

The reinforced care unit in medical or surgical hospitalization: an important component of the reorganization of care in health facilities

Press release from the French National Academy of Medicine (*)

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The reflection undertaken by the public authorities on critical care in hospitals (intensive care, multipurpose intensive care units) is to learn from the Covid-19 pandemic how to better meet the care needs under normal conditions and to prepare this healthcare sector to adapt rapidly to an influx of patients in a crisis.

In particular, the aim is to prevent that the increase in the need for critical care results, as in the spring of 2020, in a significant interruption of scheduled care, particularly operations, whether performed by surgeons or doctors, including seriously ill patients (patients awaiting transplants (1), or patients with cancer, for example).

During the first pandemic wave of Covid-19, this interruption was made necessary by the unavailability of critical care beds, thus prohibiting the reception of patients requiring a short-term continuous monitoring following major surgery, but also by the unavailability of post-interventional monitoring rooms (SSPI: ex recovery rooms) or outpatient units, transformed into temporary covid units. During this first wave, it led to a high level of surgical deprogramming (more than 50%) (2), which resulted in a loss of chance for many patients, whose state of health worsened due to the postponement of the planned operation.

The establishment or maintenance of reinforced care units at the heart of the surgical or specialized medical care sectors, based on an adaptation of article D 6124-117 of the Public Health Code, would be a way of better responding to the care needs, both in the usual mode of activity and in crisis situations.

This type of unit is characterized by an adapted number of beds allowing short-term care for patients who have undergone complex surgical procedures and require close monitoring and specific post-operative care, but whose condition is stable, without acute visceral failure, and therefore without the need for hospitalization in critical care units.

Such a unit does not require a permanent medical presence on site, but requires that the continuity of care be based on an operational surgical or medical on-call service within the departments concerned, particularly during the night and on weekends, and on a density of non-medical staff adapted to the burden of care required by these patients.

This type of unit:

- is attractive for nurses, allowing them to acquire the basis for advanced practice training in the concerned specialty;
- makes bed management more fluid;

- allows pooling which, depending on the specialties and the wishes of the professionals concerned, leads to units of a size adapted to their functionality;
- is cheaper than a critical care unit.

The National Academy of Medicine underlines the importance that, in the context of the reflection undertaken on hospital critical care to learn from the Covid-19 pandemic how to improve it in the future, attention should be paid to reinforced inpatient intensive care units, as such units allow:

In their usual mode,

- to cope with the increase in the number of seriously ill patients in specialized surgical or medical structures, even though the growing share of outpatient surgery avoids hospitalization for the least serious patients;
- to respond to the increased care burden on non-medical staff, in post-operative hospitalization sectors that are currently under-staffed and disorganized;
- to avoid receiving such patients operated on in a critical care sector, when they above all need specific post-operative care, requiring time and special technical skills, and continuous monitoring by a trained staff;
- to group and pool these reinforced care beds according to the organization and nature of the activities within the Health Establishment. This would promote complementarity and cooperation between some surgical or medical departments, diversification of skills, and harmonization of the workloads of non-medical staff;

In critical situations,

- to quickly have structures capable of implementing heavy care and, above all, staffed with a non-medical personnel used to intensive care and continuous monitoring, and therefore able to come, if necessary, to reinforce critical care sectors;
- to avoid the closure of SSPIs or ambulatory units, which was a major source of deprogramming in 2020.

References:

[1] How to maintain a vital surgical activity in the event of a serious health crisis? The example of adult transplantation. Press release of the French National Academy of Medicine and the National Academy of Surgery, June 23, 2020

[2] DREES, In 2020, the number of hospital stays excluding Covid-19 decreased by 13% compared to 2019, Etudes & Résultats, September 2021, 1204, p. 6

(*) Press release from the Academy's Rapid Communication Unit validated by the members of the Board of Directors on February 28, 2022.