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Abstract: Background. The aim of this study was to evaluate the influence of prolonged length of stay in an intensive care unit (ICU) on the mortality and morbidity of surgical patients. Methods. We performed a monocentric and retrospective observational study in the surgical critical care unit of the department of surgery at the Medical Center of the University of Freiburg, Germany. Clinical data was collected from patients assigned to the ICU with a length of stay (LOS) of 90 days and greater. Results. From the total of the 19 patients with ICU LOS over 90 days, ten patients died in the ICU whereas nine patients were discharged to the normal ward. The ICU mortality rate was 52%. The overall survival one year after ICU discharge was 32%. Regarding factors affecting mortality of the patients, significantly higher mortality was associated with age of the patients at the time point of the ICU

admission and with postoperative need of renal replacement therapy. Conclusions. We found a high but in our opinion acceptable mortality rate in surgical patients with ICU LOS of 90 days and greater. We identified age and the need of renal replacement therapy as risk factors for mortality Background : A growing number of patients with cancer require intensive care treatment with still limited data about their long-term outcomes. Our purpose was to assess 1-year mortality and functional status (ECOG PS) among cancer patients with malignancies admitted to a polyvalent intermediate care unit (ICU) with specific beds of intermediate care unit (ImCU). Materials and methods : Retrospective monocentric study of all adults registered with cancer and admitted to the ICU or ImCU at the District Hospital of Lorient between 1 January 2017 and 31 December 2017. Results : 108 patients with a malignancy were admitted to ICU (median age 69 years; 73,6% men; median SAPS II 55). Pre-ICU ECOG PS was good (0-1) for 57,4% of patients. ICU survival and 1-year survival were 65,7% and 41,7%. In multivariate analysis, best predictors of 1-year mortality in ICU were a higher SAPS II (OR 1,08 [95% CI 1,04-1,12]), a poor ECOG PS at 3-4 (OR 20,67 [95% CI 2,3-628,44]), medical admissions (OR 6,10; [95% CI 1,63-27,71]) and admissions for cancer-related reasons (OR 5,31 [95% CI 1,28-25,63]). About one in two survivors (48,9%) showed a good ECOG PS (0-1) 1 year after ICU admission. 96 patients registered with cancer were admitted to ImCU (median age 67 years; 57,3% male, median SAPS II 25), with a good ECOG PS (0-1) in 56% of the patients. Survival rates at ICU discharge and at 1 year were 96,9% and 75%. After adjustment, a greater SAPS II was the only independent risk factor of 1-year mortality in ImCU (OR 1,07 [95% CI 1,01-1,14]). One-year ECOG PS was 0-1 for 44,4% of ImCU survivors. Conclusion : Long-term survival of cancer patients after ICU discharge is acceptable and even substantial after ImCU discharge. This study may help intensivists and oncologists in better selecting cancer patients who are more likely to benefit from ICU/ImCU admission. This best-selling resource provides a general overview and basic information for all adult intensive care units. The material is presented in a brief and quick-access format which allows for topic and exam review. It provides enough detailed and specific information to address most all questions and problems that arise in the ICU. Emphasis on fundamental principles in the text should prove useful for patient care outside the ICU as well. New chapters in this edition include hyperthermia and hypothermia syndromes; infection control in the ICU; and severe airflow obstruction. Sections have been reorganized and consolidated when appropriate to reinforce concepts. This book is a sequel to my first book entitled Families in the ICU: A Survival Guide, and was developed from a growing concern that families were lacking critical information to assist them while their family member is in a rehabilitation

center. It is designed to ease the tremendous stress on families as they seek information about rehabilitation and have the resources they need to transition their loved one from rehab to home. Transitions from hospital to rehab to home are difficult, and the information compiled here in a quick-reference format will assist families and patients in locating needed equipment, caregiver assistance, home health, and further rehabilitation. The information contained in this book has been used in actual practice by the author for thirty-seven years in educating families and training patients to be as independent as possible, following a hospitalization. The book is broken up into chapters and there are places for making notes after each chapter, just as in my first book. None of the information contained in this book is my creation. I have given credit to websites, organizations, and authors. My efforts in creating this book were to merely compile information into one resource, making it more easily accessible to you, the family. My hope is that this book will provide needed information regarding resources and will answer important questions for you, the family, while your loved one is receiving rehabilitation and preparing to return home. Cardiac arrest has become one of the most common cause of death faced by individuals in today's scenario. Cardiopulmonary arrests or cardiac arrests can occur unexpectedly and increase the mortality rates. Cardiopulmonary Resuscitation (CPR) is a technique developed in an effort to save the life of patients experiencing a cardiac arrest. However, the modern CPR, in spite of being introduced 40 years ago, has not been able to improve the mortality rate. Dataset and Methods: The Study involved the analysis of publicly available information was conducted at ASIR Central Hospital in Saudi Arabia in order to collect the data of cases regarding in-hospital heart arrests in the ICU to answer the hypothesis question. In this study, the effective use of ADE has also been explored, which can be an important technique in saving the lives of patients suffering from a cardiac arrest. Some solutions can be suggested afterwards, based on the study to improve the survival rate. The study will help in exploring the important factors, which will help in improving the survival rate of patients and improving the quality of the life of patients. Conclusion: The survival outcome indicated that patients were significantly more likely to die (55.3%) than survive (44.7%) and The vast majority of patients were treated with adrenaline (96.1%) at the time of cardiac arrest, Out of those individuals who received three doses of adrenaline, a majority survived (42.5% died). Out of those who received four doses of adrenaline and were under 61 years of age. Evidence-Based Practice of Critical Care, 2nd Edition, presents objective data and expert guidance on managing critically ill patients in unique question-based chapters that focus on best practices. Now thoroughly updated by Drs. Clifford S. Deutschman, Patrick J. Neligan, and nearly 200 critical-care

