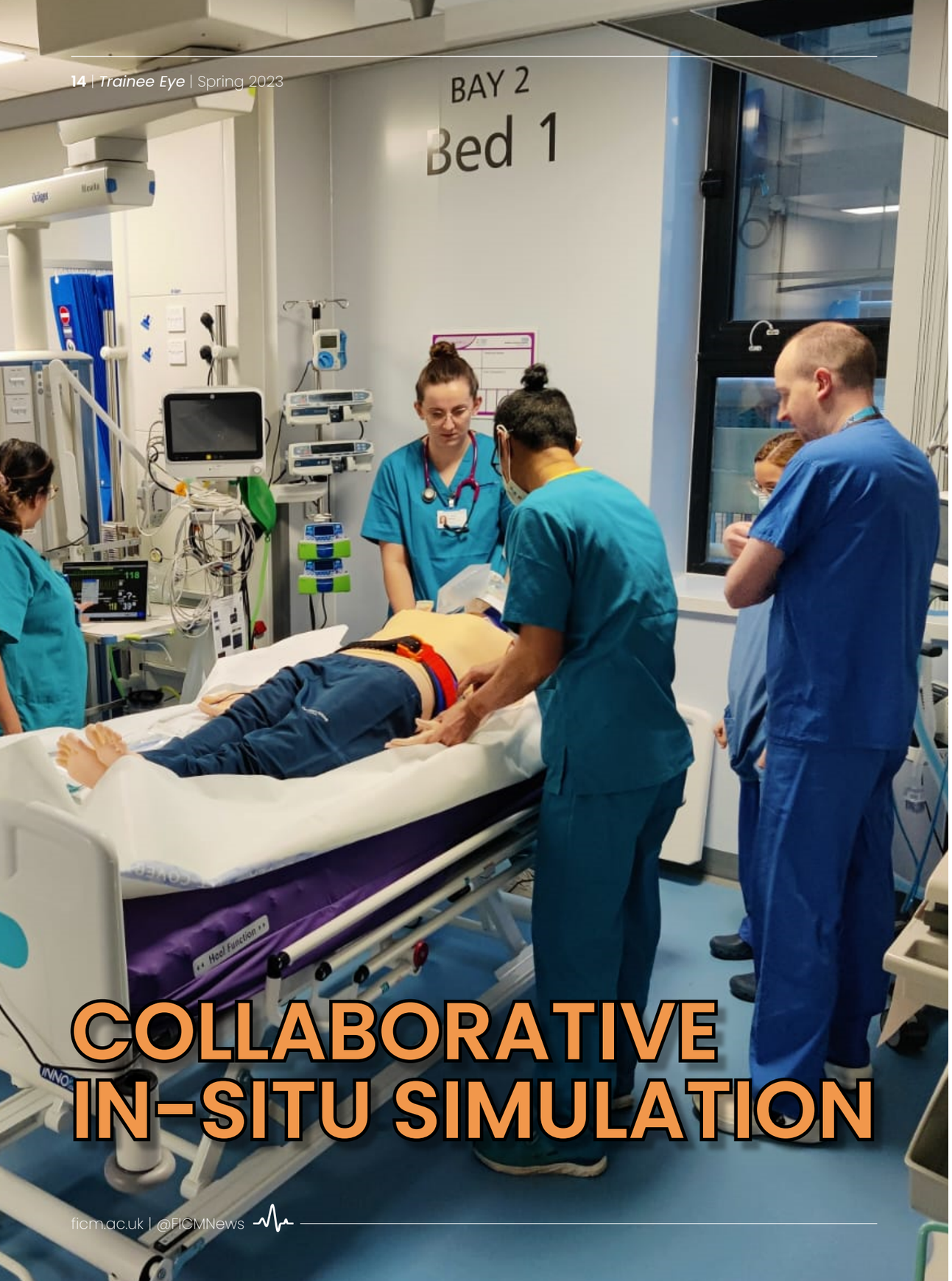
Look out for details on our website and Twitter @FICMNews

www.ficm.ac.uk/events

FFICM EXAMINATION CALENDAR

FFICM FINAL MCQ	
Exam applications open	25 September 2023
Exam applications close	23 November 2023
EXAM DATE	10 January 2024
Fee	£560
Results	31 January 2023

