Australasian College for Emergency Medicine

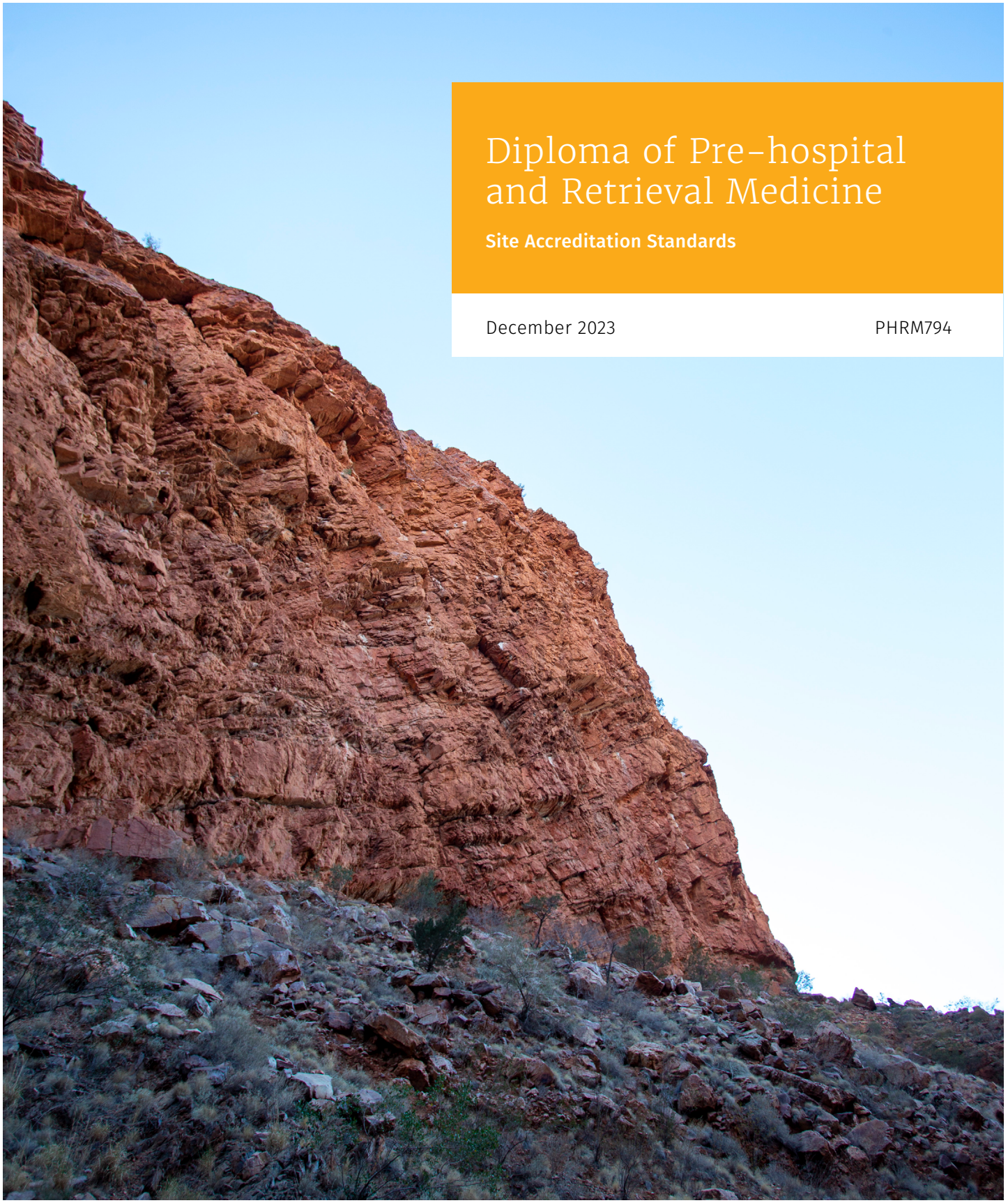
Royal Australian College of General Practitioners