experts, this highly regarded title remains the only book of its kind that provides a comprehensive framework for translating evidence into practice, making it a valuable resource for both residents and practitioners. Tap into the expertise of nearly 200 critical-care experts who discuss the wide variety of clinical options in critical care, examine the relevant research, and provide recommendations based on a thorough analysis of available evidence. Think through each question in a logical, efficient manner, using a practical, consistent approach to available management options and guidelines. Find the information you need quickly with tables that summarize the available literature and recommended clinical approaches. Navigate a full range of challenges from routine care to complicated and special situations. Stay up to date with new issues and controversies such as the redefinition of sepsis . changing approaches to fluid administration . immune suppression in sepsis . monitoring the microcirculation . the long-term sequelae of critical illness . minimizing ventilator associated lung injury . the benefits of evidence-based medicine management guidelines . rapid response teams . and more. Benefit from all-new sections covering persistent critical illness and the role of advanced practice nurses and physician assistants in the ICU. Background: Despite the improvements in burn care during the last decades, burns remain catastrophic for the patients and a challenge for the care-givers. The early outcome of burn care is to assess its quality and to improve it, but the crucial outcome is mortality, which is the main focus of this thesis. In particular, I address questions about mortality that have arisen from working with burned patients and that can have clinical consequences: the impact of pre- existing medical conditions; long-term survival; the causes of unexpected deaths; and the possible differences between sexes in the provision of resources. Patients with burns share the fact that the time of their injury is known, its severity can be quantified from the size of the burn, and the care is relatively standardised. The analysis of outcome among burned patients treated at a single burn centre may therefore be of general value to others who treat burns. Methods: We retrospectively analysed data that had been collected prospectively (the burn unit database) from patients with burns admitted consecutively to a national burn centre in Sweden during the last 25 years. Results: Age and percentage of total body surface area burned (TBSA %) affected the in- hospital mortality, whereas pre-existing medical conditions did not influence the prediction of outcome (Paper I). After discharge, both age and the presence of full thickness burns reduced the long-term survival, whereas the extent of the burn (TBSA %) did not (Paper II). Most patients with moderate burns who die in hospital despite a good prognosis, die for reasons other than the burn (Paper III). Previously, it has been shown that sex is not an independent factor for mortality during burn care; in this thesis

we show that the sex of the patients did not affect the number of medical interventions given either (Paper IV). Conclusion: The addition of "coexisting condition" to a mortality model based on age and size of burn does not improve its predictive value; rather, the factor "age" is sufficient to adjust for comorbidity in the assessment of a burn and its outcome (Paper I). If patients with burns survive, the long-term prognosis is good. The effect of age is the one that governs survival, whereas the effect of the extent of the burn ends when the patient is discharged (Paper II). The in-hospital mortality during burn care is low, but some patients die for reasons other than the actual burn (Paper III). In a centre where the mortality is independent of the sex of the patient, the provision of medical interventions is also equal between men and women (Paper IV). Questa tesi tratta del rischio di morte in seguito ad ustioni ed affronta, con approccio scientifico, alcune domande sollevate frequentemente da pazienti e da addetti ai lavori. In particolare: a presenza di altre malattie a prescindere dall´ustione (diabete, nefropatie, alcolismo, etc.) peggiora la prognosi del paziente?L´essere sopravvissuto ad un´ustione riduce l´aspettativa di vita dopo la dimissione dall´ospedale?Qual è la causa di morte in quei (rari) pazienti che muoiono con ustioni di modesta entità?Il sesso del paziente influenza le cure prestate durante il ricovero ed, in tal caso, qual è l´effetto sulla prognosi? Spesso avevamo risposto a questi interrogativi di interesse clinico basandoci sull´esperienza o su luoghi comuni accettati acriticamente. Con questa tesi abbiamo cercato con metodo scientifico delle risposte di valore generale, analizzando i dati raccolti durante l´ultimo ventennio sui pazienti ricoverati a causa di traumi termici al Centro Nazionale Grandi Ustioni dell´Università di Linköping. In Svezia, come negli altri paesi a reddito medio-alto, il tasso di mortalità in seguito ad ustioni è diminuito notevolmente negli ultimi anni, tuttavia l´obbiettivo principale tra gli addetti ai lavori rimane quello di diminuire ulteriormente la mortalità. L´identificazione precoce di pazienti ad alto rischio di morte fornisce un mezzo utile per migliorarne la prognosi. A tale proposito sono stati sviluppati numerosi modelli matematici in grado di calcolare la probabilità di morte in seguito ad ustioni, basati principalmente sull`età del paziente e sull´ estensione dell´ustione. Infatti, è intuitivamente comprensibile che il rischio di morire aumenti con l´età del paziente e la gravità dell´ustione. Nel nostro primo studio abbiamo aggiunto ad un modello prognostico basato su età e superficie corporea ustionata informazioni sulle malattie già presenti nel paziente prima dell`ustione. Contrariamente a quanto ipotizzato, la presenza di altre malattie negli ustionati non ne aumenta la probabilità di morte. Nel nostro secondo studio abbiamo seguito i pazienti sopravvissuti all´ustione dopo la dimissione dal nostro Centro ed abbiano dimostrato che l´ustione in se´ non ne accorcia la vita ne´a breve termine (nei 30 giorni seguenti la dimissione), ne´a lungo

