

Emergency department short-stay ward at a tertiary care hospital: 4 years' experience

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Objective: A short-stay ward belonging to an emergency department and operating 24 hours a day, 7 days a week offers an alternative to conventional hospitalization. We describe activity in the emergency department short-stay ward (16 beds) at Hospital Clínico San Carlos in Madrid, Spain.

Methods: Descriptive study of all short-stay emergency admissions for the years 2003 through 2006. Information was obtained retrospectively from case records and discharge summaries.

Results: A total of 10 942 admissions to the ward, representing 13.2% of all hospital admissions from the emergency department, were included. The mean (SD) age was 78.8 (18.5) years and 62.5% of the patients were female. The occupancy rate was 87% (mean number of beds occupied, 14.6 [1.5]). The main reasons for admission to the short-stay ward were the exacerbation of chronic conditions (heart failure and chronic obstructive pulmonary disease), infections (of the respiratory and urinary tracts), syncope, arrhythmia, diarrhea, gastrointestinal bleeding, and bowel obstruction. The main diagnosis-related groups (DRGs) were 127, 541, and 321; 20 DRGs accounted for 55% of admissions. A mean of 1.18 (0.02) admissions per DRG were made, and the mean duration of stay in the unit was 0.91 (1.39) days. In 9811 cases (89.7%) the destination on discharge was outside hospital (20.10% of discharges were on a Saturday or Sunday); 2638 discharged patients (26.9%) were given appointments for outpatient visits, 1218 (12.4%) were placed in home hospitalization programs, and 293 (3.0%) were transferred to support facilities. Discharges home, outpatient appointments, and transfers to support facilities increased significantly from year to year. A total of 1116 patients (10.9%) were transferred to another department of the hospital, 368 (32.98%) after a new diagnosis. The remaining internal transfers were due to lack of improvement in the condition for which the patient had been admitted. The rate of new diagnoses made while the patient was in the short-stay ward increased significantly over the period studied ($P < .001$). The mortality rate was 0.14% and the readmission rate, 3.7%.

Conclusions: The emergency department short-stay ward offers an alternative to conventional hospitalization. The diagnostic and therapeutic efficiency of this care model is high. [Emergencias 2009;21:87-94]

Key words: Emergency health services. Short-stay observation ward. Organization and administration.

Introduction

The Spanish health system is based on a model of universal coverage. It consumes 7% of the GNP¹, and is the second largest program of social protection. Western societies have converted to the fast food culture in more ways than one. All their needs, including health, must be covered al-

most immediately. Hospital Emergency Departments (ED) are the most accessible doorway to the health system; they are expected to be efficient without compromising the quality of health care.

During the last few decades, EDs have experienced situations of overcrowding, to the point of collapse on occasions, which undermine quality²

and efficacy³. Initially, the most relevant factors were external with respect to the hospitals themselves. ED collapse was explained by the increase in the number of visits influenced by a response to primary attention considered inadequate by the users, climate change, pollution, lunar cycles⁶, flu epidemics⁷, sporting events⁸, socioeconomic level and, more recently, by a sector of the population without a health card. But recently, interest has focused on internal hospital conditions: waiting times, insufficient number of hospital beds, delayed transfer to assigned hospital beds¹⁰, appropriate hospital admission and stay¹¹ and, within EDs themselves, the lack of infrastructure, staff, motivation and organization. ED activity has enormous repercussions on the general functioning of the hospital, especially programmed activity, mainly surgical interventions¹². Reducing surgical waiting lists is a fundamental objective for the general population and therefore for the health authorities.

Faced with this situation, alternatives to conventional hospitalization have arisen, notably day hospitals, observation wards, homecare programs and short-stay wards (SSW)¹³. These SSW are physically adjacent extensions of EDs, attended by the ED staff that provides continuous attention (24 hours a day every day of the year). This arrangement achieves greater patient/bed rotation than other hospital wards¹⁴. They have proved to be effective when admission criteria are clearly defined, including the selection of patients with certain diseases and levels of severity, limited stay times (< 3 days) and strictly defined diagnostic and therapeutic protocols. The SSW may admit patients with varied or specific pathologies (chest pain, paediatric, psychiatric etc); the role is not clearly defined¹⁵.

SSW have proved to be efficient, with a high level of resolution, thus reducing stay time, and their degree of safety and user satisfaction is at least equivalent to that of conventional modes of hospitalization^{16,17}. The objective of this study was to describe our 4-year experience of activity in a 16-bed ED short-stay ward, considered a key unit within the hospital healthcare circuit.

