VUMC Multidisciplinary Surgical Critical Care Service

DELINEATION OF MDSCC / PRIMARY SERVICE RESPONSIBILITY AND COMMUNICATION

Scope of Care:
The management of critically ill surgical patients is complex, requiring input from multiple services. Multiple service involvement can create circumstances of apparently dispersed responsibilities and lines of authority. Such circumstances can be detrimental to patient care. The following specifically outlines management responsibilities of the Critical Care and primary services.

The scope of the ICU service will be limited to evaluation and management of problems separate and distinct from routine postoperative surgical care. These services include but are not limited to:

- Ventilator management
- Hemodynamic management
- Management of coagulopathy
- Diagnosis and management of nosocomial infection
- Nutritional support
- Venous thromboembolism screening, prophylaxis and treatment
- Management of renal failure exclusive of dialysis
- Coordination of subspecialty consultations
- End-of life care

In addition, the ICU service will assume primary responsibility for interacting and coordinating ancillary services required for care of the critically ill surgical patient including, but not limited to:

- Nutritional services
- Infection control
- Respiratory therapy
- Pharmacy

Interactions with Surgical Services:
The responsibilities and activities of the surgical critical care services are listed above. These responsibilities have been chosen to complement those of the surgical services caring for patients admitted to the ICU and in essence, results in what amounts to co-management. It is expected that the surgical services first evaluating the patient on admission review their patients daily and document issues pertinent to their surgical care throughout their ICU stay.

Decisions regarding performance and timing of surgery related to surgical site:
The decision as to when and whether operative or percutaneous interventions are warranted for complications related to the surgical site will be left to the surgical

services. If an issue arises that might call for operative management (e.g. taking a patient back to the OR for bleeding or intra-abdominal sepsis), then this decision, its timing and its performance must be left to the surgical team with input form the ICU team.

Decisions regarding procedures and therapies in the ICU: The placement of central venous catheters, pulmonary artery catheters, percutaneous tracheostomy (performed outside the operating room) or feeding tube placement and insertion of chest tubes (depending on the clinical setting) will primarily be performed by the ICU team. Decisions regarding the timing and need for such procedures will be made through collaboration between the primary and ICU teams. The primary team must be notified of all invasive procedures.

Nutritional support: The timing, route and type of nutritional support will be left to the discretion of the ICU service unless there is concern over the integrity of the alimentary tract (e.g. status post bowel resection). In these scenarios it is expected that the surgical services provide guidance as to when feeding may occur via the enteral route.

Antimicrobial therapy: There are wide variations in practice patterns for the use of antimicrobial therapy for management of surgical site infections and nosocomial infections unrelated to the surgical site. Antibiotic prescribing practices within an ICU alter the rate of resistant infections within that unit. Additionally, the frequency of pathogens and their sensitivities vary from unit to unit. Thus, antimicrobial therapy directed toward pathogens at all sites will be left to the discretion of the ICU service with input from the surgical team. It is preferable that the ICU service maintains oversight of antimicrobial therapy so other infections outside of the surgical site are considered in the choice of agents.

Communication with family / End of life issues: The preference for which team maintains primary responsibility for coordinating meetings and providing information regarding plans and prognoses with family members may vary depending on the clinical scenario. However, this responsibility must be clearly delineated at all times. It is expected that the surgical services maintain contact with the family members and provide whatever information is necessary and pertinent to care but the critical care team may assume the primary responsibility for communicating current condition and prognosis when a patient's critical illness outweighs the primary surgical issues. Major decisions, particularly those specific to withdrawal of care, must be coordinated with the services caring for the patient and the ICU service will generally assume primary responsibility for relaying this information to the patient's family, ideally in concert with the most actively involved surgical service.

ICU Discharge: The ICU service will maintain primary responsibility for assessing which patients are appropriate for discharge on any given day. However, discharge decisions will be made in conjunction with the primary service. The ICU residents will write the discharge orders and communicate concerns with the receiving resident. At times, patients may require observation within the SICU after acute issues that mandate

Surgical Critical Care Service's involvement. On such occasions, the primary service will assume full responsibility for the patient and orders.

It is anticipated that there will be overlap of other responsibilities not listed above. Communication between the ICU service and the surgical services is critical to assure that the entire spectrum of care is provided. Discussions between the Surgical Attending and the ICU Attending are encouraged to coordinate care and are mandatory when treatment plans diverge.

8/19/03

_____

Addison K. May, MD, FACS, FCCM
Professor of Surgery and Anesthesiology
Director-Surgical Critical Care
Reviewed 7/1/2008