termine. È piuttosto inusuale che pazienti con ustioni di modesta gravitá muioiano durante il ricovero ospedaliero. Nel nostro terzo studio abbiamo dimostrato che la principale cause di morte tra questi pazienti non è correlata all´ustione in se´, ma ad altre patologie indipendenti dal trauma termico, quali l´ictus o l´infarto miocardico. A livello internazionale è stato ampiamente documentato un impari impiego delle cure mediche tra i sessi, a discapito delle donne. Questa disparità riguarda principalmente la diversa allocazione delle risorse terapeutiche, ma ha conseguenze negative sul´esito finale della cura. Studi provenienti da diversi centri per la terapia delle grandi ustioni (USA, Australia, India) hanno dimostrato che il rischio di morte in ospedale è maggiore per le pazienti femmine. In contrasto con questo, una precedente ricerca svolta presso il nostro centro non ha mostrato alcuna differenza nella sopravvivenza tra uomini e donne. Anche tra i pazienti della terapia intensiva generale svedese la mortalità è simile per entrambi i sessi, nonostante gli uomini ricevano più trattamenti rispetto alle donne. Questa osservazione apre le porte ad un´ovvia domanda, e cioè: se le donne ricevessero le stesse attenzioni degli uomini morirebbero esse su scala minore? In linea con i risultati riguardanti la mortalità precedentemente pubblicati dal nostro centro, col nostro quarto studio abbiamo dimostrato che non esiste alcuna disparità tra i sessi nella distribuzione delle risorse. In sintesi, con questa tesi abbiamo dimostrato che: i fattori che maggiormente influenzano la prognosi in caso di ustione sono l'età del paziente e l´area corporea ustionata; la presenza di altre patologie non aumenta significativamente il rischio di morte.L´essere sopravvissutto ad un´ustione non riduce l´aspettativa di vita dopo la dimissione dall´ospedale.Una percentuale non indifferente delle morti che si verificano durante il periodo di cura per ustioni di modesta gravità è causata da fattori indipendenti dall´ustione stessa.Uomini e donne nel nostro centro ricevono equo trattamento. La prognosi per donne e uomini ricoverati nel nostro centro è la stessa. Riteniamo che i risultati presentati in questa tesi dovrebbero essere tenuti in considerazione nella terapia dei pazienti ustionati: il trattamento attivo dovrebbe essere offerto a chiunque abbia una ragionevole possibilità di sopravvivenza, calcolata sulla base dell´età e della gravità dell´ustione. Una volta guariti da un´ustione l´aspettativa di vita è buona. Non va scordato che, tra i pazienti che muoiono in seguito ad un´ustione, le cause di morte potrebbero essere dovute a patologie di altra natura. Non si evidenziano differenze nelle mortalitá, lí dove venga offerto uguale trattamento a uomini e donne. The intention of this book is to provide information to assist families with the care of their family member and to foster good communication with medical personnel. The book is based on a book, developed in part by actual ICU families and the author, as part of a doctoral research study to measure the level of satisfaction with care and

communication between family members and the medical personnel who serve them. Results of the study suggested that family satisfaction with care and communication improved because of the information contained in the book. It is hoped that this book will contain valuable information for family members and will provide a resource to answer questions regarding the care of ICU patients with TBI or stroke. It is also hoped that this book will assist families in communicating more effectively with medical staff in order to ultimately benefit the care of the patient and improve patient outcomes. Children in Intensive Care fulfils a unique role in supporting clinical staff during the day-to-day management of the sick child. Presented in quick reference format, and in plain English, the book offers a unique guide to the wide variety of situations that a practitioner is likely to encounter during daily practice. Rich with reference tables, algorithms, artworks and 'Alert' boxes, the book offers a wealth of information which ranges from physiology to drug dosage calculation, drug compatibility lists, reference ranges, and X-ray interpretation. New chapters include oncologic emergencies, pain management and sedation, together with the latest information on the management of sepsis, the collapsed child, and care of the child following spinal surgery. Information presented in quick reference format, with accompanying reference tables, to facilitate on-the-spot usage Advanced Life Support Group algorithms provide safe and easy-to-follow protocols to the management of emergency situations Contains input from a broad range of paediatric specialists – intensivists, anaesthetists, haematologists, oncologists, air ambulance physicians and retrieval nurses, pharmacists, specialist dieticians, and respiratory physiotherapists – to ensure full coverage and accuracy of information Contains helpful 'Quick Guide' and 'Warning' boxes to provide key information at a glance, while helpful mnemonics assist with learning Contains chapters on normal child development, safe-guarding children and young people, and patient transport Perfect for use on the wards, theatres, high-dependency units and intensive care units as well as during retrieval and A&E Ideal for newcomers and experienced staff alike, whether they be junior doctors or nursing staff Additional authorship brings the expertise of Marilyn McDougall, a Senior Paediatric Intensive Care Consultant Contains brand new chapters - oncology emergencies and pain & sedation - as well as the latest information on topics including sepsis and the collapsed neonate, and care of children after spinal surgery Comprehensively expanded cardiac chapter presents new surgical approaches as well as practical tips on pacing, care of chest drains and basic echocardiograph terminology Drug chapter now includes reversal agents, new drug profiles and an updated compatibilities chart Expanded artwork program explains clinical concepts and practical procedures Fungal infections are an increasing problem in critically ill patients and these

