

## Optimizing Critical Care: Imperatives for Change

Hospitals today are finding that they must restructure and provide flexibility to the entire system of “patient care.” The efficient management of cost-effective patient care can present several problems. Multiple patient transfers, up scale staffing, cardiac monitoring surveillance, and patient diversions have historically been addressed in a reactive rather than proactive manner. These issues will continue to mount and impact hospitals operationally and financially until resolved. They require a rapid response to assure patient accommodation and operational efficiency. Frequently, however, a quick answer results in significant costs.

### Multiple Transfers

A negative consequence of additional patient care levels is the need for multiple transfers. For example, patients with complications after a “high risk” cardiac or thoracic surgery may have to undergo multiple transfers from critical care to cardiac telemetry monitoring. This process is time-consuming, has built in delays with nurse inefficiencies, and potentially increases medication errors and loss of patients’ belongings. Patients, families and physicians dislike transfers, and they are especially onerous when made late at night, causing greater inefficiencies.

According to the *Nurse Executive Watch*, studies have shown that every move a hospital patient makes impacts cost and decreases the likelihood of positive patient outcomes. Addressing this problem varies throughout each facility. Multidisciplinary critical care teams could approach the situation by creating flexible units or progressive care units and decreasing the utilization of critical care units. These units can derive a “level” of care that falls between intensive care units (ICU) and medical/surgical units. Progressive care can be separated from both units and considered more cost-effective per day—and even per hour—than the ICU. For example, patients admitted to a progressive care unit (PCU) have their level of care structured around them; therefore, hospitals experience decreased transfers, delays, dissatisfaction and costs. Some facilities report as much as a twenty-five percent reduction in length of stay in selected populations.

### Up-Scaling Staff

Up-scaling nursing unit staff requires expanding the bedside nurse’s skill set. For example, the unit can increase the acuity of its patient population by expanding the skills and broadening the focus of education. This can aid in achieving nurse goals and nurse retention. The flexibility of the unit provides greater utilization of specialized nurse-driven protocols that impact the patient’s care and decrease inefficiencies while providing greater nurse independence. This boosts the level of nurse satisfaction while providing efficient, quality, and organized patient care.

### Cardiac Monitor Surveillance

Consistency in monitoring equipment can impact critical care management and the telemetry unit’s facilitation of efficient care.

Often, hospitals use central monitoring stations with monitor technicians and a pager system to alert nurses of a patient’s potential arrhythmia. A monitor technician can assist the facility by reducing direct FTEs and allowing nurses to continue their patient care without unnecessary interruptions. Hospitals are also considering “total standardization” or complete uniform monitoring throughout the system. This approach ensures quality across the entire facility, no matter where the patient resides within the structure. This paradigm shift is often difficult to incorporate into the design of facilities that are instituting various monitoring systems pairing old technology with new. When an institution has the ability to consider the unit design and incorporate a central monitoring station, the facility can efficiently utilize space and decrease FTEs.

### Patient Diversions

With fewer beds, greater patient acuity, an aging population, and the need for monitoring capabilities, patients are often unnecessarily diverted to other facilities. Hospitals experience lost revenue and fail to fulfill their mission in providing “quality care” for the community. According to national studies by the American Hospital Association, emergency room visits increased 15% between 1990 - 1999, while the number of medical/surgical beds has declined by eighteen percent and CU beds by 4% between 1994 - 1999. To address this problem, administrators, physicians, and unit managers need to limit and adhere to strict admission and discharge criteria. This process can be supported with medical director assistance in bed triage.

Patient diversions cause dissatisfaction for patients, staff, EMS and all ancillary personnel. Traditionally, physicians have left patients who need monitoring in expensive critical care units even though their primary diagnosis was not cardiac-related. The use of flexible units accommodates patients’ changes in condition and enhances the adaptability of the entire organization.

### Necessary Steps for Future Prosperity

Although many questions remain about alternatives to expensive ICU’s, the answers are not always clear when existing units are being utilized. Despite all the medical and technological advances, only a change of mind-set about unit operations can impact all aspects of patient care. Future growth of critical care management in hospitals will rely on their ability to mobilize flexible patient care and provide amenities, while accommodating the patient-focused healing environment.

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