FFICM FINAL OCSE/SOE	
Exam applications open	26 June 2023
Exam applications close	7 August 2023
EXAM DATE	2-5 October 2023
Fee	Both £695 OSCE £385 SOE £350
Results	31 October 2023



COLLABORATIVE IN-SITU SIMULATION

Dr Alex Small
ST6 Anaesthetic & ICM Trainee
Bradford Royal Infirmary

Dr Mishti Oberoi
ST6 Emergency Medicine & ICM Trainee
Bradford Royal Infirmary

Simulation training has been proven to be a powerful educational tool, which can be employed across many acute specialties to enhance learning and experience in rare, critical or challenging clinical scenarios.

In-situ simulation can be described as simulation training occurring within the clinical environment where such scenarios may occur. This particular form of simulation has the additional benefit of increasing fidelity, highlighting limitations within the relevant working environment and improving knowledge of the department for rotational trainees.

Set-Up

At Bradford Teaching Hospitals Foundation Trust (BTHFT) we have set up a collaborative simulation programme between Emergency Medicine, Intensive Care and Anaesthesia to target high risk scenarios. The aim is to improve understanding of the department, challenge trainees with less common, but high stakes, cases and improve multidisciplinary working. As dual trainees combining Intensive Care Medicine, Anaesthesia and Emergency Medicine, we are ideally positioned to have embarked on this project.

Prior to starting, we ensured full buy-in from the relevant College and Faculty Tutors across all three specialties, as well as senior consultants and nursing colleagues in the Emergency Department. We are also fortunate enough to have a high fidelity mannikin. This programme decided on pre-planned simulation due to the multidisciplinary nature of the involvement, and to minimise any interruption in clinical work on the day.

Simulation

As a large and busy department, with a challenging demographic, Bradford ED is no stranger to critical presentations. Whilst it is not a Major Trauma Centre (MTC), life threatening trauma can, and does, present and as such the involved specialties are required to draw on all their skills and knowledge to manage these cases without the support of a full MTC set-up. Our first simulation was based on a life threatening polytrauma and subsequent sessions are planned to tackle neurosurgical emergencies and major burns. In addition, we plan to extend the scope of the teams involved to include paediatrics and maternity.

Candidate Learning Points

Structured feedback was delivered to all candidates in an open environment following the design outlined by the Simulation Debriefing Guide from The Alfred, Melbourne. Crucial learning points covered both specifics related to the clinical scenario and more transferable skills:

Communication

Detailed and specific inter-specialty communication between the anaesthetic/ICM and ED team enhances safety and helps guard against blinkered, task-focussed behaviours, especially during crucial moments such as airway management.

Major Haemorrhage

Specifics of managing a major haemorrhage in trauma were

covered in detail. This included the major haemorrhage protocol and the varying logistics of this in different hospitals; use of calcium, availability and logistics of rapid transfusers, and attention to detail for basic interventions such as positioning of pelvic binder.

Timing of transfers

Both intrahospital transfer, for cross sectional imaging, as well as interhospital transfer to major trauma centre, require careful assessment of risk benefit. The ultimate decision on timing must be made by the clinician in charge of the given transfer.

Perspective

A consistent theme emerged, whereby different teams view certain, often critical, interventions from alternative perspectives. Understanding these has allowed all team members to have greater insight into their colleague's outlook, which will lead to greater efficiency, safety and awareness in future collaborative work.

