Critical Care Leadership Network
Intensive Care Unit Capacity and Utilization Survey

The purpose of this survey is to take a snapshot of ICU utilization in the Greater New York region and to identify similarities and differences across ICUs and hospitals. With this information, GNYHA, UHF and the participating hospitals hope to gain insight into opportunities for improvement, collaboration and standardization in critical care processes. As with all GNYHA/ UHF data collection efforts, data that is submitted by hospitals will remain confidential and will only be reported on in aggregate.

Instructions for completing the 24-Hour ICU Survey

It is important that each hospital and unit complete the survey at the same time **(Tuesday, March 25, 2008)** and use the same methodology. The following are some important points to consider before administering the survey:

1) Please complete a **separate survey for each ICU** within your hospital

2) Someone who is very knowledgeable and experienced in the operations and activity of the critical care units should complete this survey (e.g., ICU Director, Charge Nurse, combination of clinicians, etc.).

3) The survey period is from **12:00AM (midnight) to 11:59PM on Tuesday, March 25, 2008**. Please collect data on all patients your ICU encounters during that period. This may require data collection to conclude on the following day.

4) Part I of the survey requests ICU-level data; please complete this portion at the end of the survey period.

5) Part II of the survey requests patient-level data; please complete a separate questionnaire for each patient who was cared for in the ICU during the survey period. Print as many copies of Part II as the number of patients you expect to have in your ICU.

6) Please submit the survey electronically at http://www.gnyha.org/ICUSurvey at the conclusion of the survey period.

7) Contact Zeynep Sumer at zsumer@gnyha.org or (212) 258-5370 if you have questions while completing the survey.

Thank you for your time and commitment.

PART I. CHARACTERISTICS OF THE ICU DURING THE 24-HOUR SURVEY PERIOD

The questions in this section of the ICU survey pertain to the ***ICU during the 24-hour survey period*** *and should be completed at the end of the survey period.*

Hospital Name: ____

Person completing the survey: ____

Which of the following units does the hospital operate? (Please select all that apply)

_____ Intensive Care Unit (includes combined units)

_____	Medical	_____	Neurological	_____	Trauma
_____	Surgical	_____	Neurosurgical	_____	Burn
_____	CCU	_____	Step-down	_____	Other (please specify)
_____	Cardiothoracic	_____	Respiratory		________________________________

What type of critical care unit are you describing for this survey? (Please select only one)

_____ Intensive Care Unit (includes combined units)

_____	Medical	_____	Neurological	_____	Trauma
_____	Surgical	_____	Neurosurgical	_____	Burn
_____	CCU	_____	Step-down	_____	Other (please specify)
_____	Cardiothoracic	_____	Respiratory		________________________________

What is the total number of patients who have been cared for in your ICU during the survey period?

_____ Total ICU patients

During the survey period, how many admissions, discharges, and deaths did the unit have?

_____ Admissions
_____ Discharges from the unit
_____ Deaths

During the survey period, how many patients were waiting for a bed in the unit?

_____ In the emergency unit
_____ In the OR, PACU and recovery room
_____ In an ancillary service area
_____ In another hospital unit
_____ In another hospital

What was the total number of beds in operation in the unit during the survey period?

_____ Full Intensity Beds
_____ Step Down Beds

Is your ICU boarding patients *from* another unit?

☐ Yes
☐ No

How many patients are you boarding ***from*** each of the following units?

_____ Intensive Care Unit	_____ Cardiothoracic	_____ Respiratory
_____ Medical	_____ Neurological	_____ Trauma
_____ Surgical	_____ Neurosurgical	_____ Burn
_____ CCU	_____ Step-down	

Is your ICU boarding patients *from* any other type of unit?

☐ Yes
☐ No

What other type of unit are you boarding patients from?

____

How many patients are you boarding from this other unit?

_____ Patients boarded *from* other unit

Is your ICU boarding patients *in* another unit?

☐ Yes
☐ No

How many patients are you boarding ***in*** each of the following units?

_____ Intensive Care Unit	_____ Cardiothoracic	_____ Respiratory
_____ Medical	_____ Neurological	_____ Trauma
_____ Surgical	_____ Neurosurgical	_____ Burn
_____ CCU	_____ Step-down	

Is your ICU boarding patients *in* any other type of unit?

☐ Yes
☐ No

What other type of unit are you boarding patients *in*?

____

How many patients are you boarding in this other unit?

_____ Patients boarded *in* other unit

What is the total number of hours per day, on average, that a board-certified, critical care specialist* was present in the unit?

Definition of a Critical Care Specialist: A physician who has completed a residency and then a one- or two year fellowship in critical care medicine or a pulmonary subspecialty training.

_____ hours

Is there a board-certified, critical care specialist available to the unit in the hospital 24 hours a day? (For example, the specialist might be present elsewhere in the hospital or on call, but able to attend to the unit when needed.)

