

2009 NRCPR Facility Profile and Census Q&As

A. GENERAL INFORMATION

1. Is completion of the NRCPR Annual Facility Profile/Census mandatory?

ANSWER:

All facilities should complete and submit the Facility Profile/Census. Information collected will provide participants with report comparison groups and help specific facilities to better understand how factors associated with resuscitation impact practices and patient outcomes. If a facility does not submit the profile, their data will not be included in a comparison group and their reports will not include comparison group data—those fields will be left blank. Submission of this data, although not mandatory, is strongly encouraged by the NRCPR Science Advisory Board (SAB).

2. Why do I have some data already entered into the software?

ANSWER:

All facilities who have submitted an Annual Facility Profile/Census in the past will have most of the data elements pre-filled. Most facilities will only need to review this data for accuracy and enter 2009 Annual Census Data.

B. ANNUAL FACILITY PROFILE

1. We are a level IV trauma so I am assuming I should mark no on question 1 and 2 regarding adult/pediatric trauma center?

ANSWER:

A Level IV trauma center provides the stabilization and treatment of severely injured patients in remote areas where no alternative care is available. Level IV status is part of the American College of Surgeons standard for trauma system designation. We do not offer this selection choice within the FDS, so you will need to answer “no” to this question.

2. What are the definitions of the nursery/neonatal ICU levels I-III?

ANSWER:

These are the current definitions according to Policy Statement of American Academy of Pediatrics (Stark AR, Couto J. Levels of neonatal care. Pediatrics 2004; 114(5):1341-7.

Level I (basic): a hospital nursery organized with the personnel and equipment to perform neonatal resuscitation, evaluate and provide postnatal care of healthy newborn infants, stabilize and provide care for infants born at 35 to 37 weeks' gestation who remain physiologically stable, and stabilize newborn infants born at less than 35 weeks' gestational age or ill until transfer to a facility that can provide the appropriate level of neonatal care

Level II (specialty): a hospital special care nursery organized with the personnel and equipment to provide care to infants born at more than 32 weeks' gestation and weighing more than 1500 g who have physiologic immaturity such as apnea of prematurity, inability to maintain body temperature, or inability to take oral feedings; who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis; or who are convalescing from intensive care. Level II care is subdivided into 2 categories that are defined by the capability to provide mechanical ventilation for brief durations (less than 24 hours) or continuous positive airway pressure.

Level IIA units do *not* have the capability

Level IIB units *have* the capability

Level III (subspecialty): a hospital neonatal intensive care unit (NICU) organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness. Level III is subdivided into 3 levels differentiated by the capability to provide advanced medical and surgical care.

Level IIIA units can provide care for infants with birth weight of more than 1000 g and gestational age of more than 28 weeks. Continuous life

support can be provided but is limited to conventional mechanical ventilation.

Level IIIB units can provide comprehensive care for extremely low birth weight infants (1000 g birth weight or less and 28 or less weeks' gestation); advanced respiratory care such as high-frequency ventilation and inhaled nitric oxide; prompt and on-site access to a full range of pediatric medical subspecialists; and advanced imaging with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography and have pediatric surgical specialists and pediatric anesthesiologists on site or at a closely related institution to perform major surgery.

Level IIIC units have the capabilities of a level IIIB neonatal intensive care unit and are located within institutions that can provide extracorporeal membrane oxygenation (ECMO) and surgical repair of serious congenital cardiac malformations that require cardiopulmonary bypass.

3. Our facility has two nurseries - one is a Level I, the other a Level II. What do I enter in the profile?

ANSWER:

A: Select the highest-level designation.

4. Our RRT responds to both adult and pediatric patients; there are not separate RRTs for adults and children.

ANSWER:

If your hospital has a single MET/RRT that responds to both adult and pediatric patients, complete *only* the Adult MET/RRT section.

C. LICENSED BED COUNTS

1. What is the definition of the “total number of beds”?

ANSWER:

The “total number of beds” refers to all beds for which the facility is licensed. This number is sometimes in excess of the number of beds for which you may provide staff.

2. We do not treat (a particular group of) patients. How should we handle those sections?

ANSWER:

If you don't treat a particular group of patients (e.g. pediatrics), you should enter zeros for the census questions related to that age group.

3. What is the definition of a Critical Care Bed?

ANSWER:

Critical care beds include:

Adult Coronary Care Unit (CCU)

Adult ICU (includes medical, surgical, cardiovascular, trauma, burn... ICUs)

Pediatric ICU (PICU) – (includes medical, surgical, cardiovascular, trauma, burn...ICUs)

(Note that neonatal ICU [NICU] beds are not included)

4. Are observation beds/patients included in the counts of acute care inpatient beds and inpatient admissions and discharges?

ANSWER:

Observation beds/patients are included in these counts.

5. Our ICU and telemetry unit are used for both pediatric and adult patients but there are not beds that are specified only for pediatrics (they go where there's a bed). When it asks 'how many critical care beds/telemetry beds are pediatric'; how should I answer that question?

ANSWER:

Indicate zero pediatric ICU and telemetry beds.

6. What should we do if the subcategory of bed types doesn't match the total number of beds? Example: Some Step-down beds also count as Telemetry beds?

ANSWER:

A Step-down area may or may not provide cardiac monitoring, but does provide some sort of advanced level, specialized care for a certain group of patients. A Telemetry area provides cardiac monitoring and staff trained in cardiac rhythm interpretation. You should select the appropriate number of beds allocated to each of these areas based on how your facility's beds meet the conceptual descriptions provided above.

D. TOTAL ADMISSIONS

1. What is meant by "Total Admissions" and how is this different from "Inpatient Admissions"?

ANSWER:

For many facilities, Total Admissions will be the same as Inpatient Admissions. However, some facilities may not include certain patients (e.g. 24-hour observation) as part of the 'Inpatient Admission' numbers. These patients should be included in Total Admissions.

2. For inpatients, should Rehab, SNF, and Mental Health be excluded?

ANSWER:

If Rehab, SNF, or Mental Health beds are part of your inpatient capacity, these units should be included. If they are considered to be "separate facility admissions," do not include them. As an example, many places may discharge a patient from inpatient and re-admit to SNF, even though the SNF unit is physically part of the main building. If this happens to be the case at your facility, you would not include these patient beds or admissions and discharges.

E. DEATH/DISCHARGE INFORMATION

1. For discharges do you want live discharges and deaths or total number of discharges including deaths and then a number of deaths?

ANSWER:

Please provide us with the total number of discharges including deaths and then the number of deaths, both total and as broken down in the FDS.

2. Discharges: Are these inpatient discharges only or inpatient and observation discharges?

ANSWER:

Discharges includes both inpatient and observation patients.

3. In-Hospital Deaths: Does this include all patients (including ED and observation beds)?

ANSWER:

Deaths would include all patients: inpatients, observation patients and ED patients.

F. MET/RRT CONFIGURATION

1. What is meant by "Critical Care trained" on MET team? How is that different from for example "ICU nurse" since an ICU nurse is critical care-trained? \

ANSWER:

Critical Care Training includes any formal or facility based education that qualifies the indicated member to work in a critical care area.