Faculty learning points

Creating a multidisciplinary, multispecialty simulation programme within an already stretched service comes with challenges; ensuring staff availability and access to in-situ spaces being obvious ones. However, we are convinced that within this context, high quality training opportunities are more important than ever. We are fortunate to have enthusiastic and unwavering support from key senior stakeholders which ensured this programme was delivered. Crucial learning points from running the programme

Adaptability

While the plan for this programme is in-situ simulation, the current state of emergency care across the NHS means that this is not always realistic. Consequently, ensuring a reliable, non-clinical back-up location ensures education delivery. Whilst this relocation results in a loss in fidelity, it does allow for greater privacy and focus.

Technical Challenges

No matter what level of organisation is undertaken, the unpredictability of technology cannot be fully mitigated against. Despite these challenges, the quality of the simulation can be maintained if preparation by the faculty is thorough. There was no doubt the candidates felt the pressure of the critical clinical scenario despite any reduction in realism.

Debrief

A structured and well-run debrief is, without doubt, the most valued part of simulation training. It must not be rushed, and all present must feel empowered to contribute. A valuable tool within debrief is the use of timings, to allow candidates to understand the often vast difference between their perception of time periods, and the reality. We have identified that whatever the location used for simulation; we must ensure access to a spacious and private area for debrief.

Leadership

Designing, organising and leading the programme has taught us invaluable lessons in educational organisation. Specifically, leading the debrief, as senior trainees to our peers, is a useful and challenging exercise. The involvement of consultant faculty who gave support to both our feedback to trainees, as well feedback to us on our leadership and education skills, proved invaluable for our development.

The future

As well as expanding the scope of the scenarios and specialties involved, the next key step in this programme is ensuring longevity. This relies on departmental buy-in. Both educational leads, and trainees, must see the immense value in multi-disciplinary simulation. With the crucial understanding that we all view situations through a different lens and, therefore, there is great value in learning from each other. The collaborative culture with enthusiastic trainees, and the feedback we received for the simulation programme so far, is a step in this direction.


The Faculty of Intensive Care Medicine

Safety Incidents in Critical Care

April 2023 | Issue 7

Introduction

Through a data sharing agreement, the Faculty of Intensive Care Medicine (FICM) can access a record of incidents reported to the National Reporting and Learning System (NRLS). The NRLS is a confidential database of patient safety incidents reported via healthcare organisations and individuals. It is important to remember that the incidents included are only those reported to the NRLS, rather than all that occurred. The other key feature is that the available information is limited, and from a single source; all that we know about these incidents is what is presented in this report.

The purpose of the Safety Bulletin is to highlight incidents that are rare or important, and those where the risk is perhaps something we just accept in our usual practice. It is hoped that the reader will approach these incidents by asking whether they could occur in their own practice or on their unit. If so, is there anything that can be done to reduce the risk?

Case 1 | A message lost in the pursuit of perfection?

A patient with severe sepsis was reviewed mid-morning on the ICU ward round. The consultant instructed the patient to receive antibiotic A, but to also discuss with a microbiologist. The antibiotic was not prescribed. Approximately an hour later, the microbiologist advised antibiotic B, but this was also not prescribed. During the evening ward round, an ICM consultant asked for antibiotic A to be given. This was prescribed with the first dose to be given four hours later. Before that time, the patient suffered a cardiac arrest and died.

Comment

Whether the patient received antibiotic A or B the outcome may have been the same, however somewhere in the complex communication that was occurring that day, the central message that the patient needed antibiotics was lost.

Case 2 | A faulty line?

A patient suffered a cardiac arrest soon after the central line lumen containing noradrenaline became occluded. This was identified immediately because of the audible alarm on the syringe driver. The incident report comments that there had been previous episodes of line occlusion with this type of central line.

Comment

In England and Wales, if you believe a medical device has caused, or almost caused, an injury to a patient or other person you should report this via the yellow card system to the Medicines and Healthcare products Regulatory Agency (MHRA). In Northern Ireland it should be reported to the Northern Ireland Adverse Incident Centre (NIAIC), and in Scotland to the Health Facilities Scotland online incident reporting system. The device should be retained if possible.

