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Dedicated Resuscitation Unit Improves Transfer Times

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A critical care resuscitation unit (CCRU) at the University of Maryland Medical Center (UMMC) has significantly improved transfer times for non-trauma critically ill patients, according to a recent study (Scalea et al. 2016).

In its first full year of operation, for the subset of adult patients admitted for critical care, transfers increased 64.5 percent compared to a previous year (2,228 vs. 1,354), with a 93.6% increase in critically ill surgical patients. Of the 2,228 patients, 1,318 (59.2%) were transferred to the CCRU; the remaining 910 patients were transferred directly to a UMMC ICU. More transfer patients required an operation during their hospital stay (46 percent vs. 31.1 %) and a higher percentage were in the operating room within 12 hours of arriving (41 % vs. 21.4 %). For patients requiring operations, median time to arrival and operating room (118 vs 223 minutes and 1,113 vs 3,424 minutes, respectively) and median hospital length of stay (13 vs 17 days) were reduced significantly. Patients arrived in nearly half the time (129 vs. 234 minutes). The CCRU also significantly decreased the percentage of lost admissions from 25.7 % to 14 % in this subset.

Co-author Lewis Robinson, MD, PhD, Associate Professor of Medicine at University of Maryland School of Medicine, said in an email to *ICU Management & Practice*: "We believe this is a game changer. We have begun to emulate the trauma system for non-trauma time-sensitive critical care and believe this is a logical and powerful way for academic centres to coordinate all of their time-sensitive transfers rather than having them occur haphazardly."

Dr. Robinson added: "Direct transfer to ICUs makes sense to reduce another round of handoffs. The dilemma is that availability for admissions must be 24/7. Workflow in ICUs works contrary to admissions when there are many patients to round on—either rounding gets short changed or the admission does not receive all hands on deck. When rounds are over, direct transfers could receive more attention but there is not always bed availability. In addition, most ICUs are not set up to take the referring facilities' information and establish a pre-arrival readiness posture to be able to optimise immediate evaluation, resuscitation and intervention for patients. Lastly, if we directly admitted to each specialty ICU than each would require 24/7 open staffed available beds to be able to meet emergent demand. We have 7 adult specialty ICUs and the amount of resources which would be required to make sure each individually is always ready for an emergent admission would be tremendous. Also, the different ICUs would not have optimal capability to take a patient outside of their specialty. The ability to move patients from receipt and resuscitation allows for an ongoing readiness posture to take the next patient."

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