SWEDISH CRITICAL CARE UNIT

Intensive Care Unit Practice Guidelines

I. Personnel

A. Physicians and surgeons caring for patients in the Swedish Medical Center Adult Intensive Care Unit (ICU) must have Critical Care Clinical Privileges. Attending physicians and surgeons in the ICU must have Category I Critical Care Attending Privileges (Non-Intensivist). Intensivists must have Category I and Category II Critical Care Privileges (Medical Intensivist/Critical Care Medicine or Surgical Intensivist/Surgical Critical Care). Consulting physicians do not require Non-Intensivist privileges, but they are expected to adhere to the ICU Practice Guidelines.

B. Each day, an Intensivist from the above specialties will be designated as the Intensivist of the day. The designated intensivist physician or surgeon will provide care exclusive to Swedish Medical Center, with no concurrent outside call responsibilities. That Intensivist will round on patients on their ICU service and provide critical care consultation and management to new patients admitted to the ICU that day. That Intensivist will supervise his/her specialty multidisciplinary ICU rounds, as detailed below.

C. The Medical Intensivist of the day will be physically present in the ICU during daytime hours for 12 continuous hours, 7 days per week. During daytime hours, the Medical Intensivist will respond to all phone calls within 5 minutes and be available to the bedside of an ICU patient within 5 minutes. During non-daytime hours or when not physically present in the ICU, the Medical Intensivist is expected to respond to all phone calls within 5 minutes and be available at the bedside of an ICU patient within 30 minutes.

D. In the event of a life-threatening patient emergency during non-daytime hours, the Surgical Intensivist will respond to the bedside of any ICU patient within 5 minutes. If the patient is covered by the Medical Intensivist, the Surgical Intensivist will assess the patient and immediately notify the Medical Intensivist, who will be available at the patient’s bedside within 30 minutes.

E. The Surgical Intensivist will be physically present on the Swedish Medical Center campus and available to respond to the bedside of his/her unstable patients within 5 minutes for 24 hours per day, 7 days per week, as per the requirements of a Level I Trauma Center. The Surgical Intensivist will provide non-daytime cross-coverage of patients on the Medical Intensivist service who experience life-threatening emergencies, as above.

F. In the event of a patient emergency calling them from the ICU, Intensivists from different specialties may arrange cross-coverage in the ICU by another Intensivist.

G. The Medical and Surgical Intensivists of the day will work jointly to control ICU beds, determining which patients are appropriate for ICU admission or transfer/discharge.

H. Swedish Medical Center will designate one Medical Intensivist to serve as ICU Director for a defined term. That physician will oversee physicians and surgeons practicing in the ICU for adherence to ICU Practice Guidelines, utilization of ICU protocols, and achievement of quality indices and Core Measures.
II. Procedures - All physicians and surgeons practicing in the ICU are expected to adhere to the following guidelines, in order to maintain ICU privileges.

A. All patients admitted to the ICU will be classified as “stable” or “unstable” based on acuity of illness.

1. **Unstable patients** are those patients with
   
   a. Acute respiratory failure requiring mechanical ventilation through an endotracheal tube via a nasal or oral route, excluding post-operative patients who remain mechanically ventilated after general anesthesia.
   
   b. Hemodynamic instability requiring intravenous medications to maintain blood pressure in a defined target range.

2. **Stable patients** are all others.

B. Source of patient admission.

1. When a patient is identified for ICU admission from the Emergency Department (ED), the ED physician will assign the patient to an Attending Physician or Surgeon based on the request of the outpatient primary care physician (PCP). For patients who are unassigned, ED physicians will assign patients to the Attending based on the established protocol for ED assignment. The ED physician will contact the designated Attending to notify him/her of admission. If the Attending is not an Intensivist, the ED physician will also contact an Intensivist (medical or surgical) to evaluate the patient in conjunction with the Non-Intensivist Attending.

2. When a patient is admitted to the ICU from the operating room (OR), post-anesthesia care unit (PACU), or another inpatient medical ward by a Non-Intensivist Attending Physician or Surgeon, they will contact an Intensivist (medical or surgical) to evaluate the patient.

3. When a patient is admitted to the ICU by direct hospital transfer to a Non-Intensivist Attending Physician or Surgeon, they will contact an Intensivist (medical or surgical) to evaluate the patient.

C. Following notification of patient admission to ICU from the ED, OR, PACU, or floor transfer, Intensivists must begin their evaluation of a new ICU patient within the following time frame:

1. **Unstable patients** – within 30 minutes.
2. **Stable patients** – within 120 minutes.