The College of Intensive Care Medicine of Australia and New Zealand

ANZCA FPM

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

acem.org.au



Diploma of Pre-hospital and Retrieval Medicine

Site Accreditation Standards

December 2023

PHRM794

Document Review

Timeframe for review:	every two years, or earlier if required.
Document authorisation:	Conjoint Committee of PHRM
Document implementation:	Executive Director, Training
Document maintenance:	Certificate & Diploma Programs Team

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
1	Dec 2019	V1 Approved by ACEM Board
2	Aug 2021	V2 Approved by ACEM Board
3	Jun-2023	Minor updates throughout
4	Dec-2023	V4 Approved by ACEM Board

This set of standards was developed by:

Australasian College for Emergency Medicine
Australian College of Rural & Remote Medicine
Australian and New Zealand College of Anaesthetists
College of Intensive Care Medicine of Australia and New Zealand
Royal Australian College of General Practitioners

1. Introduction

1.1 Rationale and objectives

The Diploma in Pre-hospital and Retrieval Medicine (DipPHRM) curriculum emphasizes that competency is achieved through an incremental process of learning and development in key domains. Training Supervisors, consultants, paramedical staff, nursing staff, other health professionals and aircrew members involved in the training of DipPHRM trainees, and the environments in which they work, are crucial to this process in guiding day-to-day learning. The standards detailed in this document specify what each site must provide as part of its obligations as a Conjoint Committee of PHRM (CCPHRM)-accredited DipPHRM training site(s).

The objectives of accreditation and re-accreditation of DipPHRM training sites are:

- To ensure that the core requirements for clinical and educational experience, as defined in the DipPHRM Curriculum, are being met for all trainees;
- To assist the accredited sites in their role as training providers, not just service providers, by identifying factors that are adversely affecting their capacity to deliver effective and supported training to DipPHRM trainees; and
- To work with sites and the CCPHRM to formulate strategies that maximize training opportunities and ensure efficient and safe service delivery by DipPHRM trainees.

1.2 Essential components of the training program

The DipPHRM Training Program is a structured, postgraduate program which leads to the Diploma in PHRM. The DipPHRM is aimed at those appropriately experienced doctors who wish to work within PHRM services to actively participate in missions.

All DipPHRM training must be prospectively approved. That is, a PHRM service must apply and obtain accreditation before a trainee is to commence training. Training undertaken prior to accreditation will not be credited.

It is recognised that, due to the nature of pre-hospital and retrieval medicine, the trainee will need to have a level of functional independence, and so will need to be suitably experienced and advanced in their specialist training or be a suitably experienced Fellow. Further eligibility criteria for enrolling in the DipPHRM can be found on the ACEM website.

The ideal placement length for the DipPHRM is 12 months undertaken at 0.5FTE. However, the term may be undertaken at 1.0FTE or a minimum of 0.25 FTE*. It is recognised that differing term lengths may determine learning objectives and duties. Trainees may take a maximum period of 3 years to complete all components of the DipPHRM.

The DipPHRM training and assessment requirements are outlined in Table 1 below. However, these are subject to change and reference should be made to the DipPHRM Curriculum and Regulatoin F.

Table 1. Requirements of the DipPHRM Training Program

Placement Duration	6-months FTE
Assessment Requirements	Training Supervisor Reports every three calendar months 4 Multi-source Feedback 2 Mission Assessments 4 Direct Observation of Technical Skills 3 Direct Observation of Procedural Skills 3 Case-based Discussions
Examination	Written Examination Practical Examination

As the sites for the training of clinicians actively providing PHRM services, be they stand-alone services or units within hospitals providing PHRM services, the role and responsibilities of these sites cannot be overestimated. The Diploma curriculum emphasises that competency is achieved through an incremental process of learning and development in the domains, themes and subthemes.

** Due to FACEM Training Program regulations, ACEM Trainees must undertake the DipPHRM at a minimum of 0.5FTE.*

2. Accreditation standards

2.1 Clinical Experience

The site may provide fixed-wing, rotary wing or surface transport, or any combination thereof. It is acknowledged that some road-based services may wish to apply for DipPHRM Training Site accreditation. These sites will be assessed on a case-by-case basis by the CCPHRM. If a trainee undertakes a placement at a road-based service then they will be required to undertake a placement at a CCPHRM-accredited site that utilises an aeromedical platform.

