INTRODUCTION
Many tertiary healthcare organizations experience capacity constraints for both the inpatient areas, as well as the Emergency Department (ED). Due to the inpatient capacity constraints, Surgical transfers/direct admits (TDA) were found to often access the hospital via the ED resulting in compounding overcrowding and boarder hours.

Misercola et al unexpectedly found that 1/3 of transferred patients were accepted from the ED accounting for a reduction of >850 ED boarder days. As a result of these concerns, the need for a surgical receiving unit was identified.

LITERATURE REVIEW
A PubMed search of “surgery admission unit” failed to find any specific manuscripts. Many publications deal with surgical patients’ effect on access, ED boarding and overcrowding, but few publications were found directly related to surgical delays in transferred patients.1-2 Misericora et al unexpectedly found that 1/3 of transferred patients underwent basic surgical procedures, or did not need intervention at all, concluding that many rural communities lack general surgery resources.1 In Canada, Desai et al showed a median delay from admission to operation of 93 hours in general surgery patients, which is called Erlanger Surgical Transfer and Receiving Unit (eSTAR).3

METHODS
A six month retrospective review of Surgical TDA patients accessing the facility through the ED was conducted. This data revealed sufficient volume to support an 8-10 bed admission unit specifically for non-trauma, surgical TDA patients, which is called Erlanger Surgical Transfer and Receiving Unit (eSTAR).

RESULTS
After process development, our Regional Transfer Center and key stakeholders were educated on the eSTAR admission criteria, priority, and procedure. Admissions were prioritized with transfers/direct admits given first beds in an effort to limit unnecessary presentations to the ED (limiting costs and overcrowding). Secondly, surgical patients presenting to the ED were next assigned eSTAR beds, reducing the number of boarder hours in the ED.

In the first 19 months of operation (June 2017-January 2019), eSTAR has prevented >1250 unnecessary ED presentations, resulted in $3,450,000 savings to the customers, and reduced ED overcrowding.

DISCUSSION
For the unit to be successful, it is critical that patient selection criteria and acceptance priority be easily understood and contain few “exceptions.”

CONCLUSION
In our institution, a surgical subspecialty “receiving” unit, eSTAR: decreased unnessary ED admissions by TDA, decreased healthcare cost, decreased the amount of time a non-trauma surgical admit lingers in the ED, reduced ED overcrowding, and facilitated faster delivery of surgical care to transfers and direct admits from our region.

ACKNOWLEDGEMENTS
The authors would like to acknowledge clerical assistance from Amy Morgan and Patricia L. Lewis, RN.

WORKS CITED

Implementation of a Surgical Transfer Unit: An Innovative Approach to Increase Timely Access to Surgical Subspecialists
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Additional findings included:
• eSTAR could be useful in alleviating OR Holds resulting from PACU boarders.
• PACU and ER patients could significantly impact the units available to accept TDA

For the unit to be successful, it is critical that patient selection criteria and acceptance priority be easily understood and contain few “exceptions.”

As for priority 2 and 3 patients, acceptance criteria needs to take into account the requirement to maintain the ability to accept TDAs at the facility.