



Joint Faculty of Intensive Care Medicine of Ireland

College of Anaesthesiologists of Ireland • Intensive Care Society of Ireland
Royal College of Physicians of Ireland • Royal College of Surgeons in Ireland

Higher Specialist Training in Intensive Care Medicine

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Introduction

Intensive Care Medicine (ICM) training is structured in Ireland as a 'supra-specialty', competency based, training programme. Supra-specialty training comprises training which is undertaken in addition to the achievement of full accredited training in a post-graduate medical 'base-specialty'. Currently, these base specialties are Anaesthesia, Internal and Emergency Medicine and Surgery. As a supra-specialty programme, knowledge, skill and competency from the base specialty of the trainee is enhanced and focussed with 2 years supra-specialty intensive care training. The overall training programme is that of a higher specialist training programme.

At the successful completion of higher specialist training in ICM, a doctor will have acquired the additional knowledge and competencies to allow consultant practice in ICM – in addition to the competencies (already attained) in his / her base-specialty. Such a doctor will have achieved a standardised set of ICM competencies, compatible with European Board of Intensive Care Medicine-approved Competency Based Training Programme in Intensive Care Medicine for Europe (CoBaTrICE).

Mission Statement of JFICMI

"To promote excellence in the practice of Intensive care medicine through a continuum of education, training, accreditation of specialists and research to meet the needs of the critically ill patients in Ireland."

Entry Requirements

As per the introduction, specialty training in intensive care medicine comprises base specialties (Anaesthesia, Internal and Emergency Medicine and Surgery) and 2 years supraspecialty intensive care training.

Base specialty training is commonly 6 years. One year of JFICMI-supervised intensive care training is allowed within the base specialty programme, either as a year out-of-programme or a special interest year. A second year is undertaken post base specialty CSCST. Hence the total duration of training is between 6 and 7 years for many trainees. The corresponding pathways to ICM training are outlined below in accordance with the particular specialty background of the prospective Intensive Care Medicine post-graduate trainee doctor.

Application Process

Trainees are appointed to supervised training posts through a central applications process under the auspices of the JFICMI. Currently there is an annual intake of trainees, with variable training numbers contingent on the numbers of applicants for special interest year posts and those eligible for post-CST appointment. The numbers of each is approximately 8 at special interest year and 4 at post CSCST year in 2017.

Application process is advertised in October, interviews in November / December, and appointments generally commence in July of the following year.

All training posts are in intensive care units accredited via the JFICMI visitation process (see website for accredited hospital list, (www.jficmi.anaesthesia.ie)).

Training Pathways

a) Current Training pathways and regulations

Year 1 of specialty ICM training is characterised by the acquisition of the competencies specified within the curriculum, technical and procedural expertise (see Logbook / Procedures) and success at a summative Fellowship exam (Written, Clinical plus Viva) which is undertaken (FJFICMI) at the end of year 1. Intensive Care training at Year 1 may be achieved as a special interest year (SIY) in ICM, as per the established CAI training programme. Completion of Year 1 shall be in the senior years of advanced training for all base specialties (i.e. SAT 5/6 for anaesthesia trainees and equivalent for other base specialties). Where this year of intensive care training is not completed within the anaesthesia or other training programme, the trainee will need to complete 2 years of ICM training post base specialty CSCST.

During year 2 of specialty training, there is no further exam in ICM but publications / project or other accreditation (for example in critical care echocardiography) is required - as is suitable to a pre-consultant year of training. Competencies to be attained are as outlined in the JFICMI Curriculum document, with a particular focus on professionalism, and clinical leadership.

Up to 6 months of ICM training may be completed in a Pediatric Intensive Care training post.

By the end of training, year 2 trainees will have completed 24 months of dedicated ICM training to include:

- Completion of all the 12 domains of ICM competency
- Basic Critical Care echocardiography competence
- Attendance at a BASIC course
- Attendance at an IDAP (Donor Awareness Programme) course
- Completion of a prospectively approved audit or research project with associated presentations and publication(s)
- Specific advanced training in critical care echocardiography or extra-corporeal life support (ECLS) training and accreditation or an alternative pathway to research (duration of training would preclude satisfactory completion of both research and specific advanced training modules).

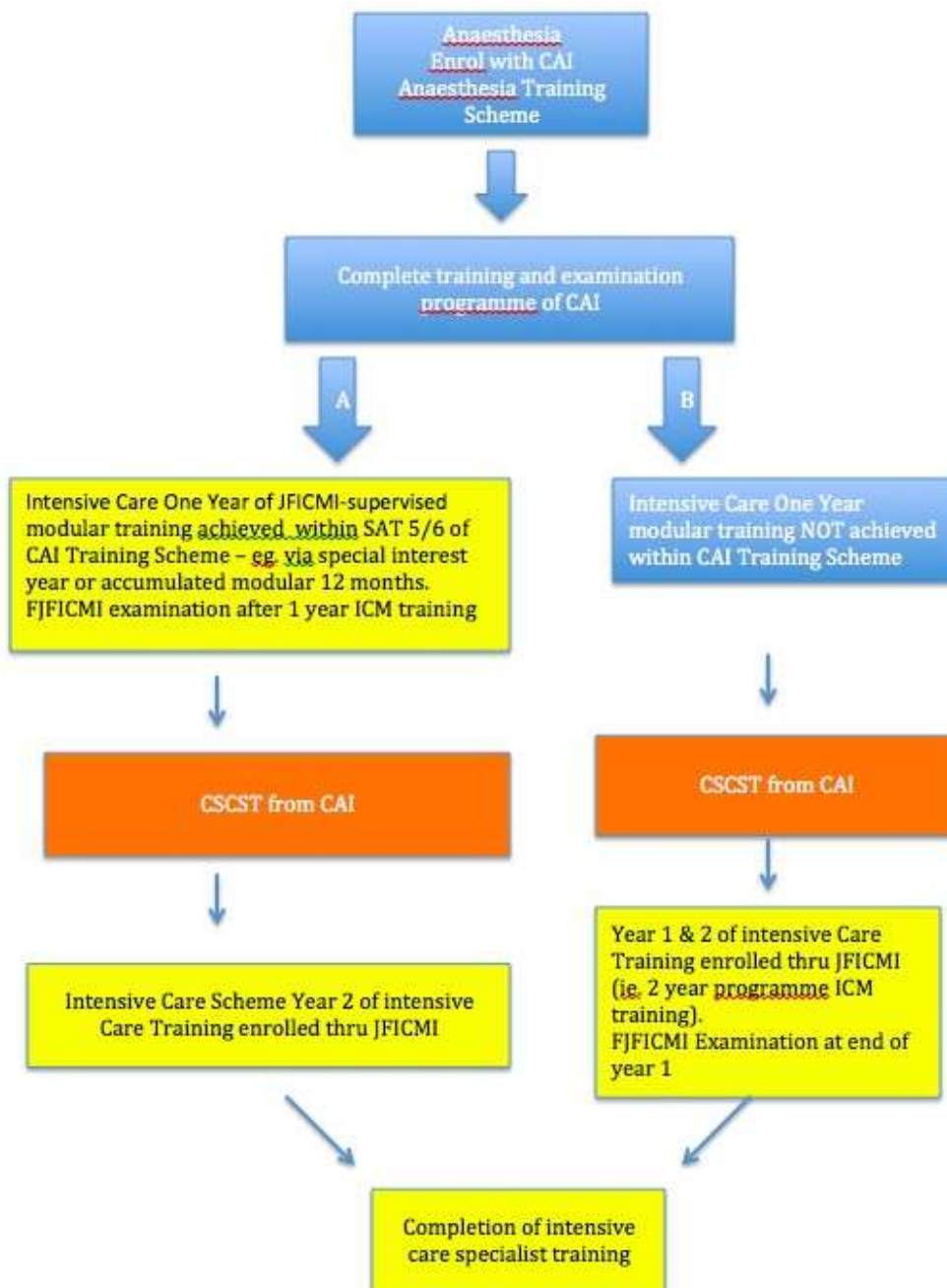
b) Current Training Outcomes and Career Structure:

The successful completion of one year of ICM training (as above), which includes success at the FJFICMI exam, allows eligibility (in Ireland) for a 'consultant with a special interest in ICM' position provided also that CSCST in base specialty is achieved. This career option is only utilised / available in Anaesthesia at present.