2.1.1 Caseload for fully accredited sites

The site must have a caseload that reconciles with the requirements for a trainee within the employed medical FTE workforce, ensuring the trainee is involved in a minimum of 50 tasks per six-month period, of which:

(a) a minimum of thirty must involve direct patient contact on supervised or solo tasks, ideally including paediatric patients;

(b) a minimum of twenty must involve an aeromedical platform;

(c) a minimum of ten must be pre-hospital tasks;*

(d) a minimum of fifteen must be retrieval tasks;**

(e) a minimum of twenty critical, acuity tasks;

(f) a maximum of ten tasks to involve activated but stood down tasks and/or rescue tasks, and/or clinical co-ordination; and

(g) a maximum of ten be in simulated scenarios.

Sites may be accredited to provide:

(1) the full DipPHRM Training Program; or

(2) pre-hospital only; or

(3) retrieval only.

* If this minimum requirement is unable to be met, then the site may only be accredited for the retrieval component of the DipPHRM Training Program. Trainees will be required to complete a placement at a CCPHRM-accredited site that does offer pre-hospital experience.

** If this minimum retrieval requirement is unable to be met, the site may only be accredited for the pre-hospital component of the DipPHRM Training Program. Trainees will be required to complet a placement at a CCPHRM-accredited site that does offer retrieval experience.

Key definition for caseload terminology are provided in Appendix 1.

2.1.2 Importance of primary 'operator' experience

(1) Trainee experience as the primary 'operator' when on tasks should be maximised, although this will be at the Training/Task Supervisor's discretion, based on an accurate assessment of the trainee's abilities.

(2) There must be provision for trainees to participate in non-clinical duties when not tasked on a mission. These should be focused on pre-hospital and retrieval medicine and could include preparation of morbidity and mortality meetings, case reviews and participations in clinical audits and simulations. Evidence of these activities will need to be provided in a report from the site provider.

2.1.3 Accessing educational/training opportunities

Rosters must be designed with the objective of meeting training obligations. There must be recognition that it is essential that trainees have regular access to key educational and training opportunities.

2.1.4 Responsibility for rostering

Rostering arrangements should be arranged by staff aware of the specific training needs of DipPHRM trainees. The rostering process should ensure timely roster distribution and equitable exposure to all shift types whilst balancing trainee workload, case-mix exposure, DipPHRM training requirements, the service needs of the site, safe working hours and leave arrangements.

2.1.5 Buddy shifts

Training sites must provide DipPHRM trainees with a minimum of four buddy shifts during a six month 1.0FTE placement, or equivalent, two of which must occur during orientation. A buddy shift is when a trainee and consultant are rostered together for the duration of the same shift, to accompany each other on tasks and work side-by-side for the purpose of identifying and addressing the trainee's specific learning needs and undertaking clinical assessments and WBAs, as appropriate.

2.2 Staff

2.2.1 Supervision

Training Supervisors for the DipPHRM training program must be:

(1) specialists with qualifications in an appropriate discipline (e.g. FACEM, FANZCA, FCICM, FACRRM, FRACGP);

(2) in good standing with their parent College (CPD up-to-date, College fees paid);

(3) have demonstrated experience and expertise in pre-hospital and retrieval medicine, of at least 3 years;

(4) located and actively engaged in PHRM practice at the site to be accredited; and

(5) able to meet regularly with their trainee (i.e. at least monthly) to review the trainee's assessment, discuss cases and the trainee's training progress.

The Training Supervisor(s) must not be the Director of the site.

PHRM services that operate multiple sites within the one service must have a nominated secondary supervisor for each base to which trainees are rotated. The primary supervisor must be located at the site where the trainee(s) will undertake the majority of their DipPHRM training. A supervisor may not supervise more than ten (10) trainees at any one time.

