Welcome to the Department of Intensive Care & Hyperbaric Medicine at The Alfred Hospital

These job descriptions and role responsibility outlines apply to all International and Australian Junior Medical Staff (JMS) employed to work in the Alfred ICU. Individualised changes are made when particular needs are identified for any particular trainee.

Training is a focus of the Alfred Intensive Care. Opportunities are created whenever possible to encourage learning and training in a supported and supervised environment, with an emphasis on patient safety and outcomes.

The Alfred ICU is a large, complex, interesting and enjoyable place to work, and we are confident that regardless of your background, seniority, and career aspirations, you will find your time here extremely rewarding.

The Alfred is a quaternary level hospital providing state referral services in Heart and Lung Transplant, Heart failure including ECMO & ventricular assist devices, bone marrow transplantation, HIV medicine, hyperbaric medicine, cystic fibrosis, haemophilia, burns and trauma. It provides all adult tertiary teaching hospital services except for liver transplantation, and obstetrics. There are no routine paediatric services however the Alfred is the national paediatric lung transplant centre – and we see a few of those per year.

In November 2008 the new 45 bed ICU was opened. This is a brand new state of the art facility which accommodates all critical care patients in the one unit. The unit is geographically and demographically divided into three connected “pods” of 15 beds each. The 3 pods are Cardiac, Trauma and General; each one is staffed by a separate ICU Consultant, Senior Registrar, Registrar or SRMO and Resident.

The Cardiac pod accommodates all post op cardiac surgical patients (elective, emergency and transplants), cardiology patients (e.g. after cardiac arrest) and all extracorporeal supported patients (ECMO, VAD etc). The Trauma pod accommodates all trauma and neurosurgical patients. The General pod accommodates pretty much everything else (e.g. haematology, burns, post-op surgical, general medical etc), including veno-venous ECMO support for respiratory failure.

The beds are made up of a variable mix of “ICU beds” (1:1 nurse patient ratio) and “HDU beds” (1:2 nurse patient ratio). Funding limits the number of beds that can be opened at any one time. We have opened 10 additional beds in the last 7 years and are currently funded for 35 ICU equivalents. There is an average of 40 patients at any one time in the department, but, depending on the ratio of ICU patients to HDU patients this may vary between 35 to 44 patients. Whilst we always attempt to cohort patient groups i.e. trauma patients in the Trauma pod and cardiothoracic patients in the cardiac pod, limited bed numbers and patient load may occasionally mean that there is crossover of patient groups. We try to minimize this and patient movement between pods is discouraged unless absolutely necessary.

Staff within Intensive Care, include 14 full time ICU consultants, 5 fractional time ICU consultants, 15 senior registrars and Fellows, one Hyperbaric registrar, 8 Registrars, 6 SRMOs, 6 residents, and in excess of 300 nurses in addition to physiotherapists, dieticians, pharmacists, occupational therapists, speech therapists, orthotists, social workers, orderlies and scores of support staff not directly involved with patient care. It cannot be stressed enough that the key to good intensive care practice is teamwork and communication.

We hope you enjoy your time working in The Alfred Intensive Care Unit, and learn new skills relating to the management of the critically ill patient.
This document outlines some of the job specifics for the ICU junior medical staff. We put a lot of emphasis on teaching and training, and much of this is consultant led. Additionally, we value high quality patient care. To this end there are some explicit requirements for all of the Junior Medical staff also:

There is an online learning package relating to some of the most important guidelines and protocols that must be completed by the end of orientation to the ICU.

Hand hygiene is also regularly audited, and an online certification for minimum standards relating to this must also be completed prior to starting work in the ICU.

If there are any questions regarding the information within this document, please contact Owen Roodenburg o.roodenburg@alfred.org.au
DEPARTMENT OF INTENSIVE CARE

MISSION STATEMENT

As intensive care specialists, *our primary responsibility* is to provide safe, appropriate, high quality care and comfort to all Alfred patients with any form of critical illness and to support those that care for them.

- **Clinical care:** Our aim is to provide best possible patient outcomes through the practice of excellent, evidence-based, compassionate and consistent team-oriented intensive care medicine. In every situation, the wishes of the patient and the hopes of those around them will be balanced with the likelihood of success and suffering. Our practice will include dignified end-of-life care if treatment becomes futile.

- **Communication:** To keep our patients and their relatives well informed. To communicate effectively with our colleagues and other hospital staff.