The successful completion of a pre-approved second 'supra-specialist' year of ICM training (see guidance above) will allow accreditation as a completed trainee in ICM. Such status will allow eligibility for specialist registration in ICM with the Medical Council of Ireland and eligibility to apply for a Consultant in Intensive Care Medicine position.

Overview of Training Pathways

I. ICM Trainees with Anaesthesia as base-specialty:



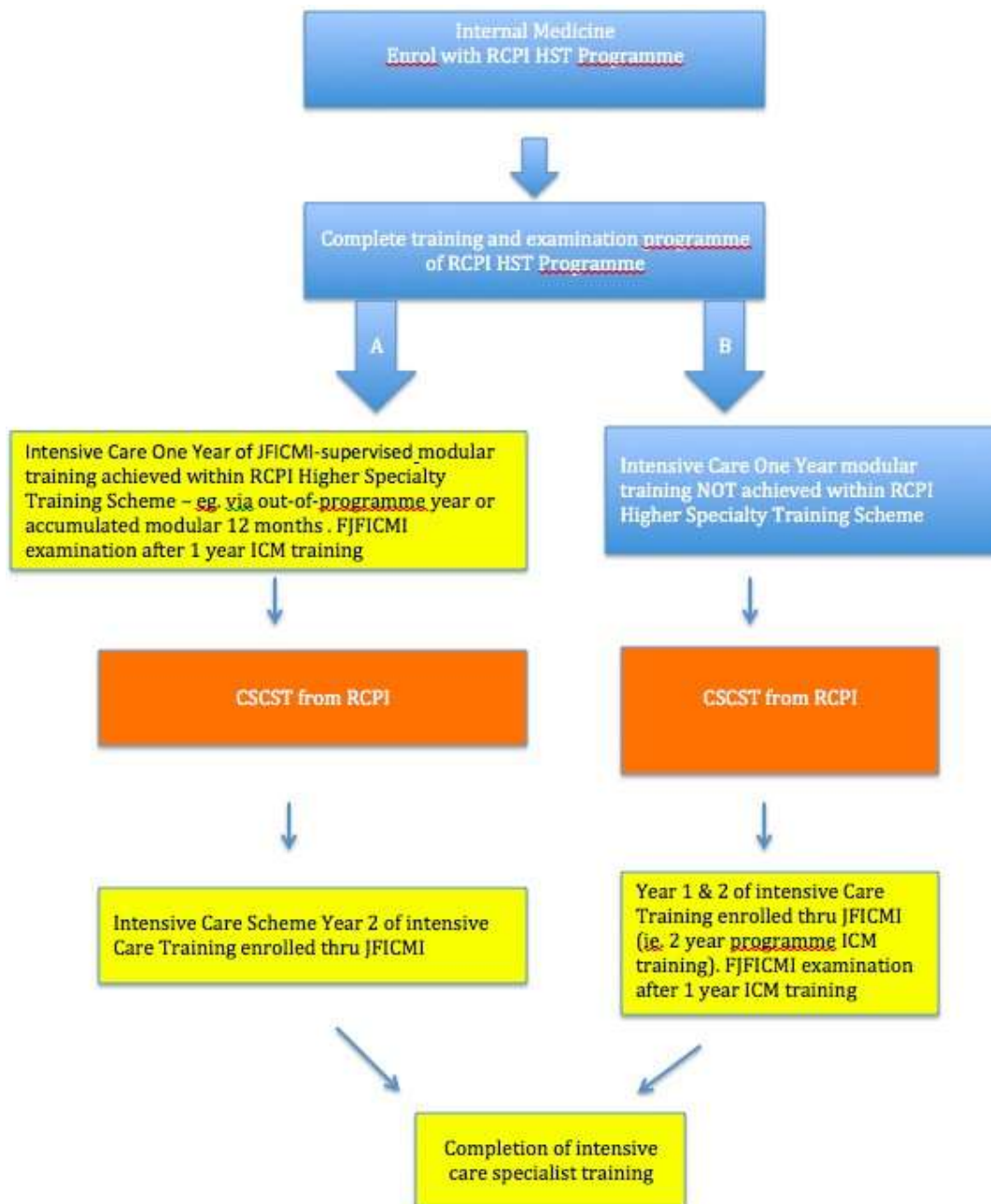
A JFICMI-accredited ICU and Hospital training position will provide the trainee with exposure to a broad range of medical disciplines within a suitable teaching environment while undergoing ICM training. Their programme of continuing medical education must include a wide range of general medicine topics and access to the Medicine specialty PCS / CME programme as applies to Internal Medicine training in

the Hospital. Specific access to certain skills and training opportunities (e.g. bronchoscopy, echocardiography, laboratory microbiology) may also be incorporated as relevant.

Duration of Training:

The duration of training for an anaesthesia trainee who wishes to complete specialty accreditation in intensive care medicine shall be 7 years for those who follow pathway (A) in the above organogram. For those who follow pathway (B) in the above organogram the duration of training shall be 8 years.

II. ICM Trainees with Internal Medicine as base-specialty:



Internal Medicine trainees:

An accredited centre for ICM training must include one day per week (or equivalent) of dedicated anaesthesia training. The trainee, over the course of year 1 of ICM training must achieve 100 intubations (2 per week approx.). Of these 100 intubations, at least 20 must be undertaken in emergency circumstances (emergency anaesthesia, emergency department, cardio-pulmonary resuscitation, intensive care patients). Competence with general airway management is required and attendance at a Difficult Airway course is mandatory.

Duration of Training / Internal Medicine:

The duration of training for an internal medicine trainee who wishes to complete specialty accreditation in intensive care medicine shall be governed by the duration of training of the choice of Higher Specialty Training scheme with the RCPI, with the added supra-specialty intensive care medicine training duration.

There is some variability in HST durations.

Example 1. Respiratory Medicine:

This is a 5 year HST programme within which is allowed one out-of-programme year. This out-of-programme year has been allowed to date to be a year in intensive care medicine. Hence via pathway (A) in the above organogram, the trainee would have a duration of training of 2 years at BST, 5 years HST including one year ICM, then a final year of ICM, giving a total of 8 years training.

For those who follow pathway (B) in the above organogram the duration of training shall be 9 years.

Example 2. Infectious Diseases:

Eight or nine years same as above

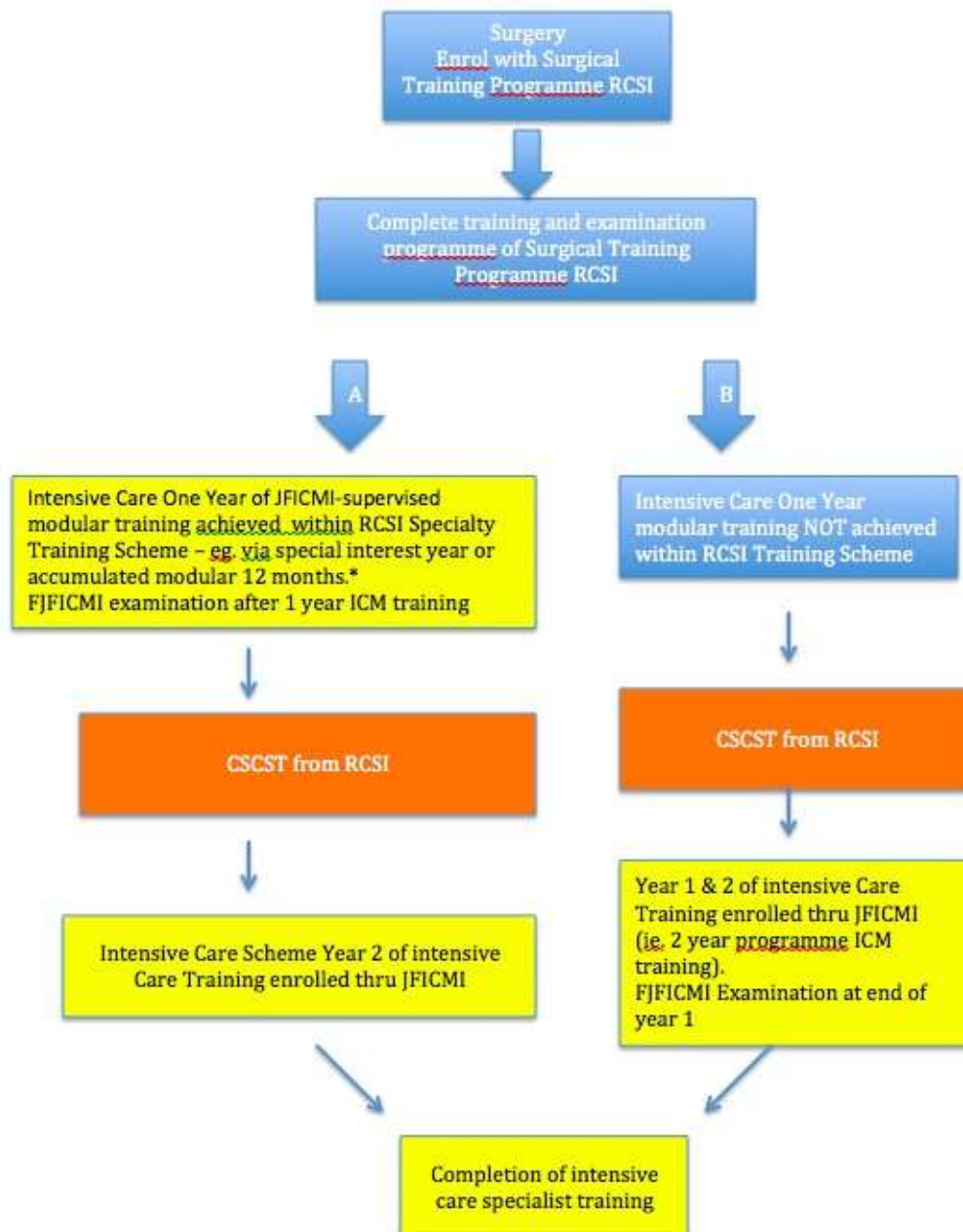
Example 3. Medical Oncology:

This is a 4-year programme within which is allowed one out-of-programme year.

Pathway (A) therefore is 7 years.

Pathway (B) therefore is 8 years.

iii. ICM Trainees with Surgery or Emergency Medicine as base-specialty:



An accredited centre for ICM training must include one day per week (or equivalent) of dedicated anaesthesia training. The trainee, over the course of year 1 of ICM training must achieve 100 intubations (2 per week approx.). Of these 100 intubations, at least 20 must be undertaken in emergency circumstances (emergency anaesthesia, emergency department, cardio-pulmonary resuscitation, intensive care patients). Competence with general airway management is required and attendance at a Difficult Airway course is mandatory.

A JFICMI accredited ICU and Hospital training position will provide the trainee with exposure to a broad range of medical disciplines within a suitable teaching environment while undergoing ICM training. Their programme of continuing medical education must include a wide range of general medicine topics and access to the Medicine specialty PCS / CME programme as applies to Internal Medicine training in the Hospital. Specific access to certain skills and training opportunities (e.g. bronchoscopy, echocardiography, laboratory microbiology) may also be incorporated as relevant.

Duration of Training / Surgery:

The National Surgical Training Programme is an 8-year programme.

* The RCSI Specialty Training Scheme currently is unable to provide a year out of programme or special interest year in intensive care medicine, and hence for surgical trainees wishing to follow a career in intensive care medicine the current pathway is (B), and therefore 10 years duration.

Emergency Medicine trainees:

Core specialist training in Emergency Medicine (CSTEM) includes a mandatory module of 6 months Anaesthesia / Intensive Care Medicine. For those progressing to intensive care training recognised by the JFICMI, the trainee, over the course of year 1 of ICM training must achieve 100 intubations (2 per week approx.). Of these 100 intubations, at least 20 must be undertaken in emergency circumstances (emergency anaesthesia, emergency department, cardio-pulmonary resuscitation, intensive care patients). Competence with general airway management is required and attendance at a Difficult Airway course is mandatory.

Duration of Training / Emergency Medicine:

The National Emergency Medicine Training Programme is a 7-year programme. Approval for Pathway (A) above would therefore allow the trainee to complete training in an 8-year period. Year 3 of Core Specialist Training in Emergency Medicine currently has a structure 6month period of Anaesthesia and/or Critical Care Medicine. On an individual basis to date a longer period of intensive care training has been recognized. This provision requires ongoing engagement with the Irish Committee for Emergency Medicine Training.

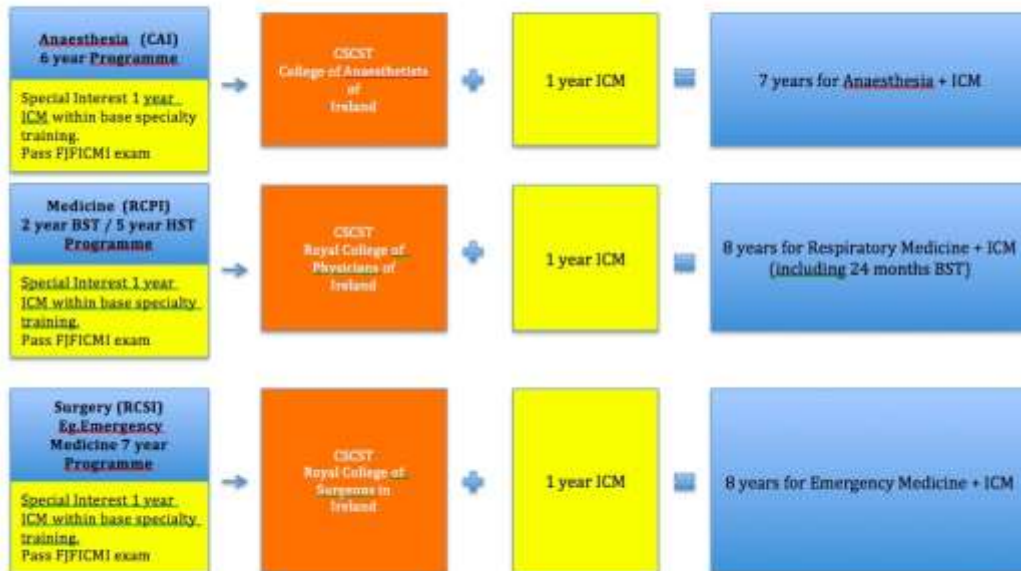
Pathway (B) would allow a duration of training over a 9-year period.

iv. ICM Monospecialty Training:

There is no approved programme for monospecialty training in intensive care medicine in Ireland.

Summary of Training Duration per Base Specialty

A) Training in ICM Commences within Base Specialty



B) Training in ICM Commences after Base Specialty completion of CCST:



Curriculum

CoBaTrICE is an international partnership of training organisations under the aegis of the European Society of Intensive Care Medicine. The programme has developed an internationally acceptable competency-based training programme by using consensus techniques (Delphi and Nominal Group) to develop minimum core competencies for specialists in intensive care medicine.

The competencies have been developed as the roles and skills of the intensivist develop and change over the years and are informed by advances in medical education. The CoBaTrICE curriculum is endorsed by the European Board of Intensive Care Medicine and the national training organisations of 28 European countries. A number of countries have adopted the CoBaTrICE curriculum directly, e.g. Netherlands. In others, e.g. UK Faculty of Intensive Care Medicine, the relevant competencies have been mapped to the CoBaTrICE competencies.

The JFICMI has adopted the CoBaTrICE curriculum, though similar to the FICM UK, has articulated the syllabus in such a manner to map the competencies to assessment methodology and to the Medical Council Domains of Good Professional Practice

The full curriculum for the JFICMI is available on the JFICMI website - <https://jficmi.anaesthesia.ie/>

The competency based training structure is designed to make available to trainees the required practical skills, clinical experience, and theoretical knowledge through clinically based education programmes and exam preparation.