Further eligibility criteria and responsibilities of the DipPHRM Training Supervisor are detailed in the DipPHRM Training Supervisor Position Description (PD746).

It is acknowledged that a Training Supervisor working at a site accredited only for the pre-hospital or retrieval component of DipPHRM Training may not have experience in both pre-hospital and retrieval medicine.

2.2.2 Senior medical staffing

The site must have sufficient senior medical staffing to provide clinical supervision for the trainees whilst undertaking tasks. If a 24-hour service is provided, then 24-hour supervision is required. It is recognised that, due to the nature of PHRM work, the on-duty supervisor may not always be present in person and may have limited ability to attend to assist the trainee at short notice. The supervisor should have access to telemedicine as a source of supervision. Clear processes, including verification of trainee competence (see Section 2.4.3.2), must be in place to ensure that trainees are not exposed to situations that are beyond their level of expertise. Trainees should only be sent on tasks alone when they are deemed to be competent with remote supervision.

2.2.3 Clinical support time

The site must allocate to the CCPHRM-approved Training Supervisor(s) protected time to provide the trainee with support, including but not limited to, hands-on teaching, provision of feedback, and monitoring of trainee progress.

2.3 Facilities

2.3.1 Amenities

Appropriate amenities and accommodation must be readily available should the on-duty medical team be required to be on-site continuously or require rest for safety reasons. This should be consistent with standards for Fatigue Risk Management Systems.

2.3.2 Teaching and learning

Appropriate workplace supports including, but not limited to, a networked computer with access to Clinical Infomation Access Portal (CIAP) or similar online academic library, suitable study facilities, and access to a suitable room for education and quality assurance activities.

2.4 Activities

2.4.1 Orientation

The site must provide a formal structured orientation/induction program for trainees, including occupational health and safety, a minimum of two formal buddy shifts with seniors, and

- orientation to clinical medicine in the PHRM environment;
- where air transport is provided, the fundamentals of aviation medicine and safety around aircraft (e.g. 20:11 Aircraft Orientation, Helicopter Underwater Escape Training);
- where water transport is provided, safety around watercraft; and
- where road response is used, an authorised orientation to rapid response driving and use of signals, where those skills are part of the trainee's role.

2.4.2 Formal instruction

The trainee will receive formal instruction with respect to learning outcomes stipulated in the DipPHRM curriculum:

- the formal induction/orientation program;
- clinical teaching during the course of their duties, including operational exposure to a variety of cases; scheduled buddy shifts (i.e. one per month following orientation); supervised tasks; case reviews with a senior specialist; and
- participation in the site's structured education program. The education program must support the DipPHRM curriculum and as such, include education pertaining to all transport platforms, including those not utilised at the site. The structured program may comprise tutorials, case presentations, simulation, and morbidity and mortality sessions.

2.4.3 Clinical Governance Program

Across all sites, the service must provide a strong safety culture and an active quality assurance program. The quality assurance program should consist of, at a minimum, a monthly review of airway interventions, review of complex cases, and a monthly morbidity and mortality session. These should be open-forum multidisciplinary sessions involving site leaders as well as hospital practitioners and other healthcare professionals. It is expected that all staff have the opportunity to attend and participate in such sessions. When attendance is not possible, cases should be confidentially documented and available for staff review. There should also be evidence of audit involving the complete quality improvement cycle with documentation of quality improvement activities.

2.4.3.1 Clinical Practice Guidelines

As part of the implementation of consistent, up-to-date and safe training practices, the site must ensure that all clinical practice guidelines are regularly reviewed and revised, and consistently followed by all staff through a process of organisational governance, clinical audit or case reviews.