☐ Yes
☐ No

PART II. PATIENT INFORMATION

The questions in this section ask for information about ***each patient*** *that was in the ICU during the 24-hour survey period,* ***including those that the unit was boarding from another unit.*** *On the other hand, if you are boarding patients in another unit,* ***please do not include the data for those patients in this section.*** *Therefore, please copy this section and complete, as many times as there were patients in the unit. Because there may have been turnover during the study period, the number of patients may exceed the number of beds. It may be helpful to begin collecting this data in the 24 hours prior to the survey start time.*

Hospital Name: ____

Person completing the survey: ____

What type of critical care unit are you describing for this survey? (Please select only one)

_____ Intensive Care Unit (includes combined units)

_____ Medical	_____ Neurological	_____ Trauma
_____ Surgical	_____ Neurosurgical	_____ Burn
_____ CCU	_____ Step-down	_____ Other (please specify)
_____ Cardiothoracic	_____ Respiratory	______________________

What is the patient's age?

_____ Patient's age

Is the patient…?

☐ Male
☐ Female

At what date and time was the patient first admitted to the unit?

______________________ Date and time of admission

Source of admission to the unit:

☐ Within the hospital
☐ Outside of the hospital

Where was the patient transferred from within the hospital?

☐ Emergency department
☐ OR, PACU or recovery room
☐ Medical/surgical unit
☐ Ancillary service area

What type of incident was the admission a result of?

- [ ] Direct Admit
- [ ] Consult
- [ ] Arrest/Code Team
- [ ] Rapid Response Team
- [ ] None of these

Where was the patient transferred from outside of the hospital?

- [ ] Other acute care hospital ICU
- [ ] Other acute care hospital ED
- [ ] SNF or other facility
- [ ] Home
- [ ] Other (please specify)

Did the patient require language services in the last 24 hours?

- [ ] Yes
- [ ] No

When were advance directive options discussed with the patient and/or family? *Please select all that apply.*

- [ ] On admission to the hospital
- [ ] During hospital stay (another unit)
- [ ] On admission to the unit
- [ ] During the ICU stay

Does the patient have any of the following on record? *Please select all that apply.*

- [ ] Do Not Resuscitate Order
- [ ] Do Not Intubate Order
- [ ] Health Care Proxy
- [ ] Living Will
- [ ] None of these

Please select the patient's primary admission indication:

- ☐ Acute Life-Threatening Event
- ☐ Adult Respiratory Distress Syndrome
- ☐ Arrhythmia
- ☐ Burn
- ☐ Cardiac arrest – in hospital
- ☐ Cardiac arrest – out of hospital
- ☐ Congenital Abnormality
- ☐ GI Hemorrhage
- ☐ Heart Failure
- ☐ Hemodynamic Abnormalities
- ☐ Intoxication/Drug Overdose
- ☐ Intracerebral hemorrhage
- ☐ Ischemic Heart Disorder
- ☐ Metabolic/Electrolyte Abnormality
- ☐ Monitoring/Nursing Care Required
- ☐ Neurological Dysfunction
- ☐ Organ Failure - AIDS-Related
- ☐ Organ Failure - Cancer-Related
- ☐ Organ Failure - Multiple
- ☐ Organ Failure - Other
- ☐ Peripheral Nerve Disorder
- ☐ Preoperative Evaluation
- ☐ Postoperative Management
- ☐ Procedure-Related Complication
- ☐ Renal Insufficiency/Failure
- ☐ Respiratory Insufficiency/Failure
- ☐ Seizures or status epilepticus
- ☐ Sepsis
- ☐ Shock
- ☐ Stroke - Ischemic
- ☐ Stroke - Hemorrhagic Stroke or Subarachnoid Hemorrhage
- ☐ Trauma - Blunt with Head Injury
- ☐ Trauma - Blunt without Head Injury
- ☐ Trauma - Penetrating
- ☐ Other (please specify) ______________________________

Please select all other conditions that are present:

- ☐ Acute Life-Threatening Event
- ☐ Adult Respiratory Distress Syndrome
- ☐ Arrhythmia
- ☐ Burn
- ☐ Cardiac arrest – in hospital
- ☐ Cardiac arrest – out of hospital
- ☐ Congenital Abnormality
- ☐ GI Hemorrhage
- ☐ Heart Failure
- ☐ Hemodynamic Abnormalities
- ☐ Intoxication/Drug Overdose
- ☐ Intracerebral hemorrhage
- ☐ Ischemic Heart Disorder
- ☐ Metabolic/Electrolyte Abnormality
- ☐ Monitoring/Nursing Care Required
- ☐ Neurological Dysfunction
- ☐ Organ Failure - AIDS-Related
- ☐ Organ Failure - Cancer-Related
- ☐ Organ Failure - Multiple
- ☐ Organ Failure - Other
- ☐ Peripheral Nerve Disorder
- ☐ Preoperative Evaluation
- ☐ Postoperative Management
- ☐ Procedure-Related Complication
- ☐ Renal Insufficiency/Failure
- ☐ Respiratory Insufficiency/Failure
- ☐ Seizures or status epilepticus
- ☐ Sepsis
- ☐ Shock
- ☐ Stroke - Ischemic
- ☐ Stroke - Hemorrhagic Stroke or Subarachnoid Hemorrhage
- ☐ Trauma - Blunt with Head Injury
- ☐ Trauma - Blunt without Head Injury
- ☐ Trauma - Penetrating
- ☐ Other (please specify) ______________________________
- ☐ None of these

