Extended Abstract

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ICU Management

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Extended Abstract

The care of hospitalized critically ill patients must be suitably balanced independently of the functional unit to which they have been admitted. Most of these patients are admitted to the Intensive Care Unit (ICU), where uninterrupted management is provided, with important technological and care resources. However, hospitalization of the critically ill patient must be understood as a scale of starting and ending beyond hospital stay. Expecting critical worsening of patient requiring admission to the ICU would be of benefit to the patient, avoiding greater clinical worsening, and also would be of benefit to the hospital, by allowing improved resource management.

Intensivists are the professionals best fitted to this purpose, since they're trained to acknowledge the seriousness of an always dynamic clinical situation. Addressing this task implies a change within the traditional way of working of the ICU, since a critical patient isn't only a patient already admitted to the Unit but also the other patient admitted to hospital whose clinical situation is becoming destabilized. In this circumstance, ICU has established two planned lines. One consists of the identification of patients in danger outside the Unit and is predicated on the popularity, diagnostic orientation and early treatment of the seriously ill patient, in association with other clinical hospitals and independently of the hospital area to which the patient has been admitted. The second line successively comprises clinical care within the particular Unit, and is predicated on the promotion of safety and therefore the vigilance of nosocomial infections.

The approach adopted by this organizational model of the activities of the Intensive Care Unit has several connotations. A first and simple concern is to actively ensure the care of those patients admitted to the ICU properly in an efficient, effective and safe manner. This is easily generalizable, requiring the modifications logically related to the individual characteristics of each center and Unit. It is also necessary, and to one degree or other, and in a more or less systematized manner, has always been present in our professional activity.

A second and not always easily generalizable concern is the change in the traditional functional model of the ICU at both organizational and conceptual levels. In effect, the patient is no longer seen as only the individual admitted to the Unit, but now moreover also includes those individuals whose clinical condition can worsen, regardless of where they're hospitalized, because early clinical care in such cases can benefit the ulterior patient course. Benefit in this case is not limited to the patient, since modifying patient flow from the emergency circuit to the preferential care circuit makes it possible to lessen the burden upon the former–supervised only by professionals on duty. More precise knowledge of the clinical situation of these evaluated patients therefore allows for improved management of the existing resources. Lastly in our experience, working closer to the rest of the clinical specialties has served to improve knowledge of our daily work as intensivists, affording greater professional recognition and, undoubtedly, a greater institutional influence on the part of our Unit within the hospital.

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