A site will need to provide evidence that they have Clinical Practice Guidelines relevant to their case mix, such as (but not limited to):

- Rapid Sequence Induction
- Front-of-neck airway access
- Chest Trauma Management, including resuscitative thoracotomy
- Pelvic and Limb Trauma Management
- Lateral Canthotomy
- Maxillofacial Haemorrhage Management
- Hypovolemic Resuscitation
- Resuscitative Hysterotomy
- Escharotomy
- Retrieval Amputation
- Ventilation Strategies
- Ultrasound (eFAST, vascular access)

2.4.4 Verification of trainee competence

The site must have an active and documented process which verifies each trainee's competence in core PHRM procedures. The verification process and documentation must not be regarded as a substitute for formal assessment of trainee competency in the Diploma Training Program. Trainees must be verified as competent to perform the following procedures by the completion of the orientation period:

- sedation,
- analgesia,
- advanced airway management,
- mechanical ventilation,
- central and peripheral vascular access and pressure monitoring,
- inotropic support,
- minor surgical interventions (simple wound care and haemorrhage control),
- ultrasound eFAST, vascular access,
- splinting and patient packaging for transport,
- front-of-neck airway access,
- tube thoracostomy,
- finger thoracostomy,
- other procedures relevant to the site.

2.4.5 Compliance

The site may provide fixed-wing, rotary wing or surface transportation, or any combination thereof. The site must comply with the joint ACEM, ANZCA and CICM Policy on the Minimum Standards for Transport of Critically Ill Patients.

The site is compliant with occupational health and safety policies and implements associated procedures.

The site is strongly encouraged to utilise a quality framework informed by relevant national safety and quality health service standards.

2.4.6 Peer Support

The site must provide a formal peer support/mentoring program for trainees.

2.4.7 DipPHRM Written Examination Invigilation

The DipPHRM Written Examination will be conducted online and undertaken at the trainee's site. The Training Site must provide an invigilator for the Written Examination.

To be nominated as a DipPHRM Examination Invigilator, an individual must be one of the following:

- DipPHRM Training Supervisor, or
- CCPHRM-approved delegate;

CCPHRM-approved delegates must meet the following criteria:

- Must not be related to the candidate;
- Must be an employee of the DipPHRM Training Site, or an employee at the site where the examination is held;
- Must maintain confidentiality at all times; and
- Must strictly adhere to the requirements for DipPHRM Written Examination Invigilators

3. Accreditation and re-accreditation procedures

3.1 Accreditation of new sites

3.1.1 Applications for accreditation

A detailed application from PHRM sites seeking DipPHRM training site accreditation must be submitted to the CCPHRM using the Accreditation/Reaccreditation Application Form obtained from the ACEM Certificate & Diploma Programs Team or the ACEM website.

Sites already accredited by ACEM for PHRM Special Skills Placements for FACEM training will be required to undergo separate accreditation for the DipPHRM Training Program.

All applications are considered by the DipPHRM Accreditation Subcommittee in the first instance. The DipPHRM Accreditation Subcommittee is responsible for arranging the site assessment, writing the DipPHRM Accreditation Report and making recommendations to CCPHRM regarding accreditation. The CCPHRM will consider the DipPHRM Accreditation Report and the recommendations proposed by the Subcommittee.

In most instances, applications are considered at the next scheduled meeting of the DipPHRM Accreditation Subcommittee. If an application is received between meetings, it will be put to the Subcommittee for consideration via eVote.

3.1.2 Applications for re-accreditation

Sites already accredited for DipPHRM training and due for reaccreditation will be sent a copy of the accreditation/re-accreditation application form.

Each site is given six weeks to complete the application form and submit it to the ACEM Certificate & Diploma Programs Team, together with required supporting documentation (e.g. rosters, in-service education program outline/timetable, etc).

To ensure the DipPHRM Accreditation Subcommittee obtains a wide range of feedback about a site, the assessment also includes information about the site compiled from the DipPHRM Trainee Exit Questionnaire which all Diploma trainees are required to complete at the end of training. Caseload data at a site provided by the trainee's logbooks will be included in the re-accreditation process.

The documentation and data outlined above is evaluated according to the agreed standards as detailed in Section 2. The evaluation of the information relating to the training site is completed by two a member of the DipPHRM Accreditation Subcommittee and a member of the CCPHRM. To facilitate the evaluation process, a short template report document is used which asks the assessors to rate the site according to each standard: Satisfactory, with no recommendations; Satisfactory, with recommendations; and Not Satisfactory. In the event of disagreement about the most appropriate re-accreditation rating, the final decision is made by the Chair of the CCPHRM, in consultation with the CCPHRM when necessary.