infections carry an attributable mortality that is much higher than corresponding bacterial infections. In both Europe and North America, Candida infections predominate and much of this book concentrates on the epidemiology, risk factors, diagnosis, and treatment of these infections. Particular reference is made to the cross-infection problems of Candida infection and the importance of infection control and preventative measures. However, other fungal infections are increasingly being seen in critically ill patients. This book is designed to offer a European and North American perspective on each topic. There are many similarities in experience and clinical practice but also significant differences that we hope will stimulate further thought and study. We hope the book will be of interest to intensivists, infectious disease specialists, medical microbiologists, and all those with an involvement in critical care. Progress in intensive care medicine is resulting in a growing population of critically ill patients at risk of fungal infection. Further improvements in survival will require a multidisciplinary approach. "Medical advances have led to improved survival in the critically ill patient and in turn there has been a change in the endpoint from survival alone to the quality of that survival for the Intensive Care Unit (ICU) patient. Post-intensive care syndrome (PICS) is best described as a collection of long-term cognitive, psychological, and physical health disorders that are common among patients and family members who survive critical illness and intensive care treatment. ICU journaling has been shown to be an effective intervention at mitigating the effects of PICS. The purpose of this evidence-based practice project was to implement an ICU journal intervention in the medical ICU of a large, tertiary care facility to decrease the symptoms of PICS. Twenty patients were included in the intervention and follow up was performed with these patients 30 days following discharge from the facility. Levels of anxiety, depression, and post-traumatic stress disorder (PTSD) were measured utilizing the Post-Traumatic Stress Syndrome 14-Questions Inventory (PTSS-14). This data was compared to baseline data for similar patients prior to the start of the intervention. An ICU journal quality improvement project has the potential to mitigate the effects of PICS in the medical ICU patient who is intubated and sedated or CAM positive. More research is needed to determine the long-term effects of a journaling intervention and to address consistency in management of the journal after initial presentation to the family. " -- Abstract Measuring the quality of a complex service like critical care that combines the highest technology with the most intimate caring is a challenge. Recently, con sumers, clinicians, and payers have requested more formal assessments and comparisons of the quality and costs of medical care [2). Donabedian [1) pro posed a framework for thinking about the quality of medical care that separates quality into three components: structure, process, and outcome.

An instructive analogy for understanding this framework is to imagine a food critic evaluating the quality of a restaurant. The critic might comment on the decoration and lighting ofthe restaurant, how close the tables are to each other, the extent ofthe wine list and where the chef trained. These are all evaluations of the restaurant structure. In addition, the critic might comment on whether the service was courteous and timely - measures of process. Finally, the critic might comment on outcomes like customer satisfaction or food poisoning. Similarly, to a health care critic, structure is the physical and human resources used to deliver medi cal care. Processes are the actual treatments offered to patients. Finally,outcomes are what happens to patients, for example, mortality, quality of life,and satisfac tion with care (Table 1). There is a debate about which of these measurements is the most important measure of quality. Geared to any health care professional practicing in or rotating into a CCU, this quick referenceadopts a similar format to the author's highly regarded Cardiac Care Unit Survival Guide. Packed with full-page diagnosis treatment algorithms and management pathways, Herzog's CCU Bookensures you acquire in-depth knowledge and understand the subtleties in treating the different kinds of patients you encounter in a CCU setting. This book is geared toward cardiologists, trainees, and housestaff --anyone who rotates or practices in the CCU--who must grasp the subtleties when treating patients in a cardiac care unit. It is organized in a way to help you understand the simplified pathophysiology of the disease, the diagnosis modalities, the initial critical care management in the CCU, the clinical care in a step down unit and plan for discharge therapy. Dr. Herzog has developed unified pathways for the management of patients presenting with acute chest pain or its equivalent, acute heart failure, atrial fibrillation and flutter, syncope, cardiac arrest, hypertension and hyperglycemia. Algorithms and pathways for management are provided in each chapter for easy implementation in any health care system. In addition, because specialized units are frightening to the patients and their families, there is a section in each chapter on what the patient and family need to know, that encompasses a capsulated explanation of the condition and treatment management. A companion website accompanies the text that includes fully searchable text and patient information. This book is geared toward cardiologists, trainees, and housestaff --anyone who rotates or practices in the CCU--who must grasp the subtleties when treating patients in a cardiac care unit. It is organized in a way to help you understand the simplified pathophysiology of the disease, the diagnosis modalities, the initial critical care management in the CCU, the clinical care in a step down unit and plan for discharge therapy. Dr. Herzog has developed unified pathways for the management of patients presenting with acute chest pain or its equivalent, acute heart failure, atrial fibrillation and flutter, syncope,