- **Support:** To build positive relationships within and outside our department. To support our colleagues in our clinical and academic pursuits so that we can attract, inspire, and nurture diverse and committed staff wishing to continually improve their skills and knowledge.

- **Teaching:** To facilitate critical care teaching of all intensive care and hospital staff. We wish the Alfred to be the premier place for intensive care training in Australia.

- **Research:** To maintain the Alfred Intensive Care as an international Centre of Excellence in research. To encourage and support a broad range of research activities. To present regularly at critical care conferences nationally and internationally.

- **Management:** To deliver best-practice, cost-effective, responsible intensive care with wise management of human and material resources.

- **Quality Assurance:** To continually improve our performance by regular review of all aspects of service so that we change our strategies if required. To set both long and short-term goals on an annual basis which we strive to accomplish by working together.

- **Values:** To apply the following values to all aspects of our work: compassion, honesty, commitment, respect of personal beliefs and differences. To remain open-minded to new ideas and approaches.
SPECIFIC JUNIOR MEDICAL STAFF (JMS) ROLES AND RESPONSIBILITIES

CONSULTANT-LED CLINICAL CARE

Presently four daytime consultants are rostered during the day (Mon – Sunday); one for each of the three ICU areas and one for the hospital wards/referrals. In addition there is a night consultant (taking over from 4:30pm) who is responsible for all 4 areas overnight. The night ICU consultant stays “in house” until all problems are sorted out. This is usually until midnight. Beginning at 19:30 pm the night consultant will conduct the night handover ward round with the night internal senior registrar and the pod registrar or SRMO and see all ICU patients and referred patients waiting for ICU admission with the registrar/SRMO looking after them. They remain in house until at least midnight, and on call until 8am and many remain “in house” all night.

ALL JMS

All ICU doctors are expected to
1. Arrive to work punctually (NB: commencement time varies between ICU pods and for ICU SRs)
2. Dress and behave in a professional manner
3. Represent The Alfred in accordance with their employment contract
4. Become familiar with clinical protocols and emergency procedures
5. Communicate major changes in patient status to senior medical and nursing staff
6. Maintain appropriate documentation in patient files and on ICU Active
7. Participate actively in the education program
8. Promptly complete any online education package required
9. Observe all ICU rules and successfully perform on ICU key performance indicators such as hand hygiene, procedural technique, CLABSI prevention etc.
10. Complete a BASIC course if they have not worked in ICU prior to starting in Alfred ICU (Senior Registrars and Fellows are exempt from this requirement)

Expectations of each doctor reflect their experience and training.
The individual pay scale will be commensurate with their level of experience in line with their other Alfred jobs for that contract year. They will not be expected to act above this level without mutual agreement, and an explicitly altered contract.
Senior Registrars and Fellows are paid a fixed rolled up salary- calculated to include average overtime and penalties. The following are guidelines for the responsibilities of each position.
**Resident medical officers (Residents/HMO/RMO)**

Includes HMO2 & HMO3

Hours – 76 per fortnight on a week on/week off basis (Mon –Sun). No nights.

Responsibilities include:

1. attend ward rounds
2. maintain high quality medical notes in the patient file to ensure continuity of information and patient care
3. update salient aspects of patient management on ICU active including
   a. admission
   b. daily events and “To do list”
   c. handover sheet
   d. discharge summary
4. following up on important investigations and results
5. HMOs are responsible for pre-ordering pathology for the following day. Routine daily blood tests include FBE, U&E, LFT Ca, Po4, Mg, coagulation profile. Patients on high dose vasopressors/inotropes should have CK and troponin assays. Other bloods may also be required as requested.
6. liaise with medical staff outside the ICU when requested to do so
7. perform limited numbers of invasive procedures in low risk patients under strict supervision
8. attend to educational responsibilities as per the education roster
SENIOR RESIDENT MEDICAL OFFICERS (SRMO)

HMO3 and above, usually Critical Care 3+ and BPT3+

Always answerable to or directly supervised by Senior registrars or fellows, SRMOs share responsibility for general patient management. SRMOs have the opportunity to perform many of the procedures, transports and patient examinations in the ICU. Transports often mean that these doctors are away for parts of the day. Ventilated patients who need to leave the ICU to attend an investigation, (e.g. X-ray, CT or MRI) or a procedure, (e.g. hyperbaric unit), must be accompanied by a SRMO, or more senior doctor.

SRMOs who are interested may choose to learn and perform procedures under supervision of the respective SR/fellow or consultant. Routine ICU care includes various procedures such as Central venous lines, and arterial lines. These procedures may be performed by SRMOs who are not registrars; however there are strict criteria for training and accrediting that must be adhered to. These must not be undertaken without supervision until completing the ICU accreditation for these procedures.