3.1.3 Accreditation and Re-accreditation Ratings

In accordance with the current standards detailed in Section 2, the evaluation of applications results in one of the following outcomes:

- **Accredited**: Training site meets all standards and is granted full, Pre-Hospital or Retrieval accreditation for the maximum period of 2 years, or
- **Accredited with conditions**: Training site falls short of meeting all standards and is granted accreditation with conditions for one year. The site is advised of recommendations for improvement which must be addressed within a specified period if accreditation is to continue, or
- **Not accredited:** Training site falls short of meeting all the standards and the application is rejected. If required, a site visit is conducted to investigate the site further before a final decision is made about rejection/loss of accreditation.

The training site receives a brief template report document which indicates the outcome of the application. If accreditation with conditions is granted, the report will detail reasons for the rating, recommendations and the timeframe for addressing those recommendations (where applicable).

In the event that a training site is dissatisfied with an accreditation outcome, training sites may apply for reconsideration of the decision as per the ACEM Reconsideration, Review and Appeals Policy.

3.1.4 Site assessment

Accreditation of training sites for DipPHRM training will be conducted in-person or via videoconference. The CCPHRM reserves the right to conduct a site visit as part of the accreditation/reaccreditation process in the following circumstances:

- It is a site's first accreditation as a DipPHRM training site;
- In the event there are concerns about the site's effectiveness as a training site;
- At least every second accreditation cycle.

Site visits may be conducted at random for quality assurance purposes.

The purpose of site assessments, conducted by CCPHRM and DipPHRM Accreditation Subcommittee representatives, is to make balanced and objective assessments of each site's suitability for accreditation in accordance with curriculum and training requirements and the defined accreditation standards as specified in this document. In doing this, the site assessment team will gather and analyse a range of information and viewpoints at each site, including feedback from specialists, trainees, senior nursing staff, other health professionals, and site management. Telephone interviews may also be conducted.

The relevant training site will be given notice of the assessment, which will be scheduled for a mutually convenient date. A timetable for the visit will be prepared by the Certificate & Diploma Programs Team, in consultation with the Director of PHRM Services at the training site or their nominee.

Each site assessment team will comprise:

- One member of the CCPHRM from a state/District Health Board other than the one in which the site assessment is being conducted; and
- One representative of the DipPHRM Accreditation Subcommittee from a state/District Health Board other than the one in which the site assessment is being conducted; and
- A senior member of the ACEM Education and Training staff; and
- A trainee representative from the relevant Diploma training program (optional, at the discretion of the Chair of the CCPHRM).

In the circumstance that sufficient representation from either the DipPHRM Accreditation Subcommittee or Conjoint Committee of Pre-Hospital & Retrieval Medicine cannot be confirmed, a recent (within five years) member of either committee or a member of the DipPHRM Board of Examiners from a state/District Health Board other than the one in which the site assessment is being conducted, can be selected provided their representation is approved by the DipPHRM Accreditation Subcommittee.

Site assessments will usually take place over a two-hour period and will comprise most, but not necessary all, of the following:

- Confidential interviews with the Director of PHRM Services, Director of Training, Training Supervisor, consultants, senior nursing staff, paramedics, at least one Diploma trainee, other appropriate health professionals, site management, aviation provider/base manager;
- Virtual tour of the training site, as required, including, but not limited to, the room to be set aside for the use of trainees, and other areas as suggested by the training site. CCPHRM reserve the right to request images of particular areas.

In collaboration with the Manager, Certificate & Diploma Programs, the site assessment team will complete a report based on the interviews using the CCPHRM-approved template. This report will be submitted to the DipPHRM Accreditation Subcommittee when it considers the training site's application for re-/accreditation. If further information is required from the site in order to complete the report, the Director of PHRM Service will be contacted by an appropriate member of the site assessment team.