If a patient’s transfer to the ICU is delayed, the Intensivist must evaluate the patient in the ED or PACU.
D. For all unstable patients, the Intensivist will admit the patient to the ICU and primarily manage the ICU care. He/She will serve as attending of record during the patient’s ICU stay until the patient becomes stable.

1. The Intensivist will evaluate the patient within 30 minutes of ICU admission, dictate a history and physical examination note, round on the patient daily, review and act on test results, write orders, perform procedures consult specialists, communicate with support staff, and review care for adherence to ICU protocols and quality measures. The Intensivist will field all phone calls from critical care nurses and staff regarding patient’s ICU care.

2. The Intensivist will communicate with the Non-Intensivist Attending Physician at the time of the initial evaluation of the patient and daily thereafter. The Intensivist will work with Attendings in medical or surgical specialties to utilize all order sets and clinical pathways pertinent to their specialty.

3. The Intensivist will communicate with the family at the time of patient admission to the ICU and on a regular basis thereafter. For unstable patient requiring ICU stay for more than one week, the Intensivist will coordinate and lead weekly multi-disciplinary meetings with the family.

4. The Non-Intensivist Attending will evaluate the patient at a time frame requested by the Intensivist, not more than 14 hours of ICU admission. He/She will dictate a consultation note if the patient is a new hospital admission, or provide a written transfer note if the patient is an in-hospital transfer. He/She will round on his/her patient daily, during the ICU stay and through hospital discharge.

5. As needed, the Non-Intensivist Attending will communicate with the patient’s PCP on ICU admission and thereafter. He/She will communicate with the patient’s family on admission and participate in weekly multi-disciplinary family meetings at the request of the Intensivist.

6. Non-Intensivist Attendings in medical subspecialties, general surgery, or surgical subspecialties will manage aspects of patient care particular to their specialty. They will perform any procedures and order any diagnostic tests or consultations they deem appropriate to their specialty care. They will implement any order sets or protocols particular to their specialty. They will field all phone calls from critical care nurses on issues pertinent to their specialty.

7. When a patient who is initially admitted to the ICU as unstable subsequently becomes stable, the Intensivist will then review the case with the Non-Intensivist Attending, and the Non-Intensivist Attending will assume primary ICU management responsibilities, with the Intensivist co-managing ICU care, as below. The Non-Intensivist Attending will then write an order in the chart stating that he/she will become attending of record from that time onward in the patient’s hospital stay.
E. For all stable patients, the Non-Intensivist Attending Physician or Surgeon will admit the patient to the ICU and serve as attending of record. The Intensivist will co-manage the patient’s ICU care.

1. For all stable ICU patients, the Non-Intensivist Attending will evaluate the patient within 2 hours of notification of ICU admission and provide a dictated history and physical if the patient is newly admitted to the hospital. He/She will round on the patient daily, review and act on test results, write orders, consult specialists, communicate with support staff, and field all phone calls from critical care nurses regarding the patient’s care.

2. The Non-Intensivist Attending will communicate with the PCP on ICU admission and as needed thereafter.

3. The Non-Intensivist Attending will communicate with the patient’s family on ICU admission and on a regular basis thereafter. For patients requiring ICU stay for more than one week, he/she will coordinate and lead multidisciplinary meetings with the patient’s family.

4. The Intensivist will be available within 2 hours of notification of ICU admission at the patient’s bedside to perform the initial evaluation of the stable patient and assist the Non-Intensivist Attending with co-management of ICU care of the patient.

5. In co-managing ICU care, the Intensivist will provide a written and/or dictated consultation note, round on the patient daily, write orders, perform procedures, communicate with support staff, ensure adherence to ICU protocols and quality standards, and communicate to the Non-Intensivist Attending at the time of his/her initial consultation and daily thereafter.

6. The Intensivist will communicate with the patient’s family at the time of his/her initial consultation and on a regular basis thereafter. He/She will participate in multidisciplinary family meetings at the request of the Non-Intensivist Attending.

7. When a patient who is initially admitted to the ICU as stable subsequently becomes unstable, the Non-Intensivist Attending is required to immediately notify the Intensivist of the change in patient status. The two physicians will then discuss the patient’s case, and the Intensivist will assume primary ICU management responsibilities, as above. The Intensivist will write an order in the chart stating that he/she will primarily manage ICU care of the patient and become the attending of record from that point onward.