Case 3 | Communication and transfer of care

A patient was transferred at approximately 2200 from the ICU to a ward. The incident form states that no medical handover had taken place and that the receiving team were unaware of the stepdown. In the early hours of the morning the patient suffered a cardiac arrest and died.

Comment

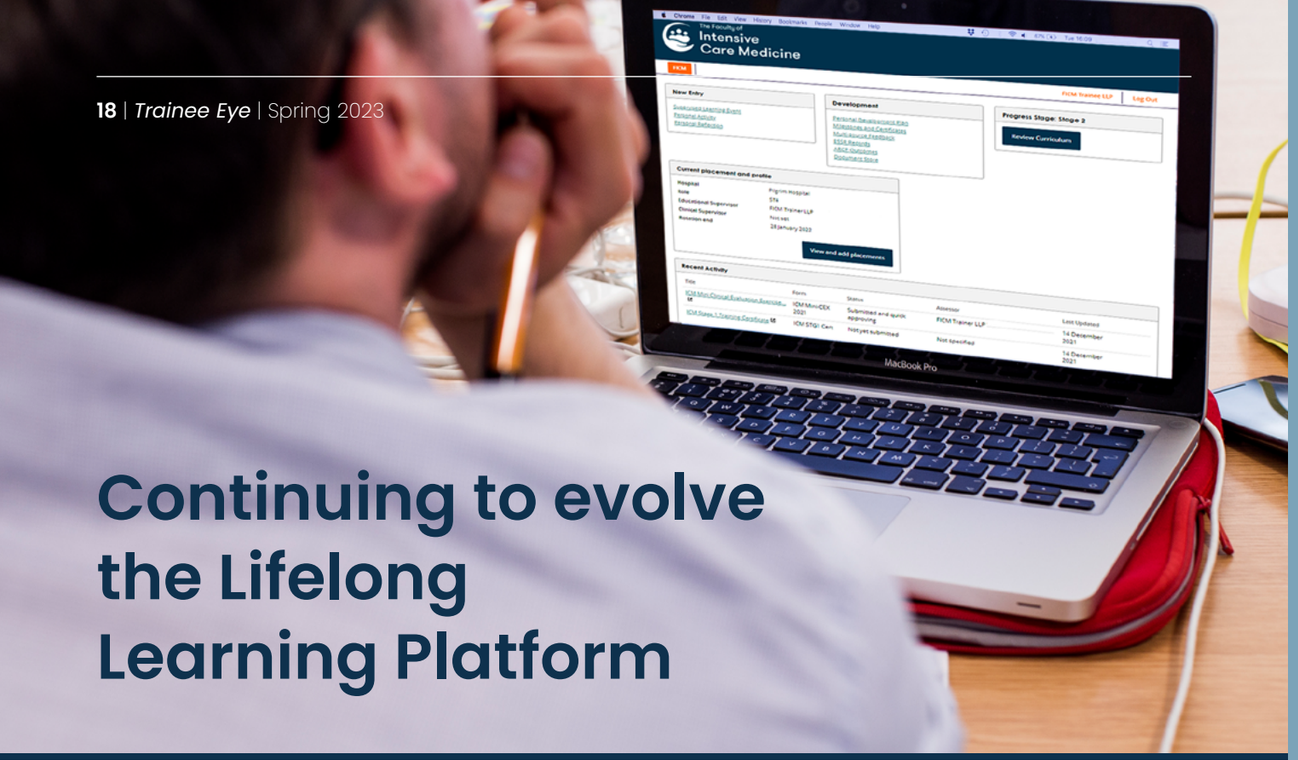
The National Institute for Health and Care Excellence (NICE) state that "Adults admitted with a medical emergency have a structured patient handover during transitions of care," and GPICS V2.1 contains the following standard: *"There must be a standardised handover procedure for medical, nursing and AHP staff for patients discharged from critical care units with a formalised transfer process. This must include their structured rehabilitation prescription."* How can we ensure that when busy and under pressure a handover is never forgotten?