Training sites must inform the CCPHRM immediately if there is a change in staffing or services provided as detailed in the Accreditation/Reaccreditation Application Form.

Given the implications for trainees at sites that lose accreditation, the final decision on whether or not to withdraw accreditation is made by the entire CCPHRM. The CCPHRM may decide that a physical or additional site visit is required to further assess the site's suitability as a training site before a final decision is made.

If the CCPHRM agrees that loss of accreditation is appropriate, their recommendation will be referred to the ACEM Board. The final decision on withdrawing accreditation is made by the ACEM Board. The training site and trainees at the site will be given a minimum of six months' notice of loss of accreditation, so that trainees can make other training arrangements, if necessary.

A site which has lost accreditation may write to the Chair of the CCPHRM requesting reconsideration of the decision. The final decision on whether or not to uphold the loss of accreditation is made by the ACEM Board, in consultation with the CCPHRM. In the event that a training site is dissatisfied with the reaccreditation outcome, training sites may apply for reconsideration of the decision as per the ACEM Reconsideration, Review and Appeals Policy.

A site that has lost accreditation may re-apply for accreditation at a later date, once it is in a position to meet the standards.

4. References

- ACEM Regulation F - DipPHRM Training Program
- DipPHRM Curriculum
- Policy P03: Guidelines for Transport of Critically ill Patients
- DipPHRM Accreditation/Reaccreditation Application Form
- DipPHRM Trainee Exit Questionnaire
- DipPHRM Training Supervisor Application/Resignation Form
- PD746 DipPHRM Training Supervisor Position Description

1. Appendix Caseload Terminology

The term Pre-hospital and Retrieval Medicine (PHRM) refers to a system of specialist clinical practice inclusive of clinical coordination, operational response, and clinical governance

Clinical coordination

Clinical Coordination involves the dedicated multidisciplinary (medical, nursing, paramedical, logistics) Coordination system or processes/ led by appropriately qualified and credentialed specialist medical practitioners in Pre-Hospital and Retrieval Medicine (PHRM) offering high level clinical and logistical advice and decision-making. Specialists should be employed after demonstrating competency in PHRM and maintaining Fellowship in at least one of the CCPHRM Colleges. Ideally, Clinical Coordination should be provided from a dedicated, centralized, operational centre with 24/7 access via a single point of communication (ie, statewide telephone number).

Clinical coordination commences with a referral for medical assistance (usually from a referral facility, incident scene, or ambulance despatch service). Planning and intervention priorities for each case must be determined quickly and efficiently via Standard Operating Procedures (SOP's) and can include:

- immediate care or advice;
- Telemedicine;
- need for retrieval team and optimal skill set required;
- urgency of despatch;
- destination planning;
- consideration of complex decision-making involving logistics, crew, and transport platforms.
- creation of pre-flight assessment documentation and updates on clinical/logistical considerations during transport.

Operational response

Operational Response refers to the dedicated multidisciplinary teams with flexibility to respond to the referral facility or incident scene and provide a level of clinical care at least equivalent to the referring facility and preferably enhanced. This team should provide 'point to point' care from referral centre to receiving facility overseen by the Clinical Coordination Centre. For the purposes of DipPHRM accreditation, PHRM tasks can be subdivided into the following, depending on the patient's location;

- Pre-hospital task ('primary') - A pre-hospital task is any clinically coordinated task that involves a patient requiring assessment +/- intervention in the out of hospital environment. A patient assessment +/- intervention may occur by the roadside, in a public place or in a private dwelling. It is a location that does not normally have 'medical' personnel on site to assess and manage the patient. The out of hospital environment typically has nil or limited health resources available such as oxygen, suction and other conventional treatment therapies although these will arrive with healthcare teams (e.g., ambulance).
- Modified primary - occurs when, due to time and/or distance, a pre-hospital patient (as defined above) has left the scene of the incident and by the time the PHRM team arrives that patient is in a healthcare environment with minimal health infrastructure (e.g., rural clinic, GP practice, back of an ambulance) and with limited clinician input (e.g., nurse/paramedic only, single handed GP)
- Retrieval task – A retrieval task is a clinically coordinated inter-hospital transfer of critical, high dependency, high risk, ill and injured patients using specialised clinical retrieval staff, transport platforms, and equipment. The scope of these tasks encompasses transfers from (and between) all health care facilities with an inpatient capability and also includes transfers to and from an Intensive Care Unit (ICU).