Further caveats include:
1. Only suitably trained registrars (not SRMOs) should perform non-emergent intubation
2. Percutaneous tracheostomies (or the associated anaesthetic) are not to be performed except by Consultants or Senior Registrars/Fellows under direct supervision.
3. Airway procedures and central venous access on high-risk patients (e.g. severe coagulopathy) should not be performed by SRMOs.

SRMO Administrative responsibilities include database entries (ICU Active) and discharge summaries

For patients admitted during their shifts, SRMOs need to ensure that the ANZICS diagnostic category and chronic health evaluation are entered onto the ICU ACTIVE database at the time of patient admission. Clinical details and some admission demographic data are required. Our data collectors will provide further orientation on this process. The medical staff must complete all sections in yellow.

Discharge summaries (entered in ICU Active) are an extremely important form of communication in the ICU. Even patients that die in the ICU require completion of the discharge summary giving the details surrounding death clearly such that it can be followed by someone not present at the time. Discharge summaries of deceased patients (and patients that are readmitted to ICU) are reviewed at weekly consultant mortality and readmission meetings and it is noted when there are insufficient details included. The ICU Active discharge summary is an important link for the follow up team and all active management issues should be listed. Completion of the discharge summary is the shared responsibility of the SRMO and HMO. In addition to a written discharge summary, whenever a patient leaves the ICU for the ward, the primary treating team should be notified by way of phone call to outline any specific ongoing issues.

SRMO Educational responsibilities

The SRMOs on day shifts are expected to prepare for and run the “labs and ‘lytes” data interpretation section of the education meeting every Wednesday. This involves selecting interesting radiology and laboratory results from 2 or 3 current inpatients and producing a powerpoint presentation, the template for which is available on the ‘H’ drive of the hospital’s computers. Each patient presented should have a brief synopsis of the clinical issues followed by the relevant investigations; the session is interactive and requires
that you ask members of the audience to interpret investigations. The preparation for this session is not intended to be onerous, and it is regularly considered the most enjoyable and useful aspect of the teaching program. The powerpoint presentations are subsequently saved on the shared drive of the computers as a useful resource for those preparing for exams.

Summary:

SRMOs are

- Part of a team (usually with a HMO, SR/Fellow, and Consultant)
- Always answerable to a Senior Registrar or Fellow
- Never responsible for deciding admissions or discharges
- Not able to undertake procedures unless specifically trained and accredited
- Never on call
- Responsible for several clinical, administrative and educational duties
- Work approximately 50% of their time on days and
- Approximately 50% of their time night shifts without a HMO
  (still answer to an SR/Fellow)
REGISTRARS (not including Senior Registrars and Fellows)  
usually ICU, Emergency, or Anaesthesia trainees

Registrars work as part of a team much like the SRMOs above. However, being more experienced, and with more relevant training, they have greater responsibilities than the SRMOs.

Along with the expectations of the SRMOs (above), Registrars have
1. responsibility for learning, being accredited, and performing routine ICU procedures including Central venous catheters, arterial lines, Intercostal catheters, dialysis vascular access catheters (vas caths)
2. expectations to be studying for or having completed a primary exam in College of either Intensive Care, Emergency Medicine, or Anaesthesia (or equivalent)
3. extra rostered role as the “lines/transport” registrar.
4. An expectation that they perform their responsibilities at a higher level than the SRMOs and RMOs.
SENIOR ICU REGISTRARS

There are 6 positions through which these registrars rotate – one for each pod during day, an external day SR and 2 SRs at night (one internal to provide supervision and support to the REGISTRAR OR SRMOs working in each of the three pods, and one external to cover MET calls, trauma calls, referrals and ward follow up). They are advanced trainees in intensive care medicine.

They are expected to have successfully completed a primary exam for the CICM (or equivalent), and have at least 6, but preferably 12 months Anaesthesia experience and training. They may have already completed their Fellowship exam. They are usually in their final year of training or after.

Each SR is allocated a consultant mentor for feedback, support and development.

Special SR duties: meeting attendance

The Trauma ICU SR attends the multidisciplinary Trauma X-ray meeting every Monday and Thursday at 07.30 in the ED Seminar room on the ground floor.
The Cardiac ICU SR attends the Transplant meeting every Friday at 0730 in the cardiology seminar room in the Alfred Heart Centre on the 3rd floor.