8. At the time of ICU discharge, the Intensivist will review the patient’s ICU course and plan of care with the Non-Intensivist Attending and provide him/her with an interim ICU summary and formal hand-off. The Intensivist will not follow the patient out of the ICU, unless specifically requested by the Attending to provide ongoing consultation.
F. Trauma Surgeons will admit their patients to the ICU and serve as attending of record on their patients. Trauma surgeons and their team who have Surgical Critical Care privileges will manage all aspects of their patient’s ICU care. The trauma surgeons may consult the Medical Intensivist for co-management at their discretion. Patients on the trauma service will be covered by the daily multidisciplinary trauma rounding team, as below. Trauma surgeons are available to other physicians as Critical Care consultants for stable patients, which will suffice for an Intensivist consultation.

G. Cardiovascular Surgeons will admit their patients to the ICU and manage all aspects of their ICU care. At their discretion, they may consult the Medical or Surgical Intensivist. The Medical Intensivist will review the charts of all patients admitted to the Cardiovascular Surgery service at the time of their ICU admission, by the time frame noted above, and make a notation in the chart of their review. They may contact the Cardiovascular Surgeon at that time with any recommendations regarding ICU care. The Medical Intensivist and medical multidisciplinary ICU rounding team will round on these patients daily to assess adherence to ICU protocols and Core Measures.

H. Neurosurgeons will admit their patients to the ICU and manage all aspects of their ICU care. At their discretion, they may consult the Medical or Surgical Intensivist. The Medical Intensivist will review the charts of all patients admitted to the Neurosurgery service at the time of their ICU admission, by the time frame noted above, and make a notation in the chart of their review. They may contact the Neurosurgeon at that time with any recommendations regarding ICU care. The Medical Intensivist and multidisciplinary medical ICU rounding team will round on these patients daily to assess adherence to ICU protocols and Core Measures.

I. Neurologists will admit to the ICU all acute stroke patients who require ICU care. The Medical Intensivist will serve as a critical care consultant to the neurologist in the ICU and will either manage or co-manage all non-neurologic aspects of ICU care, depending on whether the patient is unstable or stable, as above.

If neurologists require the assistance of a hospitalist for continuity of general medical care outside of the ICU, the neurologist may consult a hospitalist early in the patient’s ICU course to allow the hospitalist to follow the patient. Once the patient is ready to transfer out of the ICU, the Medical Intensivist will sign off the case and pass on to the hospitalist ongoing management of medical issues. The Medical Intensivist will not follow the patient out of the ICU unless requested by the neurologist or hospitalist.

J. Consulting physicians must evaluate all new ICU consults within the time frame requested by the Non-Intensivist Attending Physician or Surgeon or Intensivist but no later than 24 hours from the time the consult is requested.

K. If emergent consult is necessary, the requesting physician shall personally communicate such to the consulting physician. Requests for routine (non-urgent) consultations may be documented in the progress notes or by using the prescribed Request for Consultation Form. The ultimate responsibility for securing the necessary consultation is upon the requesting physician.
L. All attending and consulting physicians must keep an updated list of contact numbers available for the ICU nursing staff. These must include direct cell phone or pager numbers, along with their answering service number. All physicians and surgeons practicing in the ICU, Intensivists, Non-Intensivist Attendings, and Consultants, must respond to telephone calls or pages from the ICU within 5 minutes. Critical care nurses will convey added urgency of pages by appending *911 to the page.

M. Intensivists from each service (medical or surgical) will conduct daily multidisciplinary ICU rounds on their patients. The ICU rounding team will consist of the Intensivist, the ICU Nursing Director or Assistant Director, the ICU charge nurse, bedside critical care nurse, respiratory therapist, pharmacist, nutritionist, case manager, and chaplain, as available. The ICU team will use a rounding check sheet to track quality information. As necessary, the Intensivist will make documentation in the chart or telephone the Non-Intensivist Attending with recommendations regarding patient care.

N. In emergent circumstances, the critical care nursing staff may call upon an Intensivist from any specialty to write orders on his/her own authority for any ICU patient. However, the nursing staff must immediately inform the Non-Intensivist Attending, and the Intensivist must initiate a follow up discussion with that physician and, as needed, with the main Intensivist on the case.

O. All physicians and surgeons with Non-Intensivist Critical Care Privileges will be required to submit a minimum of 8 ACGME approved Category I continuing medical education (CME) hours in topics related to critical care at the time of each reappointment. This includes topics in critical care pertinent to the physician’s specialty. Recommended providers of CME credits on critical care topics include a) national conferences through the American College of Surgeons, American Board of Internal Medicine, Society of Critical Care Medicine, etc.; b) Board Review courses or modules for Critical Care Medicine through the ABIM or Surgical Critical Care through the ABS; and c) the FCCS course provided by the Society of Critical Care Medicine. Alternate sources of CME credit are subject to approval by the ICU Advisory Committee or the Medical ICU Director.