Independent of location, patient acuity can be described as:

- Critical acuity
- High dependency
- Low/Nil acuity

Tasks not considered for the PHRM accreditation process include cases in the Low/Nil acuity bracket that are not directly requiring clinical coordination.

Clinical governance - In addition to specialist medical practitioner led clinical oversight, PHRM services must also utilise a dedicated multifaceted clinical governance framework. This should encompass multidisciplinary audit, morbidity and mortality reviews, risk management, training and education, competency and credentialing and research, where possible. These facets must be specifically designed for the pre-hospital and retrieval environment and ideally delivered by specialists in PHRM. For example, training and education in PHRM must also encompass the low frequency, high acuity, high consequence challenges inherent in the PHRM environment in addition to critical care knowledge and skills from the hospital environment. Clinical governance also extends to operational performance ie response times, online service availability etc.

The DipPHRM Accreditation Standards specify that the caseload for a fully accredited site includes a minimum of twenty (20) critical acuity patients. It is expected that critical acuity cases are shared between the pre-hospital and retrieval environments for services accredited in both areas.

The following definitions are to be used as a basis for DipPHRM Training Sites to assign cases for trainees to achieve their volume-based practice and are subject to audit. It is expected that trainees aim to cover a breadth of the cases listed during their training.

Critical acuity includes (but not limited to):

- Intra-Aortic Balloon Pump
- ECMO
- Multiple vasoactive infusions
- RSI or pre-hospital anaesthesia
- Invasive and/or non-invasive ventilation
- Requirement for emergent blood/blood product transfusion by team
- External/internal pacing
- External ventricular drain
- Head injury with altered level of consciousness (LOC) or decreasing LOC (GCS ≤ 13)
- Multi system trauma with CVS compromise
- Undifferentiated trauma with abnormal vital signs
- High spinal injury
- Limb threatening injury with neurovascular compromise requiring intervention before/during retrieval.
- Active labour in high-risk pregnancy
- Maternal cardiac failure
- Eclamptic or Pre-eclampsia on MgSO4 infusion
- Ante-partum or post-partum haemorrhage with abnormal vitals
- Heavy IV sedation for disturbed or agitated patients (e.g., ketamine infusion)

- Requirement for procedural sedation by team
- Preterm or term neonate with significant comorbidities
- Advanced life support interventions, adult, paediatric or neonate (e.g., BVM, defibrillation)
- Any winch rescue requiring physician intervention.
- Two or more high dependency criteria below

High dependency includes (but not limited to):

NB If patient has more than one high dependency criteria then is classified as critical acuity;

- ICU or HDU admission
- Transport for revascularisation/interventional radiology procedure (cardiac, neuro, pulmonary, vascular)
- High risk chest pain for primary PCI or immediately post lysis.
- Single organ failure requiring support.
- Low dose single vasoactive infusion
- Moderate injury in one body compartment
- Confirmed/suspected unstable spinal injury.
- Single long bone injury with significant MOI
- Operating theatre within two hours of arrival
- Threatened labour
- High-risk pregnancy
- Any tasking requiring two or more-person manual handling (e.g., patient on spinal board)
- Significant envenomation
- Significant potential for deterioration that may require critical intervention (e.g., threatened airway)

Low/Nil dependency include (but not limited to):

Most transfers not included above will fall into this category, but some specific examples are included below.

- Cases not directly requiring clinical coordination
- Cases not requiring PHRM team members (ie use of service assets only)
- Isolated distal fracture or NOF, low MOI
- Observation/monitoring only with normal or near normal vital signs.
- Transfer for clinic/outpatient appointment/review.
- “Step-down" care for rehabilitation
- Transfer back to referring facility at completion of care

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au