Please select all of the interventions that are being taken with the patient:

Monitoring

- [ ] Standard Monitoring (rhythm, heart rate, non-invasive blood pressure monitoring, oxygenation)
- [ ] Invasive Monitoring (pulmonary artery catheter, peripheral arterial catheter, central venous pressure catheter)
- [ ] Routine dressing changes
- [ ] Frequent dressing changes
- [ ] Care of drains (excluding gastric tube)
- [ ] Pulse Oximetry
- [ ] Electrocardiogram
- [ ] End-tidal carbon dioxide (CO2) monitoring
- [ ] None of the above

Cardiovascular Support

- [ ] Intravenous Anti-arrhythmic Infusion
- [ ] Vasoactive/Inotropic Infusion - 1 Agent
- [ ] Vasoactive/Inotropic Infusion - > 1 Agent
- [ ] External Pacemaker
- [ ] Invasive pacing
- [ ] Left atrium monitoring
- [ ] Central Venous Line
- [ ] Cardiopulmonary resuscitation after arrest (past 24 hours)
- [ ] Cardioversion
- [ ] External Ventricular Device (EVD)
- [ ] None of the above

Mechanical Ventilator Support

- [ ] Volume-controlled - Assist control ventilation (A/C)
- [ ] Volume-controlled - Control mode ventilation (CMV)
- [ ] Volume-controlled - Intermittent mandatory ventilation (IMV)
- [ ] Pressure-controlled
- [ ] Daily spontaneous breathing trial
- [ ] Prone-positioning (for ARDS)
- [ ] Non-invasive ventilation (eg bipap)
- [ ] Ventilation via endotracheal tube
- [ ] Ventilation via tracheostomy
- [ ] Tracheostomy other than for ventilation
- [ ] None of the above

IV Therapy

- [ ] Insulin Drip
- [ ] Analgesics
- [ ] Paralytic Agents
- [ ] Sedative
- [ ] None of the above
- [ ] Other (please specify)

____

Transfusions

- [ ] Red cells
- [ ] Plasma
- [ ] Platelets
- [ ] None of the above
- [ ] Other (please specify)

____

Renal Replacement Therapy

- [ ] Continuous Veno-Venous Hemofiltration (CVVH)
- [ ] Continuous Veno-Venous Hemodialysis (CVVHD)
- [ ] Slow Continuous Ultrafiltration (SCUF)
- [ ] Sustained Low-efficient Daily Dialysis (SLED)
- [ ] Peritoneal Dialysis
- [ ] Standard Hemodialysis
- [ ] None of the above

Other Interventions

- [ ] Measurement of intracranial pressure
- [ ] Electroencephalogram (EEG)
- [ ] Endoscopy
- [ ] Emergency surgery (past 24 hours)
- [ ] Gastric lavage
- [ ] Hypothermic resuscitation for brain injury or cardiac arrest
- [ ] None of the above
- [ ] Other (please specify)

____

Type of Nutritional Support:

- ☐ Enteral by mouth
- ☐ Enteral by naso/oro gastric tube
- ☐ Enteral by percutaneous or surgically placed tube
- ☐ Total parenteral nutrition
- ☐ Peripheral parenteral nutrition
- ☐ None at this time

Please indicate the general health status of the patient:

- ☐ Recovery Expected - No Isolation Needed
- ☐ Recovery Expected - Isolation Needed
- ☐ Low Probability of Recovery
- ☐ Terminally Ill
- ☐ Other (please specify)

  ____

Has the patient received specialty consult services while in the ICU?

- ☐ Yes
- ☐ No

Please list all non-ICU, sub-specialty consultants who are actively following the patient's status during the survey period.

Consult 1	____________________	Consult 6	____________________
Consult 2	____________________	Consult 7	____________________
Consult 3	____________________	Consult 8	____________________
Consult 4	____________________	Consult 9	____________________
Consult 5	____________________	Consult 10	____________________

Discharge from the unit

Has the patient been discharged from the unit?

- ☐ Yes
- ☐ No

At what date and time was the patient discharged from the unit?

________________________________ Date and time of discharge

Does the patient need to be transferred out of the unit?

☐ Yes
☐ No

Please indicate the reason that the patient does not need to be transferred:

☐ Patient died
☐ Patient was already discharged
☐ Care in the unit is appropriate

Please indicate the reason for the patient needing to be transferred out of the unit:

☐ Requires higher level of care than is available
☐ Awaiting transfer
☐ Other (please specify)
____

You indicated that the patient requires a lower level of care than available in the unit. What level of care is appropriate?

☐ Acute Care
☐ Comfort Care
☐ Isolation
☐ Other (please specify)
____

How many days has the patient been waiting to be transferred out of the unit?

_____ Days _____ Hours