The curriculum outlines the elements of knowledge, skills, and competencies mapped to the Medical Council 8 domains of Good Professional Practice.

Assessment

Progression through training is predicated on satisfactory participation and performance in the following assessments:

- Consultant feedback at interim (“in-term”) training assessment. This is a structured meeting between the trainee and their training supervisor to discuss the trainee’s performance to date as well as to update the trainee’s learning goals for the remainder of their ICM module. Feedback delivered to the trainee is derived from observation of their daily performance by the training supervisor and by other consultants within the clinical department. This process seeks feedback from the trainee and is signed off by both parties.
- Workplace-based assessments:
 - Direct observation of procedural skills (DOPS): a real-time observation of a trainee-patient interaction which involves a clinical procedure. This is followed by structured feedback from an ICM consultant observer.
 - Mini-clinical examination exercise (Mini-CEX): a real-time observation of a trainee-patient clinical interaction followed by structured feedback from an ICM consultant observer.
 - Case-based discussion (CbD): a retrospective discussion between the trainee and an ICM consultant about a clinical case managed by the trainee in the course of their daily practice.
 - Entrustable professional activities (EPAs): discrete tasks or competencies of high importance in intensive care medicine. Trainees are rated from 1-5 (increasing order of competence) based on their performance as assessed by DOPS, Mini-CEX or CbD.
- Review of eLogbook at www.jficmi.anaesthesia.ie website. This enables the training supervisor to view a trainee’s record of clinical time spent in the ICU, the case mix of patients managed during this time as well as the procedural skills undertaken during the module.
- Consultant feedback on involvement in departmental audit and journal club activities

- Clinical microbiology / infectious disease multidisciplinary ward rounds – all trainees participate and present cases at these rounds. These are a mandatory part of the JFICMI hospital accreditation as a training site and part of the assessment of knowledge as per the Curriculum
- ICU/Radiology multidisciplinary rounds – all trainees participate and present cases at these rounds. These are a mandatory part of the JFICMI hospital accreditation as a training site and part of the assessment of knowledge as per the Curriculum
- Trainee clinical and educational presentations and feedback.
- Trainee participation in ICU Multidisciplinary rounds with physiotherapy, occupational therapy, nutritional and speech therapy services.

Mandatory Courses:

A number of courses are deemed mandatory by the JFICMI, all of which include a completion assessment:

- BASIC Course (ICSI)
- Intensive Care Simulation Course: a mandatory course that assesses clinical reasoning as well as non-technical skills such as task management, team working, situation awareness and decision making
- Difficult airway workshop (College of Anaesthetists).
- Basic Critical Care Echocardiography training (JFICMI) and logbook: basic transthoracic echocardiography is now an essential skill for those practicing in the field of intensive care medicine and is a mandatory course for trainee completing year 2 of ICM training.
- Irish Donor Awareness Programme course (JFICMI): a mandatory course for the professionalism and skills related to organ donation

Desirable Courses

A number of courses are recommended as desirable by the JFICMI, all of which include a completion assessment. Some of these courses are delivered by the JFICMI, others as listed below.

- Critical Care Refresher course (JFICMI)
- ACLS
- ATLS
- Beyond BASIC: Mechanical Ventilation course (Intensive Care Society of Ireland)
- Beyond BASIC: Nephrology course (Intensive Care Society of Ireland) ○ JFICMI Examination short course (JFICMI) ○ APLS / PALS or equivalent ○ Transport Medicine course (HSE National Transport Medicine Programme) ○ National Patient Safety Conference attendance (College of Anaesthetists of Ireland) ○ Quality Improvement Changing Healthcare for the Better course (RCPI)

Summative assessment tools for ICM training are as follows:

- Consultant feedback at final (“end-of-term”) training assessment. This is a structured meeting between the trainee and their training supervisor and at least one other consultant colleague at the end of an ICM module. The purpose of this assessment is to review a trainee’s performance and thereby decide to either (a) recommend trainee progression to the next stage of their training or (b) to highlight any concerns about the trainee’s performance that might delay progression to the next stage of their training. The latter information is transmitted to the JFICMI Training Committee via an online link on the <https://jficmi.anaesthesia.ie/> website. This process seeks feedback from the trainee and is signed off by both parties.
- JFICMI Fellowship examination:
 - Short answer questions: 8 SAQs in written format
 - Multiple choice questions: 100 questions with single-best-answer questions (type A).
 - Bedside clinical examination: one-hour process comprising two long cases.
 - Data interpretation: a combination of laboratory and radiology intensive care tests presented in an electronic format

- Viva examination: cross-table discussion about a combination of clinical, non-clinical, administrative, professional and ethical topics relevant to intensive care medicine
- Review of eLogbook on www.jficmi.anaesthesia.ie website
- Confirmation of attendance at mandatory JFICMI educational courses
- Confirmation of satisfactory participation in ICM educational and research activities during training modules
- Evidence of completion of advanced training course (e.g. Transthoracic echocardiography)

Final “sign-off” process: A final interview between the trainee and members of JFICMI Training Committee to ensure that all training requirements have been satisfied. This is followed by a recommendation made to the JFICMI Board about whether the trainee has achieved satisfactory completion of ICM training or not.

The table below summarises the key components of training in intensive care medicine and the assessment methods used to ensure that a trainee has satisfied these components of training. They represent an abbreviated version of the 12 domains of training and assessment contained in the JFICMI Curriculum.

Key training component	Formative assessment method(s)	Summative assessment method(s)
Knowledge of critical illness	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • CbDs, Mini-CEX • Participation in clinical and educational presentations • Courses – mandatory and desirable 	<ul style="list-style-type: none"> • JFICMI examination – MCQs, SAQs and Vivas • eLogbook showing case mix of patients managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members • Attendance at mandatory courses

Diagnostic evaluation and investigation of patient with critical illness	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • CbDs, Mini-CEX, DOPS, EPAs • Participation in ICU clinical rounds (radiology, microbiology rounds) • Courses – mandatory and desirable 	<ul style="list-style-type: none"> • JFICMI examination – MCQs, SAQs, data interpretation, bedside examination, Vivas • eLogbook showing case mix of patients managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members
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Procedural skills	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • eLogbook showing procedures performed in clinical practice • DOPS, EPAs • Courses – mandatory and desirable 	<ul style="list-style-type: none"> • eLogbook showing case mix of patients managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members • Attendance at mandatory courses
Critical disease management (including perioperative care)	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • CbDs, Mini-CEX, DOPS, EPAs • Participation in clinical and educational presentations • Courses – mandatory and desirable 	<ul style="list-style-type: none"> • JFICMI examination – MCQs, SAQs, Vivas • eLogbook showing case mix of patients managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members
Managing patient comfort and recovery	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • CbDs, Mini-CEX, DOPS, EPAs • Participation in ICU multidisciplinary meetings (physio, OT etc.) 	<ul style="list-style-type: none"> • JFICMI examination – bedside examination, Vivas • eLogbook showing case mix of patients managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members

End of life care	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • CbDs, Mini-CEX 	<ul style="list-style-type: none"> • JFICMI examination – Vivas • eLogbook showing case mix of patients managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members • Attendance at mandatory donor awareness course
Transport of the critically ill patient	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • DOPS • eLogbook review of intra- and inter-hospital transfers • Transport medicine course – desirable 	<ul style="list-style-type: none"> • JFICMI examination – Vivas • eLogbook showing patient transfers managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members
Patient safety and healthcare management	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT 	<ul style="list-style-type: none"> • JFICMI examination – SAQs, Vivas • eLogbook showing patient transfers managed
	<ul style="list-style-type: none"> • eLogbook review • Consultant feedback on management and leadership skills • Involvement in organizational, administrative and committee activities in hospital and ICU • Consultant feedback on involvement in departmental audit and journal club • Courses - desirable 	<ul style="list-style-type: none"> • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members
Professionalism	<ul style="list-style-type: none"> • Consultant feedback in the workplace • Interim “in-term” assessment with SOT • CbDs, EPAs • eLogbook review • Consultant feedback on ICU educational, research and audit activities 	<ul style="list-style-type: none"> • JFICMI examination – SAQs, Vivas • eLogbook showing patient transfers managed • “End-of-term” assessment with SOT • “Sign-off” interview with Trainee Committee members

Table legend: Assessment tools mapped to components of training. For more details about courses, see section 5.1.1 or appended Curriculum document. [SOT: Supervisor of Training, MCQs: multiple choice questions, SAQs: short answer questions, DOPS: direct observation of procedural skills, CbDs: case based discussions, Mini-CEX: mini clinical examination exercises, EPAs: Entrustable professional activities]

Examination

1. General

The Fellowship exam (FJFICMI) is a summative examination process within the global training of a postgraduate doctor in Intensive Care Medicine (ICM) and is fundamental to the role of the Joint Faculty of Intensive Care Medicine of Ireland (JFICMI) in the overall supervision of Training in ICM in Ireland. The responsibility of the JFICMI to conduct a Fellowship exam is entrusted to its Examination and Training Committees and their Chairs.