Safety Incidents in Critical Care | April 2023 | 1

NEW SAFETY BULLETIN OUT NOW!

The seventh issue of the Safety Incidents in Critical Care Bulletin is now available, and you might notice a few changes to the look and content. We've condensed the information, and instead of summarising all of the reports, we have highlighted incidents that are rare or important, and those where the risk is perhaps accepted as part of usual practice. We hope that by raising awareness, we can help staff consider their own practice and prevent future occurrences.

www.ficm.ac.uk/safety/safety-bulletin



Continuing to evolve the Lifelong Learning Platform

Steven Cutler
RCoA Assessment & Quality Data Manager

The Lifelong Learning Platform (LLP) was initially launched by the Royal College of Anaesthetists in August 2018, with the FICM curriculum and assessment also moving over to the platform in 2021. It has undergone an unprecedented amount of change. As well as adding the Anaesthetic and ICM curricula, the LLP also incorporates ACCS, supports CPD Learners for Revalidation and FICM users, and automatically updates member details via our Customer Relationship Management (CRM) system.

The platform continues to receive extremely high levels of use, supporting the career lifecycle of more than 24,000 Fellows and Members in the UK across the RCoA and FICM. Currently more than 21,000 of these have used the LLP for assessments and documenting their training in general. In a typical month there will be more than 400,000 LLP user interactions, including 100,000 Logbook entries and the addition of 45,000 Workplace Based Assessments or Supervised Learning Events.

Listening to trainees

The platform is continuing to evolve, but the LLP support team needs your feedback on usability and your suggestions for improvements to maintain a product that is fit for purpose. A recent user-survey has helped us identify some underlying issues, and highlighted where some functionality needs changing.

The survey also helped us identify what our users like about the platform, and the highest scoring themes are listed below:

- a fully integrated platform that includes Logbook functionality (not currently available for ICM users)
- the user interface and general layout
- the approvals process and most workflows
- the way the platform can be fully customised
- works well across most device types (mobile phones).

The current Logbook, which is only available on the anaesthetic side of the platform, was one area that was identified as lacking in some regards, and we have been working with trainee representatives, and other stakeholders, to agree what will be included in the new version. The possibility of creating an ICM specific or ANEAS/ICM integrated logbook is currently under review. We will be running additional user-surveys to obtain your feedback after delivering any significant changes to the platform.

Dealing with your enquiries

The LLP support team receives and responds to many enquiries every day (more than 18,000 during 2022). Your emails to lifelong@rcoa.ac.uk and llp@ficm.ac.uk automatically open tickets within our Helpdesk system, which our small but dedicated team then categorise, prioritise, and proceed to work on. In most cases issues can be directly and quickly resolved by the team, but any system bugs identified must be logged with our external developers for investigation and resolution. This can lead to longer delays in a few cases, but we work closely with the developers to ensure that our tickets are prioritised correctly, focusing on security, stability, and the number of users affected by any bug reported.

Increased support budget and new projects

Towards the end of last year, the RCoA agreed to significantly increase the budget allocated to the LLP. This has already allowed us to reduce the backlog of tickets we have with our external developers and to start planning several special projects and initiatives.

We have provided a list of some of these projects below and have already successfully delivered a major security and stability update (Laravel) to the platform's web-hosting system. This update had to be implemented before any other significant projects or general improvements could start, so we are very happy to report that this was delivered within budget and without any issues at the end of January.

The London deaneries were also recently merged in a project fully funded by Health Education England. This has proven to be a significant improvement for users within the deanery, particularly those involved in organising ARCPs.

Other key proposed improvement projects are listed below, most of which are related to the security, stability, reliability, maintenance, and ease of delivering future developments:

- improved user-data storage, retrieval, and archiving
- stronger authentication
- automated regression-testing
- improved business-logic
- end-user documentation and online help.
- Recent improvements and changes

We post a list of recent changes to the platform on this web page, and recommend that users visit this regularly to check if something has been improved or an issue has been resolved.