cardiac arrest, hypertension and hyperglycemia. Algorithms and pathways for management are provided in each chapter for easy implementation in any health care system. In addition, because specialized units are frightening to the patients and their families, there is a section in each chapter on what the patient and family need to know, that encompasses a capsulated explanation of the condition and treatment management. A companion website accompanies the text that includes fully searchable text and patient information. When you're facing cancer treatment, it's easy to feel overwhelmed and alone. Between the hospital or clinic environment and the medical terminology used by doctors and health care professionals, you may feel as though you've entered a foreign country. Written by two experienced oncology nurses, this compassionate and comprehensive guide explains in plain English everything you need to know about your treatment, including what you can expect at each stage of chemotherapy and what you can do to prevent or minimize side effects. Packed with practical suggestions, nutritional advice, relaxation skills, and other techniques to help strengthen your body and calm your mind, The Chemotherapy Survival Guide is a must-have resource for anyone navigating this difficult time. This book is geared toward cardiologists, trainees, and housestaff --anyone who rotates or practices in the CCU--who must grasp the subtleties when treating patients in a cardiac care unit. It is organized in a way to help you understand the simplified pathophysiology of the disease, the diagnosis modalities, the initial critical care management in the CCU, the clinical care in a step down unit and plan for discharge therapy. Dr. Herzog has developed unified pathways for the management of patients presenting with acute chest pain or its equivalent, acute heart failure, atrial fibrillation and flutter, syncope, cardiac arrest, hypertension and hyperglycemia. Algorithms and pathways for management are provided in each chapter for easy implementation in any health care system. In addition, because specialized units are frightening to the patients and their families, there is a section in each chapter on what the patient and family need to know, that encompasses a capsulated explanation of the condition and treatment management. A companion website accompanies the text that includes fully searchable text and patient information. The worst customer situations demand more of front-line employees than good intentions and the right attitude. These kinds of issues can send seasoned service professionals into red alert, and require the communication skills of a crisis counselor. The Customer Service Survival Kit explains how to use the right words to turn volatile scenarios into calm and productive customer encounters. Anyone can learn this delicate art with the book's blend of clear techniques, lessons from behavioral science, case studies, situation-specific advice, and practice exercises. Readers will discover: * The power of leaning into criticism *

Trigger phrases that can make bad situations worse * The secret to helping people feel deeply heard in a crisis * How to use the divide-and-conquer approach to safely deliver bad news * Indispensable problem-solving tools * How to become immune to intimidation * How to wrap up transactions so that customers are happy * And more! Best yet, learning to handle worst-case scenarios has the spillover effect of boosting the skills and confidence needed to deal effectively with ANY customer-the key to radical improvements in every organization. This book highlights real clinical issues which need to be addressed if quality palliative care within ICUs is to be consistently delivered. It is presented in an easily accessible, bullet pointed style, and is illustrated with case histories from real-life patients, and drug tables. Royal Perth Hospital is the largest hospital in Western Australia and also has the largest intensive care unit (ICU) in the State. It was the first public hospital to provide intensive care services in Western Australia. This thesis examines the intermediateand long-term outcomes of patients admitted to the Royal Perth Hospital ICU between 1987 and 2002. Intermediate-term survival, defined as survival after discharge from hospital to one year and long-term survival, that exceeding one year after discharge, are important outcomes. Information on outcomes can be used by ICU staff in discussions with patients and their families and to inform policy decision-making and future research. The aim of this research was to examine one-year and long-term outcomes of patients admitted to the ICU between 1987 and 2002 and explore the factors that might be associated with the outcomes for 22,298 patients admitted to the ICU. A clinical ICU database was linked to morbidity and mortality databases by Data Linkage WA. A wide range of demographic and clinical factors were examined for their effect on outcome. These included age, sex, comorbidity, severity of illness, organ failure, ICU diagnostic groups, type of admission (medical, elective surgical and non-elective surgical), length of stay in ICU and era of admission (1987-1990, 1991-1994, 1995-1998, 1999-2002). Patients were followed-up to study end, 31st December 2003 or death if it occurred before study end, that is, up to 17 years after the index ICU admission. Kaplan Meier survival curves and Cox regression models were used to examine intermediate and long-term survival for patients who survived to hospital discharge. A comparison of admissions to hospital before and after the index ICU admission was made using descriptive statistics and logistic regression. Throughout the study period survival for the ICU cohort was shorter when compared to the Australian population. This was consistent throughout the follow-up period. The most important determinants of long-term survival were age, comorbidity, severity of illness and diagnostic group but the strength of association varied with the duration of follow-up. Although age, comorbidity and severity of illness increased among the critically ill survival