Hospital (external) Ward Senior Registrar (Day 07.30-20.00) (Night 19.30 – 08.00):

These Senior Registrars are responsible for:

1. ICU Follow-ups and review of tracheostomy patients. This is done as a ward round with the ICU consultant (on for wards) and the ICU nurse liaison staff.
2. ICU referrals. This responsibility includes monitoring bed state and bed demand. This involves liaising with all of the ICU areas as well as the Patient Access Nurse (PAN Ext 60716), and managing any patients awaiting admission to the ICU under consultant direction and supervision. ICU charts should be commenced whether in recovery or ED and clear instructions for the nursing staff written in the relevant areas. Even though these patients are not physically in ICU they should be reviewed at normal ward round times with the external ICU consultant.
3. Cardiac arrests (code blues) and MET calls
4. Data base maintenance. They are responsible for maintaining the ICU Active database at the start and end of each shift by adding all ICU or HDU referrals and refusals, potential discharges and patients follow up.
5. Daily (weekday) 15:15 elective admission planning meeting in the ICU.

ICU (Internal) Night Senior Registrar 19.30 –7:30:

This job involves overseeing the care of all ICU inpatients and supervising the Registrars or SRMOs on for all the areas. The shift starts with attendance at the night handover ward round.

There is no internal SR on Monday nights; the daytime senior registrars are on-call for their pods. The daytime SR will conduct handover on Mondays (allowing the Registrar/SRMO to leave slightly earlier) and will attend to any outstanding issues before going home. If the Registrar/SRMO covering the pod overnight has any concerns, they will contact the SR directly at home. All new admissions to the unit should be discussed with the SR at home. If the SR feels that the situation warrants their attendance in the unit, they must contact the consultant on call to notify them of their need to attend. If the SR is called in...
overnight, they are still expected to complete their duties on Tuesday. SRs are asked to keep a log of any calls, and particularly any call backs.

On Monday nights, the external night SR is not responsible for patients already admitted to the unit; however, they may be contacted in the case of a time critical emergency whilst awaiting attendance of the SR on call.

**SR educational responsibilities**

Senior Registrars have protected teaching time on Wednesday and Thursday afternoons. They will be expected to present several times during the year at both of these education sessions. They are expected to attend the Journal Club during their week on clinical service to contribute to the discussion of classic and current ICU research. In addition, they may be asked to present cases for discussion.

Attendance is also expected at echo teaching and bronchoscopy teaching when rostered on for day shifts.

All SRs are encouraged to attend the weekly consultant meeting in the ICU seminar room on Tuesday afternoon when workload permits (this is not protected time). This session is used to review morbidity and mortality, quality assurance and clinical issues, as well as administrative aspects of the consultant role. It is expected that those SRs who have passed their fellowship exam will attend these meetings when they are rostered on, if clinical workload permits.

SRs are also integral to the research endeavours of the unit. They are strongly encouraged to be involved in a research project during the year. There are ample opportunities to complete the formal project aspect of CICM training. SRs are also expected to identify patients who may be eligible for enrolment into a trial. In some cases, we also depend upon the SRs to prescribe or initiate treatment in accordance with trial methodology. Please see appendix on research for more information about the specific trials currently being undertaken in the ICU.

**ICU FELLOWS**

Fellows in the Alfred Intensive Care are senior CICM or equivalent trainees, recognised for having completed their fellowship exam, and have completed their minimum training time for the CICM (or equivalent). They must have at least 12 months Anaesthesia experience.

Their role and roster is the same as the SRs (see above), but includes a higher expectation of non clinical and administrative responsibilities. This reflects that they are not studying for a fellowship exam, and their level of training and experience. It is expected that they will be involved in elements of teaching, research, protocol and guideline writing/revision, and departmental management.

They answer directly to the rostered ICU consultant.
General JMS information:  
(applicable to all RMO, SRMO, Registrar, SR, and Fellows in the ICU)

EDUCATION

Co-ordinators: Drs Steve Philpot and Vinodh Nanjayya

The Alfred runs a multi-faceted, dedicated training program led by consultants. If you are rostered on, it is expected that you will attend all of these sessions. You are of course welcome to attend if you are not rostered on.

Please note that if you swap shifts, the teaching responsibilities will also be transferred to the replacement person. If you have organised a roster swap please make sure that you have passed on teaching responsibilities (if any) to the person you have swapped with.