LLP Regional Leads

We would like to thank everyone who recently volunteered for this important role. We are still in the process of adding the contact details for some regional leads, and will continue to update the list found on this web page.

Your regional lead has the following responsibilities, and may be able to help you with any questions or issues have when using the LLP:

- act as initial point of contact within your region for enquiries from ACCS, Anaesthetics, and ICM users. Where appropriate the role(s) may be jointly shared to provide guidance for various types of users
- provide 'hands-on' guidance and support as appropriate to users of the LLP within their region
- work with the LLP Team to report on and review common queries and improvement requests from users within their region
- join periodic 'virtual' update meetings with the LLP Team, and to report back to their region on the key messages and communications from these.

Get in touch

If you have any comments or require assistance with the FICM Lifelong Learning platform, please visit https://www.ficm.ac.uk/trainingexamslifelonglearning/llp-guidance-material or contact LLP@ficm.ac.uk.

Mass Patient Transfer

Dr Dan Sumner
ST6 Anaesthetic and ICM Trainee

Dr Mark Snazelle
Consultant in Anaesthetics and ICM

There are not many anaesthetists who enjoy patient transfers due to the planning, being outside a place of comfort and unexpected complications. Although many will have been involved in them, not many will have been involved in the mass transfer of patients from one intensive care unit to another across the same day or be privy to the amount of planning that goes into it, especially with the backdrop of the COVID-19 pandemic.

Planning

Before moving 16 patients on the same day, an initial meeting with various stakeholders involved in the transition including medical, nursing and management was held to outline the structure of the move, staffing and to highlight some 'on the day rules.' These included: no elective surgery requiring critical care on the day, no dual intensivists to be on anaesthetic lists, creation of a dedicated transfer team and a receiving team separate from usual clinical duties, all patients to receive 1:1 nursing care and no 'wardable' patients to transfer to the new unit. Other important points included 'no go' rules which would result in the cancellation of the move: Too high patient acuity, major incident declaration or unsafe staffing.

Staffing

Detailed staffing plans were outlined several weeks ahead to allow plenty of time to book additional staff, as well as facilitate extra auxiliary support from portering and cleaning staff to help with the post-move clean up.

Teams

The medical staff were divided into five distinct teams: a 'business as usual' team responsible for the overall care of existing patients, three transfer teams with an airway trained clinician, and a receiving team based solely on the new unit for safe reception and stabilisation. The lead clinician for critical care was responsible for co-ordinating and communicating with all clinical teams and was based in a hub in the existing critical care unit. Although all communication was planned to be through 'walkie-talkie,' equipment failure on the day meant reverting to a backup plan of using whatsapp instant messaging over a pre-existing group.

Dummy run

We ran a simulated patient transfer 'dummy run' to ascertain which kit should be available during the move and to identify any missing equipment. A lst planning meeting was held the day before rior t to identify wardable, end of life patients and to finalise a move order.

Moving day

On moving day, the transfer teams assembled at 7:30am prior to the daily team handover to run through the plan and familiarise themselves with a tour of the new unit. The first patients were seen by the day unit team and 'packaged' ready for transfer. The first patient moved approximately an hour later following an equipment and stock check on the new unit.

Each patient was transferred sequentially on their original bed and moved onto a new unit bed when they arrived on the new unit. One patient required a CT scan during the day; this was factored in and the assigned transfer team took the patient for the required scan before they arrived on the new unit.

The entire process took approximately six hours in total and was completed without any adverse clinical events. After the move there was a full debrief with all move team members present to highlight any issues that arose through the day.

The day was a success, primarily due to meticulous planning in the weeks prior to the move. If you are considering a large scale critical care move or mass patient transfer following the aforementioned steps may help in the smooth transition and safe move.