The exam has 2 parts: part 1 (written: MCQ and SAQ) and part 2 (clinical and viva exams).

2. Setting the Exam

The exam is set by the Examination Committee three months in advance of it being held: the written exam being normally conducted in April-May.

Exam of six sections

	Section	Content	Time allowed
Part 1			
- MCQ	1	50 Type A Questions (On line proctored)	90 mins
- SAQ	2	8 short answer questions (On line proctored)	90 mins
Part 2			
- Clinic 1	3	Major Case 1	30 mins
- Clinic 2	4	Major Case 2	30 mins
- Viva 1	5	ECGs, Radiology, Labs, Traces/curves	20 mins
- Viva 2	6	Intensive Care Topics	20 mins

Having 6 distinct sections ensures the candidate is examined by differing examination techniques and exposes each candidate to many examiners making it a balanced and fair process.

The part 1 exam consists of 50 type A multiple choice questions and 8 short answer questions. The MCQs are derived from an extensive bank housed at the JFICMI secretariat and is renewed annually by practising intensivists. With each new sitting some old questions and some new questions are used thus standardising the difficulty to previous years. MCQs are set by JFICMI examiners and then vetted by the examination committee for content, quality and accuracy. A new unique SAQ paper is set for each exam and model answers written and edited by members of the examination committee. Both the MCQ and SAQ papers are mapped to the syllabus of the training program ensuring the candidate is examined across all aspects of intensive care medicine.

3. Dates and venues

Exam: Once the date for the written exam (part 1) is set, the hospital(s) which will host the clinical exam (part 2) is (are) agreed, usually on a rotational system. The Clinical / Viva exam is conducted over one day and is usually in May.

Course: The pre-exam course is run by the JFICMI over three days in the March before the exam. Positions are limited and preference is given to registered ICM trainees who are eligible to take the JFICMI fellowship exam. The course is normally conducted in three Dublin hospitals.

Closing date for applications: This is set to allow time for administrative organisation and for review of applications by the Chair of the Examination committee to ensure compliance with exam eligibility.

4. Candidates

See Training Pathway for individual specialty backgrounds.

Applicants are also required to have attained at least one year of approved training in ICM, up to 6 months of which may have been in 'complementary discipline training'. Candidates are required to become registered trainees with the JFICMI and to have their training prospectively approved.

5. Arbitration on Candidate performance in the Exam

a) Standard of the Examination

The standard required in the JFICMI Fellowship examination is that of a senior trainee who has satisfactorily completed at least one year of specific, supervised Intensive Care Medicine training. The candidate should show evidence of skills, attitudes and knowledge that should allow him / her to take charge of an ICU (and the management of its patients) for a period.

The candidate will be expected to show consistent evidence of competence to practise independently in intensive care medicine. This will include evidence of a capacity to consult other services appropriately and in general to maximise the multidisciplinary environment of critical care for optimum patient benefit.

b) Marking system

With reference to the six-section format of the exam (see below and also the JFICMI's Exam Format document), each of the six sections is marked with equal importance i.e. a maximum of 5 marks (range 0 – 5) per section. However, the Fellowship exam is a clinical exam primarily and a premium is attached to passing the clinical sections of the exam. A pass mark (6), between the two clinical components of the exam, is a requirement to pass the exam.

c) Assessment on which marking is based:

A six point 'closed' marking system is used, the marks being:

Bad Fail / Veto	0
Fail	1
Bare Fail	2
<u>Pass</u>	<u>3</u>
Good Pass	4
Excellent	5

The marking system is designed as a closed marking system.

Each section of the exam (apart from the MCQ) is scored by a pair of examiners.

i.e.: All written SAQ papers are exchanged between a pair of examiners
2 examiners for each major clinical case
2 examiners for each viva

The scores awarded to each candidate at all interactive sections of the exam must be agreed and recorded by the examiner pair at the end of each section of the exam – before beginning to examine another candidate. It is anticipated that the Extern will examine with different pairs of examiners throughout the day, and may act at times as an observer, at his/her discretion.

d) Application of the marking system to various sections of the Exam

1. MCQ Section:

The MCQ is marked as

1 mark = correct answer

0 mark = incorrect answer or no answer

i.e. there is no negative marking in the MCQ

2. Paper (SAQs) section:

The SAQ paper is sat 1 hour after the MCQ has been completed. The candidates have 120 minutes for this paper. The model answers are vetted by the examination committee for content, quality and accuracy.

There are usually four paper-marking examiners, who are divided into two marking pairs.

Each question is to be marked in accordance with JFICMI standard marking system (0 – 5).

Examiners are requested to use the 0 (zero: i.e. veto) mark only in extreme circumstances. If it is used, the examiners will be asked to justify their mark at either the script review or call-over meetings.

At the end of the SAQ marking process, the total marks for the SAQs for each candidate are collated by the Chairman of the Examination, the composite marks being addressed as follows. In the event of the composite score being other than a whole number (e.g. 2.4), the mark (for this section of the exam) will be rounded to the nearest whole number

e.g. > 2.5 shall be rounded to 2
> 2.5 shall be rounded to 3

Admission to Part 2 (Clinical / Viva Exam):

The marks from section 1 and 2 of the exam are added for each candidate. A mark of greater than 5 is required in these two sections to qualify for admission to the clinical / viva sections of the exam. On receipt of his/her results the candidate can apply to present to part 2 of the exam. If a candidate scores a mark of greater than 5 (i.e. pass), he/she may defer presenting to part 2 for one year only. If he/she does not apply for and present at the subsequent part 2 exam, then he/she forfeits the original results of part 1 and must represent for part 1.

Part 2 of exam – Major case x 2 and Vivas x 2

Part 2 consists of 4 parts: 2 clinical sections and 2 cross-table viva sections. The clinical sections consist of two separate major cases which carries a maximum of 5 marks each. Each viva carries a maximum of 5 marks. Part 2 in total carries 20 marks. The candidate is examined in each section of part 2 by a minimum of 2 and often 3 examiners. The candidate is examined by different examiners in each section of part 2. The clinical cases have a Performa set of clinical findings that the examiners are given prior to examining each candidate, thus standardising the exam. The viva sections have pre-written model answers that have been scrutinised by the examination committee, thus standardising this section of the exam.

Overall Exam Marking – court of examiners' 'call-over'.

Once the marks from the Clinical / Viva section of the exam are collated, attention is given to the overall results from the exam. The 'call over' is the forum of the examiners where all the marks are collated and the final adjudication is agreed by all present – in accordance with the 'marking' regulations outlined.

Veto marks (0) will be the subject of discussion and issues of counselling may need to be addressed.

Overall examination result

Pass 18 marks

Provided

- a) The combined mark achieved in clinical sections (3 and 4) is 6 or greater
- b) The candidate has no mark of 0 (veto) in any section of the exam

Faculty Medal

The candidate who achieves first place in the exam provided the mark awarded is greater than 25 marks.