improved over time. Hospital admissions were more frequent after a discharge from hospital that required an admission to ICU than before the index admission, even after adjusting for the ageing of the cohort. This study provides unique information about the survival and other outcomes of patients discharged from a hospital admission that included an ICU stay. The strength of this study lies in the follow-up to 17 years and the more comprehensive range of explanatory factors than in previous studies. This thesis demonstrates that follow-up studies after intensive care should be of sufficient duration to account for the changes that occur in survival over time and indicates the range of factors that should be taken into account when making comparisons of long-term survival. Congratulations! You did it! You graduated nursing school and passed the NCLEX ... you're a real nurse! Until you realize that you're nowhere near ready for this. You can't remember a normal K level, you're not sure which way your stethoscope goes on, and there's no way you can talk to a real patient. Breathe. You can do this. And I'm here for you. I See You is a survival guide for new nurses crafted from my own experience as a graduate nurse working in the intensive care unit. With chapters on talking to doctors, taking report, and caring for dying patients, this book is a tool that you can use to help guide you through those hard days on the unit. With themes of managing work-related stress and anxiety, protecting your mental health, and providing quality patient care, this guide will help you learn how to not only SURVIVE your first year as a new nurse, but to ENJOY it! I was in your shoes and my first year of nursing almost broke me. That's why I want to help you survive your first year as a new nurse with your head held high and minimal melt downs. Let's do this. Here's what you can look forward reading: Precepting Meet Your Team Codes Taking Report Life Outside of Work Talking to Doctors Patients Your Tools Time Management Withdrawal and Death Written in a friendly, no-nonsense, style, Children in Intensive Care is a quick reference guide to the management of the acutely ill child in the hospital, or pre-hospital, setting. Fully updated throughout and rich with useful 'Alert' boxes and tables - to make learning and reference easy - this handy publication covers a broad range of essential topics such as drug dosages and compatibilities and normal reference ranges as well as harder to find information such as chest X-ray interpretation and troubleshooting technical equipment. Compiled from daily 'on the job' collation of useful facts and figures, this manual also offers practical advice about important non-acute issues such as infection control, common childhood diseases and child protection as well as new findings on the management of sepsis, the collapsed child and care of the child following spinal surgery. With over 10,000 copies sold, this book is an absolute must for any clinician involved with the management of critically ill children, whether it be on the wards, in

theatres, high-dependency or intensive care units, as well as during retrieval and in A&E. Information presented in quick reference format, with accompanying reference tables, to facilitate on-the-spot usage Advanced Life Support Group algorithms provide safe and easy-to-follow protocols to the management of emergency situations Contains input from a broad range of paediatric specialists - intensivists, anaesthetists, haematologists, oncologists, air ambulance physicians and retrieval nurses, pharmacists, specialist dieticians, and respiratory physiotherapists - to ensure full coverage and accuracy of information Contains helpful 'Quick Guide' and 'Warning' boxes to provide key information at a glance, while helpful mnemonics assist with learning Contains chapters on normal child development, safe-guarding children and young people, and patient transport Perfect for use on the wards, theatres, high-dependency units and intensive care units as well as during retrieval and A&E Ideal for newcomers and experienced staff alike, whether they be junior doctors or nursing staff Additional authorship brings the expertise of Marilyn McDougall, a Senior Paediatric Intensive Care Consultant Contains brand new chapters - oncology emergencies and pain & sedation - as well as the latest information on topics including sepsis and the collapsed neonate, and care of children after spinal surgery Comprehensively expanded cardiac chapter presents new surgical approaches as well as practical tips on pacing, care of chest drains and basic echocardiograph terminology Drug chapter now includes reversal agents, new drug profiles and an updated compatibilities chart Expanded artwork program explains clinical concepts and practical procedures Taking a different view on supporting families who have just been exposed to the NICU, little man Writer/Director Nicole Conn and Founder of Preemie Magazine, Deb Discenza have joined forces to create the "must-have and essential handbook to surviving the NICU. Cardiac arrest can strike a seemingly healthy individual of any age, race, ethnicity, or gender at any time in any location, often without warning. Cardiac arrest is the third leading cause of death in the United States, following cancer and heart disease. Four out of five cardiac arrests occur in the home, and more than 90 percent of individuals with cardiac arrest die before reaching the hospital. First and foremost, cardiac arrest treatment is a community issue - local resources and personnel must provide appropriate, high-quality care to save the life of a community member. Time between onset of arrest and provision of care is fundamental, and shortening this time is one of the best ways to reduce the risk of death and disability from cardiac arrest. Specific actions can be implemented now to decrease this time, and recent advances in science could lead to new discoveries in the causes of, and treatments for, cardiac arrest. However, specific barriers must first be addressed. Strategies to Improve Cardiac Arrest Survival examines the complete system of