FICM Learning

Visit the FICMLearning website for some fantastic podcasts, blog posts and cases of the month. Our most recent content includes:

- Podcast: Transfer of the Critical Care Patient
- Simulation Scenario: COVID ARDS Proning
- WICM Blog: Leading with Diversity – From Unicorns to Zebras and eventually Black Beauty
- Case of the Month #38 Spinal Cord Injury
- Blog: Simulation in the Intensive Care Unit
- Simulation Scenario: Overdose – Calcium Channel Blocker
- Podcast: Point of Care UltraSound training on the ICU

www.ficm.ac.uk/ficmlearning

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The latest **Critical Eye** is now available on the FICM website. Click here to read the full issue.

If you would like to contribute to future issues, please get in touch at contact@ficm.ac.uk.

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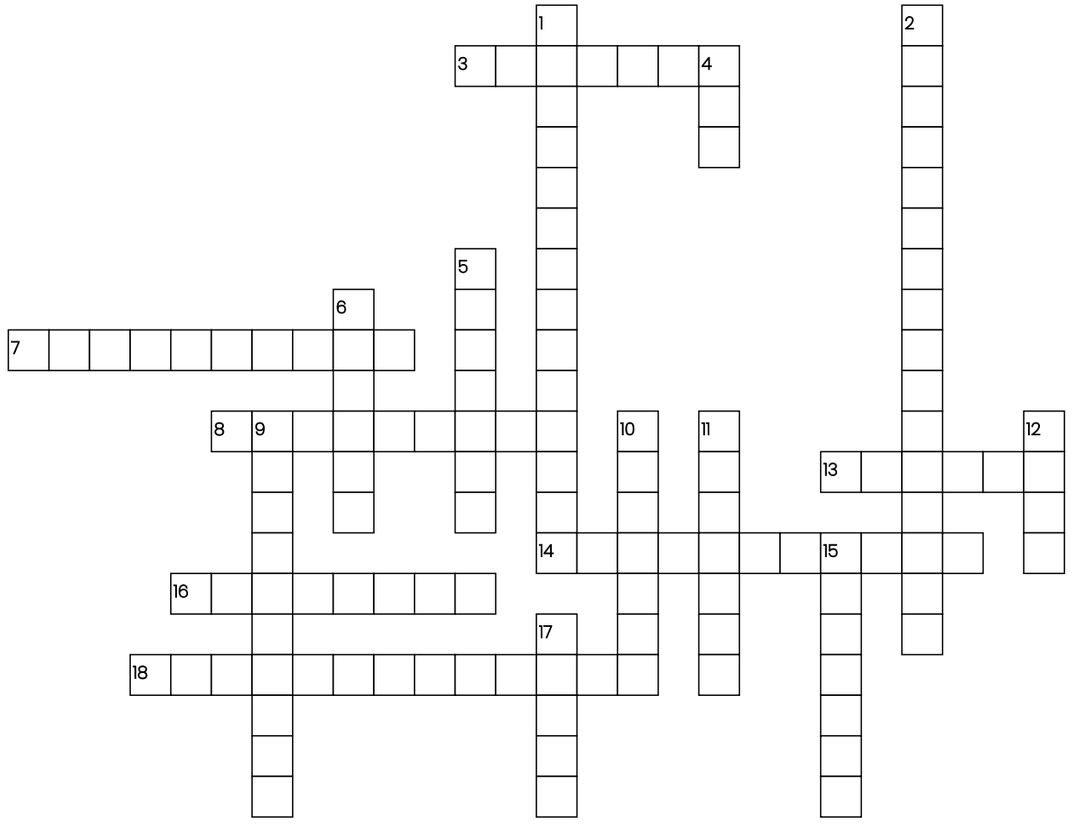
ACCU Burns Crossword



Across

3. Toxic exposure which can occur with burning upholstery, leading to shock with a raised lactate

7. What procedure is indicated by a burned moustache, soot in the nares and a hoarse voice?

8. Based on the rule of nines, what is the burned surface area in a man with burns across the front and back of his chest?

