ED to ICU Placement

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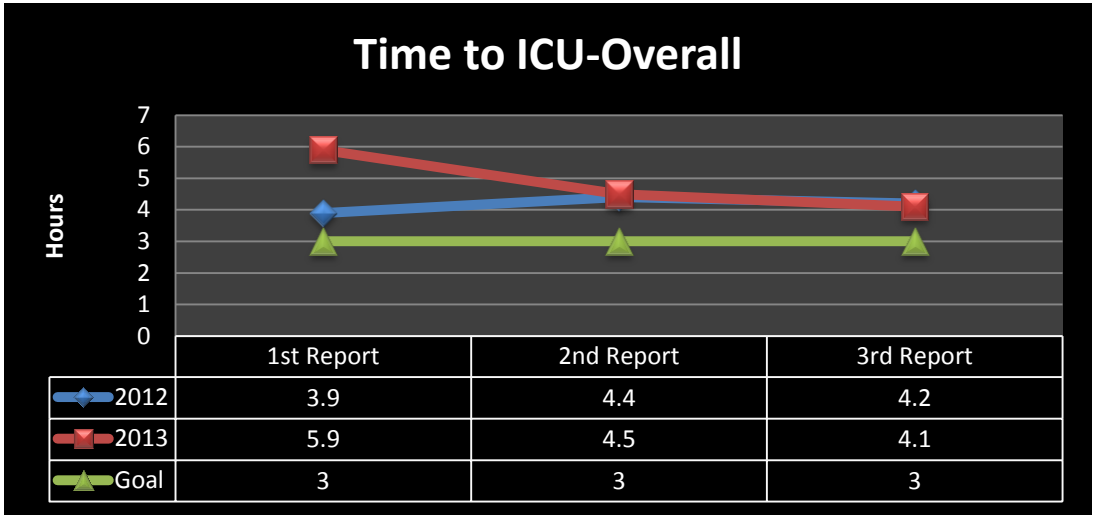
The Problem

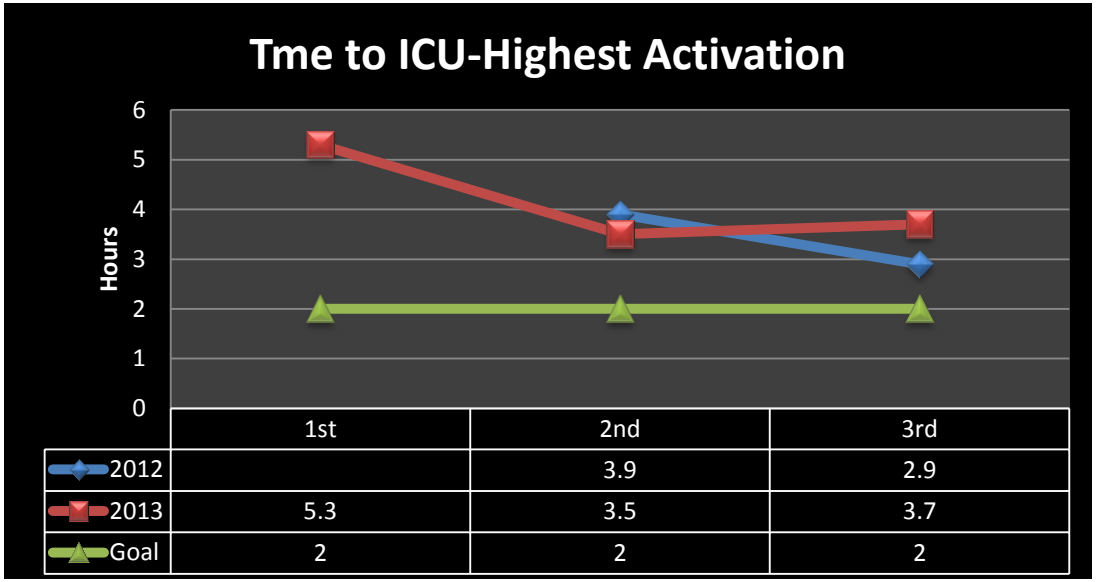
- ED boarding is associated with higher mortality and hospital length of stay
- On-going resuscitation is more appropriate in the ICU setting
- Our goal is to have the highest level activations placed within 2 hours of arrival

Intervention (s)

- Collaborated with ICU to develop a process for rapid placement of trauma patients
- ICU on the activation pager
- Review of all cases going to the ICU for delays
- ICU comes to ED to coordinate care/communication on highest level activations
- Placement dependent on bed availability:
  - Open Bed-Priority to trauma patient
  - ICU Full- Every 12hrs potential transfers out are identified.

Outcome (Results)





Sustaining The Change

- Having an empty bed available allowed placement quickly.
- We were able to get the patient from CT to the bed with no delays.
- Not having a bed available created delays.
- Open unit design fragments the ability to move pts. out quickly.

Future Directions

- Currently doing an analysis regarding high level activation timing. Possibly “holding” a bed during peak need.
- Moving towards a closed ICU
- Suggestions?