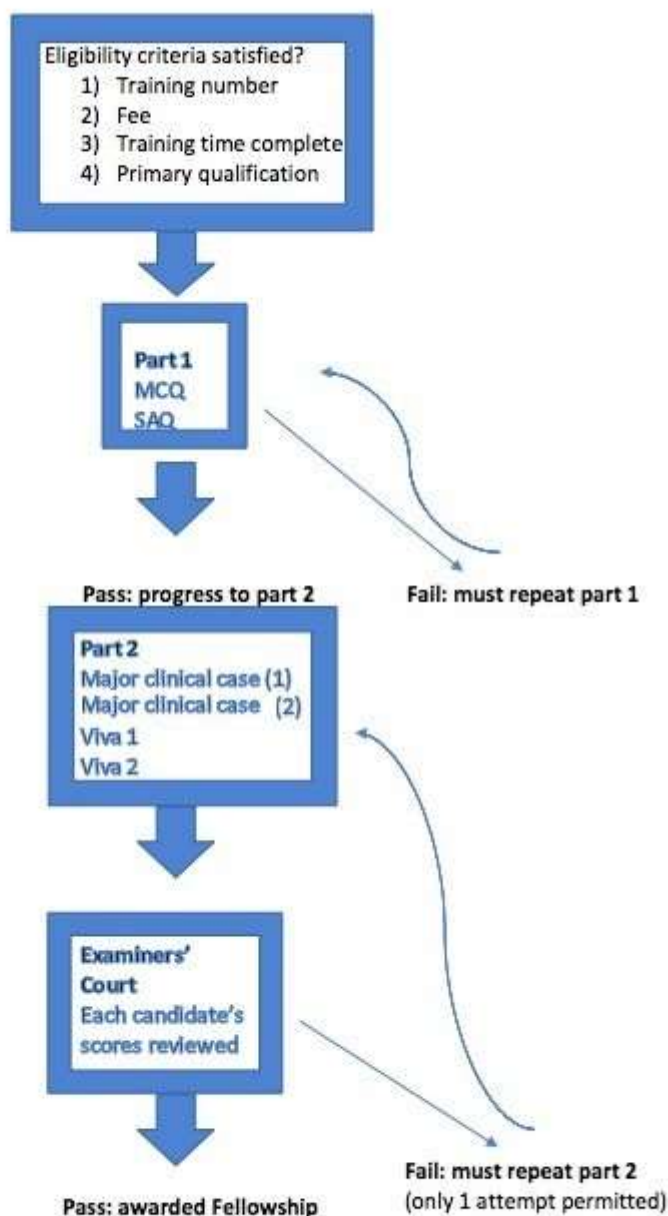
Although the overall pass mark is 18 (with provisions - see below), candidates whose composite mark is 17 shall be reviewed, provided the composite score for the clinical sections (major and minor cases) is greater than 6.

If the highest marked candidate has achieved a mark of 25 or over, (s)he is considered for the award of the JFICMI medal and a recommendation for the awarding of the Medal should go to the next Board meeting. The medal is normally awarded at the time of the conferral of the Fellowship.

Announcement of Results to Candidates

The results are announced immediately after the call-over and the successful candidates are invited to meet the examiners.

The candidates who were not successful are offered the opportunity for exam feedback on their exam performance and for advice / counselling which can take place immediately or at a later date as requested by the candidate(s). Usually the chair and another senior examiner will counsel the candidate(s) with a member of the examination secretariat in attendance.



Organogram for Joint Faculty of Intensive Care Medicine Fellowship Examination

Research

Completion of an audit or research project is a requirement of the two years of ICM specialist training. Trainees are encouraged to acquire research training and competence and the achievement of a successful (preferably published) research work during training is recognised for credit and accolades towards certification of completion of specialist training. Those who have pursued a research pathway in their base specialty training will also be encouraged to continue their academic research.

The post-CSCST year (Year 2 ICM Training) is strongly clinical in focus. A non-clinical day is built into the working week, thereby affording approximately 20% of time towards research or audit. A submission for a dedicated period of training devoted to research will be considered by the Training Committee on a case by case basis, informed by the prior research opportunities and research product of the candidate as well as cumulative intensive care and complementary training to date.

Training Progress Report

The Supervisor of Training is required to review with each trainee their knowledge and training experience. All trainees are required to acquire proficiency in the 12 competencies presented here.

The trainee's experience is also supported by their eLogbook. This is an opportunity to review the eLogbook which gives a broad overview of case-mix, complexity, procedural experience, and professionalism.

These competencies do not have to be completed all at once, but can be addressed, saved and updated at intervals during the trainee's time with you. Please note there is an option in each competency to add free text for both trainer and trainee, and each assessment should be discussed with the trainee.

If a trainee has further ICM modules to complete at another centre, their new Supervisor of Training will also be required to review a new full set of competencies. Hence, the trainee shall accrue more competencies with each module. However, the trainee needs to be advised where deficiencies exist to allow the opportunity to correct these. We would therefore also encourage frequent meetings with trainees so that any problems are identified by both sides in a timely manner.

Please note, the last option on each competence page is a statement of concern regarding a trainee's suitability for intensive care medicine. If this option is chosen, the concern is submitted to the JFICMI Training Committee for further consideration.

The Training Progress Report overview in the following pages is available on-line through the CAI Kaizen website using a Supervisor of Training login.

1. RESUSCITATION & INITIAL MANAGEMENT OF THE ACUTELY ILL PATIENT

1.1 Adopts a structured and timely approach to the recognition, assessment and stabilisation of the acutely ill patient with disordered physiology.

Satisfactory / Unsatisfactory / Requires improvement

1.2 Manages cardiopulmonary resuscitation

Satisfactory / Unsatisfactory / Requires improvement

1.3 Manages the patient post-resuscitation

Satisfactory / Unsatisfactory / Requires improvement

1.4 Triage and prioritises patients appropriately, including timely admission to ICU

Satisfactory / Unsatisfactory / Requires improvement

1.5 Assesses and provides initial management of the trauma patient

Satisfactory / Unsatisfactory / Requires improvement

1.6 Assesses and provides initial management of the patient with burns

Satisfactory / Unsatisfactory / Requires improvement

1.7 Describes the management of mass casualties / major incident plan

Satisfactory / Unsatisfactory / Requires improvement

1.7 Describes the management of mass casualties / major incident plan

Satisfactory / Unsatisfactory / Requires improvement

This assessment is based upon:

Personal Observation Feedback Logbook Overview

Additional Comments:

Discussed with Trainee: (mandatory)

Yes / No

Overall rating Section 1:

Satisfactory / Unsatisfactory / Requires improvement

ITA Rating Scale:

Satisfactory / Unsatisfactory / Requires improvement

2. DIAGNOSIS: ASSESSMENT, INVESTIGATION, MONITORING AND DATA INTERPRETATION

2.1 Obtains a history and performs an accurate clinical examination

Satisfactory / Unsatisfactory / Requires improvement

2.2 Undertakes timely and appropriate investigations

Satisfactory / Unsatisfactory / Requires improvement

2.3 Performs and interprets focused transthoracic echocardiography

Satisfactory / Unsatisfactory / Requires improvement

2.3b Performs and interprets general critical care ultrasonography (thoracic, abdominal, vascular)

Satisfactory / Unsatisfactory / Requires improvement

2.4 Performs electrocardiography (ECG / EKG) and interprets the results

Satisfactory / Unsatisfactory / Requires improvement

2.5 Obtains appropriate microbiological samples and interprets results

Satisfactory / Unsatisfactory / Requires improvement

2.6 Obtains and interprets the results from blood gas samples

Satisfactory / Unsatisfactory / Requires improvement

2.7 Interprets chest x-rays

Satisfactory / Unsatisfactory / Requires improvement

2.8 Liaises with radiologists to organise and interpret clinical imaging

Satisfactory / Unsatisfactory / Requires improvement

2.9 Monitors and responds to trends in physiological variables

Satisfactory / Unsatisfactory / Requires improvement

2.10 Integrates clinical findings with laboratory investigations to form a differential diagnosis

Satisfactory / Unsatisfactory / Requires improvement

This assessment is based upon:

Personal Observation

Additional Comments:

Discussed with Trainee: (mandatory)

Yes / No

Overall rating Section 2:

Satisfactory / Unsatisfactory / Requires improvement

ITA Rating Scale:

Satisfactory / Unsatisfactory / Requires improvement

New ICM Training Assessment for Jack Collins

Submit

Save as draft

VERSION 4

Fields marked with * are required.