BASIC

All RMOs, SRMOs, and Registrars with less than 12 months previous ICU experience are enrolled into the BASIC course prior to commencing work in the ICU. Please see section in this manual on BASIC course for more information. Senior registrars and Fellows who have passed their fellowship exam are invited to teach skills stations on the BASIC course.

The Journal Club

This occurs every Tuesday morning in the large ICU seminar room at 07.30. 2 papers are presented and discussed as a group. One of the post fellowship SRs will liaise with the education co-ordinators and take responsibility for the administration and smooth running of the Journal Club. Papers will be distributed by email to all SRMOs and registrars in the preceding week. Approximately monthly, the journal club will be replaced by a presentation by one of our consultants relating to their own research and publications, as indicated on the roster. Breakfast is provided at these meetings, and it is compulsory for those rostered on.

Wed Lunchtime Teaching

From 13.00 to 15.00 each Wed, in the large ICU seminar room, there is departmental teaching for all JMS. This is protected training time and trainees should have no ICU duties while teaching is on – i.e. the consultant on duty should take the ward phone for that period. Lunch is provided, courtesy of industry sponsorship. Again all trainees will be rostered in advance to take part in the teaching.

These sessions consist of

1) Data interpretation session; Each Registrar and SRMO working day shifts presents a 10 -15 minute Powerpoint presentation of laboratory results, radiology or any other results of interest from 2 or 3 patients in their pod. This session should be interactive; the Registrar or SRMO presenting should ask the audience for interpretation of results. The presentations are saved on the shared drive of the computer as a useful reference for those studying for exams. They should be no longer than 15 minutes each; the preparation of these is not expected to be onerous.
2) A session run by either an ICU consultant or an invited speaker from departments outside the ICU.

**Thurs pm Teaching – for SRs**
This is protected teaching time for senior registrars only, and runs from 14h00 -16h00 in the ICU meeting room. The first half of this session consists of a presentation by an SR. SRs will be rostered on for a couple of these throughout the year; it is expected that they will present on a topic of their choosing. This is followed by Short Answer Question practice, viva practice or hot case practice from 3-4 for those planning to sit the exam. Those registrars who have already passed the fellowship exam will be asked to contribute to the teaching in these sessions.

**Wednesday pm Primary examination teaching – for Registrars/SRMOs/HMOs**
These sessions are run by the anaesthetics department in collaboration with the ICU department. They run from February to November, in the Robert Orton seminar room in the anaesthetics department. They cover the syllabus for the anaesthetics primary examination, which is similar in many respects to the CICM primary syllabus. This is not protected teaching time; however, you should make arrangements with your SR/consultant if clinical workload allows so that you can attend as many of these sessions as possible. These sessions run from 3 – 5pm on Wednesday afternoons, unless otherwise advised.

**Echo Teaching: Co-ordinated by Dr Vinodh Nanjayya**
Wednesday morning at 07.30, held either in the conference room in the ICU offices, 3rd floor, or at the bedside. These sessions include lectures on ultrasound physiology, cardiac anatomy and normal and abnormal echocardiographic imaging, as well as bedside echocardiography practice. You are encouraged to perform and record bedside echocardiographic studies for review and discussion at these sessions. See the section below on “Echocardiography at Alfred ICU” for more details. JMS are sent weekly emails to confirm location of these sessions.

**Bronchoscopy and Airway Teaching: Co-ordinated by Dr Dave Pilcher (Bronch) and Dr Miles Beeny (Airway)**
Thursday morning at 07.30 in the Cardiothoracic ICU. These sessions cover all aspects of bronchoscopy in the critically ill patient, including equipment, patient set-up, and bronchoscopic procedures including BAL, retrieval of foreign bodies and trans-bronchial biopsy, and Tracheal intubation. We have state of the art simulation equipment available for you to practice your bronchoscopic, laryngoscopic, and intubation skills.

**Anaesthetic skills training sessions**
The anaesthetic sessions are predominately aimed at the HMOs, SRMOs and Registrars who have little or no previous airway experience. Ideally some basic airway skills such as being able to suction the airway, hold a mask for spontaneous respiration and also progress to hand ventilation are learned. There will also be exposure to LMA insertions plus oral endotracheal intubations. Preoperative assessment of the airway is also an important component.
First priority for attendance is for anyone that does not have a rostered work commitment on the day. This is at your own discretion, in your own time and is not paid. These are the only people who should be booking in advance. Second priority is anyone who is rostered to do a transport shift on the Friday and has some spare time. Third priority is those who are rostered on, provided you make arrangements to be available to return to clinical work immediately should you be required, remain contactable, and on the day have approval granted by your consultant for a vacancy confirmed by the ICU secretary Ms Janine Dyer (ext 93036) who administers the session allocations: workload often prohibits this.

