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To: **emap@list.pitt.edu**
Subject: **ICU transfers**
Copies to: **"AJ Pinevich, MD" <APINEVICH@mercy.pmhs.org>**
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Date sent: **Thu, 22 Jun 2006 14:44:47 -0400**

Over the past week or two there have been a lot of ICU boarders.

Had a very controversial case a couple of days ago where an ICU boarder had been in the ED for ~14 hours, and there was an ICU nurse for a while but no ICU bed and no ICU personnel to see the patient and write orders. After speaking with the ICU attending and the medical attending we arranged to transfer to the ICU at AGH. A consultant on the case objected to the transfer and was bumped up as high as AJ Pinevich, VP for Quality, which whom I spoke. After we had arranged the transfer to AGH there was talk of an ICU bed being made available but no prediction on when it might really, truly be available (I know you've had cases like this where an ICU bed will be ready "very soon now" and 12 hours later it's still "very soon now.")

For this particular patient, AJ and I discussed the case and came up with this solution, which seemed the best for the patient.

We kept the transfer to AGH goind, and the patient's ICU admission was prioritized. We decided it was basically a race. If the bed was ready in our ICU first and the patient physically went upstairs first, the patient stayed at Mercy. If EMS arrived to transfer the patient to AGH first, the patient went to AGH.

The patient went up to our ICU a few minutes before EMS was due to arrive.

While this is only one particular case, it might be worthwhile to look on it as a precedent. Since both EMS transfers to other ICUs and admits to our critical care units tend to be delayed over and over again, the idea of doing both in parallel makes operational sense, and to my mind, gives the patient te best chance of an ICU bed the fastest.

Your mileage may vary.

> On 7 Mar 2006 at 10:22, MacLeod, Bruce wrote:

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> 1) ICU attendings: There have been numerous discussions over the past
> year with the ICU attendings who are reticent to assume care without
> additional critical care nursing support to implement their plan of
> care. They want to respond as a "team", if you will. The tentative
> agreement was 4 hours after ICU admission decision, the ICU "team" would
> assume care of the patient even if they were in the DEM. The limiting
> factor at this point (and for most of the time) is the availability of
> Critical Care nurses.

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