LAST SAVED: UNSAVED

This event will be added onto Jack Collins's timeline as a **SHARED** event. All users with permissions to view their timeline will be able to view this event.

Date occurred on *

14/1/2021

Please indicate the date on which this event occurred.

End date *

14/1/2021

If this event spans multiple days, please indicate the date on which this finishes.

Description (optional)

Name of Trainers Involved in this Assessment *

Select Hospital *

Trainee Assessment Type *

Sources of Information *

Sources of Information

Assessment Start Date *

Assessment End Date *

1. RESUSCITATION & INITIAL MANAGEMENT OF THE ACUTELY ILL PATIENT

Adopts a structured and timely approach to the recognition, assessment and stabilisation of the acutely ill patient with disordered physiology.

Manages cardiopulmonary resuscitation

Manages the patient post-resuscitation

Triage and prioritises patients appropriately, including timely admission to ICU

Assesses and provides initial management of the trauma patient

Assesses and provides initial management of the patient with burns

Describes the management of mass casualties / major incident plan

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Overall Rating Section 1 ★

ITA Rating Scale

2. DIAGNOSIS: ASSESSMENT, INVESTIGATION, MONITORING AND DATA INTERPRETATION

Obtains a history and performs an accurate clinical examination

Undertakes timely and appropriate investigations

Performs and interprets focused transthoracic echocardiography

Performs and interprets general critical care ultrasonography (thoracic, abdominal, vascular)

Performs electrocardiography (ECG / EKG) and interprets the results

Obtains appropriate microbiological samples and interprets results

Obtains and interprets the results from blood gas samples

Interprets chest x-rays	
Liaises with radiologists to organise and interpret clinical imaging	
Monitors and responds to trends in physiological variables	
Integrates clinical findings with laboratory investigations to form a differential diagnosis	
If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.	
Additional Comments:	
Discussed with Trainee	
Overall rating Section 2	

3. DISEASE MANAGEMENT

Acute Disease

Manages the care of the critically ill patient with specific acute medical conditions including the following disorders: Respiratory, Cardiovascular, Neurological, Renal & Genito-urinary, Gastrointestinal, Haematological & Oncological, Infections, Metabolic, Endocrine

CHRONIC DISEASE

Identifies the implications of chronic and co-morbid disease in the acutely ill patient including the following disorders: Respiratory, Cardiovascular, Neurological, Renal, Gastrointestinal, Haematological & Oncological, Endocrine, Psychiatric

ORGAN SYSTEM FAILURE

Recognises and manages the patient with circulatory failure including the following disorders: Cardiovascular, Renal

Recognises and manages the patient with, or at risk of, acute renal failure including the following disorders: Renal & Genito-urinary, Cardiovascular, Metabolic

Recognises and manages the patient with neurological impairment Including the following disorders: Neurological, Metabolic

Recognises and manages the patient with acute gastrointestinal failure Including the following disorders: Gastrointestinal, Metabolic

Recognises and manages the patient with acute lung injury syndromes (ARDS) Including the following disorders: Respiratory, Metabolic

Recognises and manages the septic patient Including the following disorders: Infections

Recognises and manages the patient following intoxication with drugs or environmental toxins including the following disorders: Respiratory, Cardiovascular, Neurological, Renal, Metabolic, Gastrointestinal, Haematological

Recognises life-threatening maternal peripartum complications and manages care Including the following disorders: Cardiovascular, Haematological, Metabolic

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Discussed with Trainee

Overall Rating Section 3

4. THERAPEUTIC INTERVENTIONS / ORGAN SYSTEM SUPPORT IN SINGLE OR MULTIPLE ORGAN FAILURE

Prescribes drugs and therapies safely

Manages antimicrobial drug therapy

Administers blood and blood products safely

Uses fluids and vasoactive / inotropic drugs to support the circulation

Describes the use of devices to support the cardio-pulmonary system

Initiates, manages and weans patients from renal replacement therapy

Recognises and manages electrolyte, glucose and acid-base disturbances

Co-ordinates and provides nutritional assessment and support

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Overall Rating Section 4

5. SAFE USE OF PRACTICAL PROCEDURES

Administers oxygen using a variety of administration devices



Performs fiberoptic laryngoscopy



Describes emergency surgical airway management



Performs videolaryngoscopy or fiberoptic intubation



Performs endotracheal suction



Performs fiberoptic bronchoscopy and BAL in the intubated patient



Performs percutaneous tracheostomy



Performs thoracocentesis via a chest drain



CARDIOVASCULAR SYSTEM

Performs peripheral venous catheterisation



Performs arterial catheterisation



Describes a method for surgical isolation of vein / artery



Performs ultrasound for vascular localization



Performs central venous catheterisation



Performs defibrillation and cardioversion



Performs cardiac pacing (transvenous, trans thoracic, epicardial)



Describes how to perform pericardiocentesis



Demonstrates a method for measuring cardiac output and derived haemodynamic variables



CENTRAL NERVOUS SYSTEM

Performs lumbar puncture



Manages the administration of analgesia via an epidural catheter



GASTROINTESTINAL SYSTEM

Performs nasogastric tube placement



Performs abdominal paracentesis



Describes Sengstaken tube (or equivalent) placement	▼
Describes indications for, and safe conduct of gastroscopy	▼
If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.	
Additional Comments:	
Discussed with Trainee	
Overall Rating Section 5 ▼	
6. PERI-OPERATIVE CARE	
Manages the pre- and post-operative care of the high risk surgical patient	▼
Manages the care of the patient following cardiac surgery	▼

Describes Sengstaken tube (or equivalent) placement	▼
Describes indications for, and safe conduct of gastroscopy	▼
If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.	
Additional Comments:	
Discussed with Trainee	
Overall Rating Section 5 ▼	
6. PERI-OPERATIVE CARE	
Manages the pre- and post-operative care of the high risk surgical patient	▼

6. PERI-OPERATIVE CARE	
Manages the pre- and post-operative care of the high risk surgical patient	▼
Manages the care of the patient following cardiac surgery	▼
Manages the care of the patient following craniotomy	▼
Manages the care of the patient following solid organ transplantation	▼
Manages the pre- and post-operative care of the trauma patient	▼
If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.	
Additional Comments:	
Discussed with Trainee	

Overall Rating Section 6 ★

7. COMFORT & RECOVERY

Identifies and attempts to minimise the physical and psychosocial consequences of critical illness for patients and families

Manages the assessment, prevention and treatment of pain and delirium

Manages sedation and neuromuscular blockade

Communicates the continuing care requirements of patients at ICU discharge to health care professionals, patients and relatives

Manages the safe and timely discharge of patients from the ICU

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Overall Rating Section 7 ★

8. END OF LIFE CARE

Manages the process of withholding or withdrawing life sustaining treatment with the multidisciplinary team

Discusses end of life care with patients and their families / surrogates

Manages palliative care of the critically ill patient

Performs brain-stem death testing

Manages the physiological support of the organ donor

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Overall Rating Section 8 ★

9. PAEDIATRIC CARE

Describes the recognition of the acutely ill child and initial management of paediatric emergencies including transfer of critically ill child

Describes national legislation and guidelines relating to child protection and their relevance to critical care

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Overall Rating Section 9 ✖

10. TRANSPORT

Undertakes transport of the mechanically ventilated critically ill patient outside the ICU

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee

Overall Rating Section 10 ✖

11. PATIENT SAFETY AND HEALTH SYSTEMS MANAGEMENT

Leads a daily multidisciplinary ward round

Complies with local infection control measures

Identifies environmental hazards and promotes safety for patients & staff

Identifies and minimises risk of critical incidents and adverse events, including complications of critical illness

Organises a case conference

Critically appraises and applies guidelines, protocols and care bundles

Describes commonly used scoring systems for assessment of severity of illness, case mix and workload

Demonstrates an understanding of the managerial & administrative responsibilities of the ICM specialist

If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.