Places are limited to 2 - 3 people per session. Due to rostering limitations within the Anaesthetic Department, sessions other than a Friday afternoon cannot be accommodated. Once you are confirmed for a session, you need to be changed into scrubs and report to Louvella, Dept. of Anaesthesia, 1st floor, Main Ward Block by 13.00 The Consultant in Charge for the day will allocate you to a theatre for the afternoon session which commences at 13.30. You should use the 30 minutes prior to theatre starting to assess the patients on the list and liaise with the Consultant with whom you will be working.

It is really important that if your circumstances change and you are no longer able to attend a session for which you have registered, you must let Janine Dyer know.

*It goes without saying that the success of the training program is dependant upon the input from all of the junior medical staff. Whilst the consultant group are heavily involved and interested in the education program, we rely on you all to support it. We hope that the program meets the needs of all of our trainees; the program is continuously reviewed and modified. We strongly encourage feedback from you in order to help the program evolve. Please let Steve Philpot or Vinodh Nanjayyaknow if you feel that there are aspects of the program that could be improved.*

**Supervisor of training and mentoring system**

The supervisor of training is Dr Owen Roodenburg. He will meet with you early during your term, and conduct regular In-Training Assessments with you. If you have any enquiries about your training requirements, please direct them to Owen as soon as they are recognised.

Each registrar will be allocated a mentor. Please contact your mentor within the first weeks of your rotation to arrange to meet with them. Your mentor is intended to be available to help you with issues relating to work, training and other stresses.
JUNIOR MEDICAL STAFF ADMINISTRATION

JMS ROSTERING

The ICU JMS roster coordinator is Dr Vinodh Nanjayya. Following commencement of employment at the Alfred, all correspondence regarding rosters will be sent to you at your Alfred email address, in accordance with hospital policy.

If you have any concerns at anytime during your appointment please do not hesitate to bring it to our attention immediately

The roster template

The roster template is the minimum staff will be required to work in ICU. This template works on a cycle of seven shifts of work per fortnight as a minimum:

SR/Fellows: Wednesday to Tuesday (excepting the internal night job)
Registrar and SRMOs: Fridays to Thursday
RMOs: Monday to Sunday

1. Additional shifts may be rostered over and above the template minimum
2. Amended and updated rosters can be issued with not more than 7 days notice
3. These late changes are typically to cover unplanned junior medical staff leave and absences, often for illness, significant personal or family difficulties
4. Unless a staff member has approved leave for the period concerned, they are considered available to be rostered and expected to work.
5. Please ensure you have leave or swaps arranged to meet your important personal commitments as non-rostered times may change.
6. It is the responsibility of each junior medical staff member to check every published roster for changes that may affect them. Changes are indicated on the roster in bold.
7. Please also be aware of the education roster; any education commitments must be included in any shift swaps.

The Hyperbaric rotation

There is a dedicated hyperbaric registrar. At times, when the Hyperbaric registrar is not rostered, Registrars on 12 month appointments to ICU will be seconded to the hyperbaric unit for up to one month rotations. They may not take leave during these rotations but are welcome to swap rotations. Please see Dr Tim Leong or Dr Nanjayya with any queries.

Training time

There are 2 hours of formal teaching time per week. In addition, there are a minimum of 40 minutes teaching time during the usual 3.5-4.5 hours/day of consultant supervised ward rounds, X-ray sessions and procedure supervision that fulfil the remaining 3 hours of teaching time per week. There is also mortality and morbidity review, a review of unplanned readmissions to ICU, a journal club as well as numerous Intensivist-led teaching sessions throughout the year that registrars preparing for fellowship exams should attend. ICU consultants are ready, willing and able to provide exam preparation for candidates sitting the: CICM; RACP; RACS; ANZCA and ACEM exams. There is also considerable time and effort provided by Intensivists to assist registrars with presentations for the ASM of ANZICS, and preparing manuscripts for publication. We recognize that during night shift, this teaching cannot be reasonably accessed. Thus, during night shift weeks, an extra 5 hours of teaching time will be paid. During day shift weeks, the 5 hours of teaching time is deemed to have occurred during rostered hours. On weeks off, registrars will be paid for...
the formal teaching session only if they attend. There will be no other payments for teaching time provided in ICU.

Training Time only applies to registrars in a training scheme i.e. pay classification HM24 and above, with a 43 hour week.