response to cardiac arrest in the United States and identifies opportunities within existing and new treatments, strategies, and research that promise to improve the survival and recovery of patients. The recommendations of Strategies to Improve Cardiac Arrest Survival provide high-priority actions to advance the field as a whole. This report will help citizens, government agencies, and private industry to improve health outcomes from sudden cardiac arrest across the United States. Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Substantially revised since the previous edition, this Internship Survival Guide offers first-year residents practical, real-world medical and professional guidance from senior residents and faculty advisors at the Washington University School of Medicine. Advice is presented in a concise, bulleted format, lending itself to quick comprehension of the material. You'll learn the nuts and bolts of logistical issues and patient and colleague communication, as well as the basics of navigating your clinical rotations. This thesis uses the methods of clinical epidemiology to explore whether administrative datasets are a feasible methodology to evaluate the long-term survival of patients following the use of intensive care unit (ICU) technology. I conducted three main studies. First, I validated the Ontario administrative health data for identifying ICU patients using a prospective ICU registry as the criterion standard. The main finding was that administrative databases were able to identify ICU patients but no single strategy simultaneously provided ideal sensitivity, specificity, and positive predictive value. The main implication was that researchers should consider the study purpose when choosing the optimal strategy for ICU research involving these databases. Second, I examined the long-term survival following ICU care for a specific subgroup of patients, bone marrow transplant recipients. The main finding was that patients receiving any ICU procedure had increased one-year mortality (87% versus 44%, p Nurses are already nurse managers. They must manage patient caseloads and care plans as well as supervise aides, technicians, and other care providers. But moving from this type of organic management to a defined nurse manager role is not a natural progression. Nurse managers must command a vast, diverse, and robust skill set, and those skills must first be defined, explained, and operationalized for success. In an environment that offers new managers little support, where do they turn? The Nurse Manager's Survival Guide (4th Ed.) provides an overview of a nurse manager's major roles and responsibilities—all the fundamentals needed for success in one easy-to-use, consolidated, practical reference. From tips on building the right team to budgeting basics, time-management tools, and advice on taking care of one's self (and their team), author Tina Marrelli supplies the resources nurse

managers need to excel in day-to-day operations. This book is open access under a CC BY 4.0 license. It constitutes a unique source of knowledge and guidance for all healthcare workers who care for patients with sepsis and septic shock in resource-limited settings. More than eighty percent of the worldwide deaths related to sepsis occur in resource-limited settings in low and middle-income countries. Current international sepsis guidelines cannot be implemented without adaptations towards these settings, mainly because of the difference in local resources and a different spectrum of infectious diseases causing sepsis. This prompted members of the Global Intensive Care working group of the European Society of Intensive Care Medicine (ESICM) and the Mahidol-Oxford Tropical Medicine Research Unit (MORU, Bangkok, Thailand) - among which the Editors – to develop with an international group of experts a comprehensive set of recommendations for the management of sepsis in resource-limited settings. Recommendations are based on both current scientific evidence and clinical experience of clinicians working in resource-limited settings. The book includes an overview chapter outlining the current challenges and future directions of sepsis management as well as general recommendations on the structure and organization of intensive care services in resource-limited settings. Specific recommendations on the recognition and management of patients with sepsis and septic shock in these settings are grouped into seven chapters. The book provides evidence-based practical guidance for doctors in low and middle income countries treating patients with sepsis, and highlights areas for further research and discussion. For every D.O.N. or an A.D.O.N, a unit manager or shift supervisor this is a must read to add to your insight of running your facility. If you're an up and comer who is ready to climb the ladder to Long Term Care management this book provides the rungs to that ladder and will separate you from the rest of the crowd. If you are a non clinical Nursing Home Administrator who is looking for a crash course in the clinical demands of Long Term Care, your search is over. This title is directed primarily towards health care professionals outside of the United States. The needs of critically ill children are unique and this handy pocket book will be invaluable to anyone who needs a quick account of intensive care procedures. It brings together all the vital information in one source and in an accessible format. The text is organised by body systems and gives helpful hints on managing children with various conditions. Tables of normal values are included and additional information is provided about equipment needed in a paediatric emergency. ?. the information is clearly laid out and so is readily accessible ?. lightweight, pocket sized and easy to use in a clinical setting ?. written by British authors - nothing quite like it on the market ?. covers equipment needed in a paediatric emergency ?. helpful hints on managing a range of patients with various conditions . brings