Additional Comments:

Discussed with Trainee	
Overall Rating Section 11	
12. PROFESSIONALISM	
COMMUNICATION SKILLS	
Communicates effectively with patients and relatives	
Communicates effectively with members of the health care team	
Maintains accurate and legible records / documentation	
PROFESSIONAL RELATIONSHIPS WITH PATIENTS AND RELATIVES	
Involves patients (or their surrogates if applicable) in decisions about care and treatment	
Demonstrates respect of cultural and religious beliefs and an awareness of their impact on decision making Respects privacy, dignity, confidentiality and legal constraints on the use of patient data PROFESSIONAL RELATIONSHIPS WITH PATIENTS AND RELATIVES Collaborates and consults; promotes team-working Ensures continuity of care through effective hand-over of clinical information Supports clinical staff outside the ICU to enable the delivery of effective care Appropriately supervises, and delegates to others, the delivery of patient care	
SELF GOVERNANCE	
Takes responsibility for safe patient care	
Seeks learning opportunities and integrates new knowledge into clinical practice	
Participates in multidisciplinary teaching	
Participates in research or audit	
If you have marked the trainee as "requires improvement" or "unsatisfactory" for any domain, please explain the reasons in the additional comments.	
Additional Comments:	
Discussed with Trainee	
Overall Rating Section 12	

12 Marking Trainee Assessment Comments

13. Modular Trainee Assessment Summary

Start Date of Module Being Assessed

End Date of Module Being Assessed

Logbook and Competence Assessment

The final decision about a trainee's modular assessment is based on a combination of their clinical exposure during their module (guided by the on-line logbook record) and the results of their Competence Assessment.

Logbook and Clinical Exposure

The trainee must demonstrate a satisfactory record of clinical exposure to ICM in their JFICMI on-line logbook. The Supervisor of Training must be satisfied that the logbook represents a reasonable record of casemix and procedural exposure during this module (ie. that the record reasonably reflects casemix and patient throughput for your intensive care service) and that the trainee's attendance allowed satisfactory opportunity for clinical training. Where sick leave or other resulted in reduced clinical training time, please comment as to whether you can sign off on this assessment or wish the JFICMI to review further.

Logbook

Attendance

eLogbook

Every trainee is required to maintain an eLogbook. This is accessible to every registered trainee with the JFICMI using their secure login detail.

The eLogbook is used as supporting evidence of exposure to a wide range of intensive care exposure, case-mix, professional interactions, and procedural activities.

The Help section and FAQ helps guide the User in the use of this logbook. The option to create a report is described and this allows the trainee, and JFICMI, re develop and retain the eLogbook portfolio.

Please be aware the eLogbook is required for review of competencies and training progress with both the Supervisor of Training and the JFICMI Training Committee.

The eLogbook overview of content in the following pages is available on-line through the JFICMI website using your User login.

Minimum Volume of Practice (expanded version)				
		6 Months	Yr 1	Yr 2
1) General Information				
a)	Hospital			
b)	Consultant on duty			
c)	Working Hours			
	Daytime			
	On call			
	Both			
d)	Patients in ICU			
	Patient directly assigned to own care			
e)	Number of Ward rounds			
	Consultant led	40	80	80
	Led by you	2	10	30
	MDT: Radiology	5	10	10
	MDT: Micro	5	10	10
	MDT: Allied	5	10	10
f)	New admissions			
	Elective			
	Emergency			
g)	Out of ICU assessments	20	40	40
2) Disease management (new/continued care)				
[Should be able to choose multiple options in each section]				
a)	CVS	10	25	25
	Cardiogenic Shock			
	Congestive Cardiac Failure			
	Coronary Artery Disease / MI			
	Dissecting Aortic Aneurysm			
	Hypertension			
	Hypovolaemia / Shock			
	Post Cardiac Arrest			
	Rhythm Disturbance			
b)	Respiratory Failure	10	25	25
	ARDS			
	Aspiration			
	Asthma			
	COPD			
	Pneumonia/CAP/HAP/VAP			
	Pulmonary embolism			

c)	Acute severe sepsis or shock	10	25	25
	Sepsis			
	Intra-abdominal sepsis			
	Severe soft tissues infection			
	Infective endocarditis			
	Urinary tract sepsis			
	Catheter related blood stream infection			
	Neutropaenic sepsis			
	Biliary sepsis			
	Opportunistic infection in immunocompromised patient			
	Bacteraemia (unknown origin)			
	Other			
d)	Acute gastrointestinal failure	5	10	10
	Severe acute pancreatitis			
	Sever enteritis			
	Ischaemic bowel			
	Abdominal compartment syndrome			
	Bowel dysfunction after major surgery			
	Acute oesophageal perforation			
	Other			
e)	Acute Kidney Injury	10	25	25
	Acute renal resuscitation			
	Renal replacement therapy			
f)	Neurological impairment	5	10	10
	Critical illness neuropathy			
	Thrombotic or embolic stroke			
	Haemorrhagic stroke			
	Spinal cord disease			
	Status epilepticus			
	Meningitis/Encephalitis			
	Myaesthesia Gravis			
	Guillaine Bare syndrome			
	Other			
g)	Acute liver failure	2	5	5
	Acute fulminant liver failure			
	Acute decompensation of chronic liver disease			
	Othe liver failure			
h)	Injury due to environmental hazards	2	5	5
	Drug overdose			
	~Severe burn			
	Hypo/hyperthermia			
	Othr poisoning			
i)	Obstetric illness			

	Eclampsia/pre-eclampsia			
	Massive obstetric haemorrhage			
	HELLP syndrome			
	Othe obstetric			
j)	Haematology/Oncology critical illness	5	10	10
	DIC			
	Tumour lysis syndrome			
	Complications from bone marrow transplantation			
	Haematological failure			
	HITS			
	Other haem/onc diagsosi			
k)	Polytrauma/musculoskeletal/dermatological	5	10	10
	Severe multitrauma			
	Severe head trauma			
	Severe chest trauma			
	Severe abdominal/pelvic trauma			
	Rhabdomyolysis			
	Severe primary dermatological disorder			
	Othe musculoskeletal disorder			
l)	Metabolic/endocrine/rheumatology	5	10	10
	Diabetic ketoacidosis			
	Severe hypo/hypernatraemia			
	Severe hypo/hyperkalaemia			
	Other severe electrolyte disorder			
	Acute adrenal crisis			
	Acute immune-deficiency crisis			
	Acute thyroid emergency			
m)	Peri-operative Care	10	25	25
	High risk surgery	5	10	10
	Cardiac surgery	2	5	5
	Neurosurgery			
	Heart transplant			
	Lung transplant			
	Liver transplant			
3. End of Life Care		5	10	10
	Manages the process of death, including brainstem testing	1	2	2
	Manages the discussion of the potential organ donor with the family			
	Manages palliative care of the critically ill patient			
4. Transport of the critically ill patient				
	Intra-hospital	5	5	5
	Interhospital [free text]	2	2	2

5.	Core Procedure Skill			
	a)	Airway		
		BMV		
		Intubation (in ICU)	5	10
		Intubations total (including from base specialty. Eg. Anaesthesiology) at end of ICM training	100	5
		Difficult Airway	2	5
		Perc trach	observe 5	5
		Bronchoscopy +/- Lavage	2	5
	b)	Ventilation	25	50
		Invasive ventilation	20	40
		Non-invasive ventilation	5	10
	c)	Vascular Access		
		Arterial Catheterisation	5	10
		Central Venous Insertion	10	25
		Use of Ultrasound for vascular localisation	10	25
		Tube thoracostomy insertion (observe/insert)		
	d)	Renal		
		Management of CRRT	10	20
	d)	Neuro		
		Lumbar puncture	1	2
		Placement/management of epidural catheter		
	e)	Cardiovascular		
		TOE		
		TTE		15
		Cardiac pacing - transvenous and epicardial (observer)	2	5
		Cardiac pacing - transthoracic	2	2
		Cardioversion	2	5
		Invasive CO monitoring	1	2
		Extracorporeal life support (ECLS)		
	f)	Gastro-intestinal		
		Abdominal paracentesis	1	2
		Insertion of Sengstaken tube or similar (observer)		
6)	Family Conference			
		Consultant led	2	5
		Self	2	5