13. Metal ion which is used in burns dressings for antimicrobial properties

14. Surgical procedure performed in circumferential burns

16. Formula used for calculating fluid replacement in burns (3ml/kg/% burned surface area)

18. Induction agent to avoid due to risk of hyperkalaemia in burns

Down

1. O2 saturations are over-read in what form of toxicity associated with burns?

2. Chelating agent administered in a 5g dose to severe burns patients which leads to chromaturia

4. Mandatory investigation in all electrical burns

5. Zones of injury in burns (coagulation, stasis, hyperaemia)

6. Degree of burn which extends into muscle tissue and bone

9. Oxygen therapy which can be considered in patients with CO toxicity

10. Serum electrolyte which can become dangerously low in Hydrofluoric Acid burns

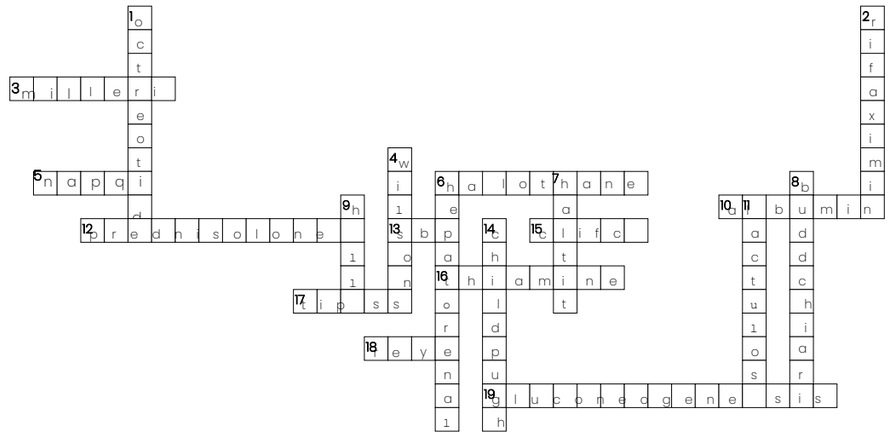
11. Inhalational burn fibrin cast formation can be reduced by nebulised Acetylcysteine and...

12. Smoke inhalation can lead to what syndrome, defined by the Berlin criteria?

15. Vaccination which should be given in all serious burns cases

17. When fluid resuscitation has been calculated in a burns patient, the first half is given over how many hours?

ACCU Hepatology Crossword: Answers



Across

3. Type of Streptococcus most likely to cause a pyogenic liver abscess

5. In a paracetamol overdose, glutathione depletion leads to a build up of which toxic metabolite?

6. Anaesthetic agent known to cause hepatitis with repeated dosing

10. IV Colloid administered to reduce the risk of hepatorenal syndrome following paracentesis

12. Treatment indicated in alcoholic or autoimmune hepatitis

13. Diagnosis is made by the presence of > 250 neutrophils per mm3 of fluid

15. Scoring system used to gauge mortality in acute on chronic liver failure, with a superior predictive value to other scoring systems

16. Vitamin supplementation that should be given to all alcoholic liver disease patients

17. IR treatment for portal hypertension which can worsen hepatic encephalopathy

18. Syndrome of paediatric liver failure and neurological disease, associated with aspirin use

19. Impairment of this hepatic process can lead to hypoglycaemia

Down

1. Somatostatin analogue used in variceal bleeds, which reduces portal venous pressure and gastric acid secretion

2. Drug used in hepatic encephalopathy dosed at 550mg BD

4. Disease of liver failure associated with Kayser-Fleischer rings

6. Syndrome characterised by release hepatic circulation vasodilators, and excessive vasoconstriction secondary to the RAAS

7. Trial which demonstrated that TXA was not found to be beneficial in GI bleeding

8. Syndrome causing acute liver failure secondary to hepatic vein thrombosis

9. Liver dysfunction associated with Pre-eclampsia

11. Hepatic encephalopathy treatment, promoting growth of non-ammonia producing bacteria and lowering colonic pH

14. Scoring system A to C used to gauge prognosis in chronic liver failure patients

The Faculty of Intensive Care Medicine

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