together information not readily available in one book step by step chest x-ray interpretation including abnormalities non-invasive ventilation and capnography differentiation of upper airway obstruction new surgical options for very complex cardiac defects. diagrams of the recommended ways to move children with a suspected neck/head injury a chapter on child protection general features of common childhood illnesses Are you a starting work in critical care? Are you an experienced nurse but need to check guidelines and best practices? This is the indispensable guide to daily procedures and problems faced by nurses working in this specialty. This book will help you to Organise your job and yourself Assess patients and communicate with them Get clinical information on a wide range of conditions What to do in emergency This UPDATED edition: Completely updated and revised content written by authors with extensive nursing experience in the field Physiological, psychological and social areas, as well as legal issues, ethical and moral dilemmas that critical care nurses and health care practitioners may face on a daily basis Boxes, tips and diagrams to help bridge the theory-practice gap while embarking on your critical care career. Part of the A Nurse's Survival Guide series Completely updated and revised content written by authors with extensive nursing experience in the field Physiological, psychological and social areas, as well as legal issues, ethical and moral dilemmas that critical care nurses and health care practitioners may face on a daily basis Boxes, tips and diagrams to help bridge the theory-practice gap while embarking on your critical care career. This book provides a comprehensive overview of improving critical care survivorship. Comprised of four sections, the text presents interventions that can be used to improve patient outcomes and reduce the burden of post-intensive care syndrome across the arc of care, from the ICU to returning home. The first section of the text focuses on preventing adverse outcomes in the ICU, with an emphasis on implementing early mobilization, engaging and supporting families, and employing various forms of therapy. The second section revolves around enhancing recovery post-ICU, focusing on physical and neurocognitive rehabilitation programs, peer support, and poly-pharmacy management. Community reintegration is the subject of the third section, with emphasis on socioeconomic reintegration, healthcare utilization, and volunteerism in ICU recovery. The book concludes with a section on future considerations, specifically spotlighting preliminary ideas that address long-term sequelae and international collaboration to solve critical care challenges. Written by experts in the field, Improving Critical Care Survivorship: A Guide for Prevention, Recovery, and Reintegration is a valuable resource for critical care clinicians and researchers interested in improving the quality of patient survival after ICU admission. For many years, intensive care has focused on avoiding immediate death from acute,

life-threatening conditions. However, there are increasing reports of a number of lingering consequences for those who do indeed survive intensive care. Examples include on-going high risk of death, neurocognitive defects, significant caregiver burden, and continued high healthcare costs. Surviving Intensive Care, written by the world's experts in this area, is dedicated to better understanding the consequences of surviving intensive care and is intended to provide a synopsis of the current knowledge and a stimulus for future research and improved care of the critically ill. Purpose: Little is known about long-term survival after In-Hospital Cardiac Arrest (IHCA). The purpose of this study is to report the one-year survival of patients after IHCA and to identify predicting factors.Methods: a single-center retrospective chart study of all adult in-hospital CPR attempts conducted between January 2003 and February 2014 in a tertiary teaching hospital in Amsterdam (NL). The demographic and clinical variables of patients were obtained at 24 hours pre-arrest, during CPR and post-CPR. All patients were tracked one year after discharge from hospital.Results: CPR was performed for IHCA on 417 patients during the study period. Return of spontaneous circulation (ROSC) was achieved in 283 (68%) patients, 234 were admitted to ICU. The survival rate of patients who were admitted to ICU after IHCA was 38% (89/234) at hospital discharge and 26% (61/234) at one year. Overall, 95 (23%) patients survived one year after discharge. Univariate analysis showed numerous variables are associated with one-year survival, for example comorbidity index and time to ROSC. Discussion: One-year survival of patients who were admitted to the ICU after IHCA was 26%. Survival of this group was associated with patient and pre-arrest, CPR characteristics and severity of diseases at ICU admission reflected by clinical scores. "Foreward by Dr. Peter Pronovost"--Cover. A Mother's Diary: How to Survive the Neonatal Intensive Care Unit is a firsthand account of one woman's journey. It represents the struggle of thousands of women every year whose babies begin life in the N.I.C.U. Menetra Hathorn writes the entire book from her perspective - a mother's point of view. She begins by introducing you, the reader, to her world and giving some background information about how her journey began. Next, you walk with her the rest of the way - through a slow and tedious hospitalization. Then, she names and discusses 10 strategies that will help you survive the N.I.C.U. (and beyond). Finally, she shares some valuable insight with relatives and friends while recommending a variety of ways that they can help. A Mother's Diary: How to Survive the Neonatal Intensive Care Unit was written because Mrs. Hathorn was unable to find anything like it during her third child's 119-day hospitalization. She wanted to know that she wasn't alone, and she needed some common sense strategies she could implement to help save herself from drowning in a sea of grief, depression, and anxiety. The New York Times bestselling author of

Being Mortal and Complications reveals the surprising power of the ordinary checklist We live in a world of great and increasing complexity, where even the most expert professionals struggle to master the tasks they face. Longer training, ever more advanced technologies—neither seems to prevent grievous errors. But in a hopeful turn, acclaimed surgeon and writer Atul Gawande finds a remedy in the humblest and simplest of techniques: the checklist. First introduced decades ago by the U.S. Air Force, checklists have enabled pilots to fly aircraft of mind-boggling sophistication. Now innovative checklists are being adopted in hospitals around the world, helping doctors and nurses respond to everything from flu epidemics to avalanches. Even in the immensely complex world of surgery, a simple ninety-second variant has cut the rate of fatalities by more than a third. In riveting stories, Gawande takes us from Austria, where an emergency checklist saved a drowning victim who had spent half an hour underwater, to Michigan, where a cleanliness checklist in intensive care units virtually eliminated a type of deadly hospital infection. He explains how checklists actually work to prompt striking and immediate improvements. And he follows the checklist revolution into fields well beyond medicine, from disaster response to investment banking, skyscraper construction, and businesses of all kinds. An intellectual adventure in which lives are lost and saved and one simple idea makes a tremendous difference, The Checklist Manifesto is essential reading for anyone working to get things right.

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