Letter to Editor

Critical Care Delivery: A Common Starting Point is Needed

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Dear Editor,

Critical and intensive care medicine has an ancient origin, but in recent years it has developed dramatically although heterogeneous, both in design and in its structure, process, and even the basic terminology [1]. In this way, it becomes essential to unify criteria in order to share experiences between groups of different locations, which would help to make changes and improve results.

According to some of the latest studies published with respect to the provision of critical care in general [2, 3], there is an urgency of terms standardisation. In addition, we need to investigate universal data within the differences from, both the industrialized countries and those with fewer resources; in peacetime situations as well as in disasters, either natural or man-made and finally, to quantify the benefits.

On the basis of the critical care model guidelines proposed by the American Society of Critical Care Medicine [4] and The Safety and Improvement Guidelines accredited by the European Society of Intensive Care Medicine [5], we believe that a consensus should be promoted to determine a minimum of parameters investigated, including:

General data
  a. Number of UCI beds/100,000 inhabitants.
  b. Number of UCI beds/number of hospital beds.
  c. Number of patients per year, number of patients studied, age, gender, reference department, condition of admission, level and priority care, severity score at admission.
  d. Epidemiological profile: Diagnostic category, secondary diagnoses.

Organization
  a. Unit type: Multi-purpose, multi-disciplinary, mixed, clinical, surgical, coronary, neurological care, etc.

Use of resources
  a. Turn of beds.
  b. Bed occupancy rates.
  c. Length of ICU stay.
  d. Length of hospital stay.

Procedures
  a. Mechanical invasive ventilation.
  b. Mechanical invasive ventilation.
  c. Renal replacement therapy.

Security
  a. Unplanned endotracheal extubation rate.
b. Early ICU re-admission rate.
c. Adverse events reporting system.

Results

a. Complications
   i. Mechanical ventilation-related infection rate
   ii. Central venous catheter-related infection rate
   iii. ICU-acquired infections

b. Mortality
   i. Crude death rate
   ii. Net rate of mortality
   iii. Standardize mortality ratio

These findings will make us understand better the nature of ICUs, considering that the provision of critical care includes a structure, a process, and a result. The parameters mentioned above would serve not only in the handling of each ICU in particular but the ICU as a whole when it comes to a country, region or worldwide.

Sincerely,
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References