Method

The study included all patients admitted to the ED SSW of Hospital Clínico San Carlos in Madrid between 1 January 2003 and 31 December 2006 (4 years). The hospital attends the population in area 7 according to health zones established by

the health authority of the Autonomous Community of Madrid. During the study period, the emergency department received a total of 659,920 visits, with a daily mean of 452 visits (including the primary attention unit, acute ward, paediatrics, traumatology, psychiatry, gynaecology, ophthalmology and otorhinolaryngology). ED pressure in this period was 58.6%, reaching 80% if only admissions for medical reasons are considered.

The SSW was created in May 2002. It has 16 beds distributed in 3 same-sex bays, two of which have 6 beds while the third bay has 4 beds. From January to March 2005, a further 12 beds were situated in a different location. The staff on normal week days includes two ED physicians in the morning, another from 15 h to 22 h, 2 registered nurses and 2 auxiliary nurses on morning and afternoon shifts and one at night, a porter and an administrative day worker. On weekends and holidays, it includes a physician from 9 h to 22 h and a nurse on morning and afternoon shift. The rest of the SSW staff is the same as that of the ED. Lastly, there is also a medical resident on duty every night to deal with incidents.

Admission criteria for the SSW were established according to diagnosis-related groups (DRGs) previously determined by the hospital for 75-178 such groups. From its creation, the objective of the SSW was to strictly comply with the 3-day stay limit, and to achieve this it uses all other available resources when necessary.

SSW patients during the study period were identified from the hospital clinical records and data base as well as from the SSW discharge reports. From the latter, the following variables were recorded: age, sex, date of admission, date of discharge, diagnosis and discharge destination (homecare protocol, with hospital outpatient consultation, support hospital admission or primary healthcare services without other resources). We also recorded internal transfers (and distinguished between reasons for admission - non-improvement of the clinical condition or definitive diagnoses established by the SSW) and lastly, the number of deaths. Variables obtained from hospital clinical records and data base were: number of admissions to the SSW and its percentage with respect to the total number of hospital admissions, index of bed occupation (the mean number of beds or the percentage of beds occupied at 8 h each day with respect to the total), source of admission (ED or programmed), main DRG and mean weight, mean stay time in days per patient, number of SSW discharges (annual total, weekend

discharges, and mean number of discharges per day). Lastly, re-admissions defined as re-admission with hospitalization for the same DRG in the first month after SSW discharge.

Between June and September 2007, we performed a systematic review of the literature on short-stay wards. In the bibliographic search we used diverse terms and phrases in both Spanish and English: "unidad de corta estancia", "emergency short stay unit", "short stay ward", "emergency department, utilization", "observation unit", "observation ward", "área y sala de observación", "alternatives hospitalization convencional". The following health-related data bases were searched: MEDLINE via Pub med, The Cochrane Library, Best Evidence and Clinical Evidence. The material obtained was published in Spanish or English between January 1975 and September 2007.

For statistical analysis, qualitative variables are presented with their frequency distribution and expressed as mean and standard deviation standard (SD). Chi 2 test was used to evaluate association between qualitative variables, or Fisher exact test when > 25% of expected frequencies had values < 5. To evaluate the hypothesis that the proportions presented an increasing or decreasing tendency, we used the linear tendency test and calculated Pearson's correlation coefficient. For the association between quantitative variables, Spearman's non-parametric correlation coefficient was used. Data processing and analysis was performed using SPSS 13.0. Differences with a p value < 0.05 were considered as significant.

Results

In total, 10,942 patients were admitted to the SSW, of whom 10,934 (99.9%) were emergency patients and 8 (0.1%) programmed (1 in 2003, 1 in 2005 and 6 in 2006): 6,839 (62.5%) were women and 4,103 (37.5%) men. Mean age was 78.8 (SD 18.5) years. The number of patients admitted to SSW represented 13.3% of the annual total of HCSC admissions (81,964). Figure 1 shows the evolution of admissions in percentages, to the SSW, the department of Internal Medicine and the Geriatric department. Admissions to the remaining departments represent 64.6% of all admissions from ED, without significant yearly change (64.3% in 2003, 64.8% in 2004, 64.4% in 2005 and 64.8% in 2006). Analysis of each DRG leading to admission showed a significant increase in the percentage

of ED patients admitted to the SSW (linear tendency $p < 0.001$; $r = 0.03$), significant decrease in those admitted to the departments of internal medicine and geriatrics ($r = -0.02$, linear tendency $p < 0.001$; $r = -0.02$, linear tendency $p < 0.001$, respectively), while the distribution of admissions in the category "other departments" showed no significant tendency (linear tendency $p = 0.58$). Mean occupation of beds per day was 88.1% (14.1/16; 14.9/16 in 2003, 13.8 /16 in 2004, 14.2/16 in 2005 and 13.6/16 in 2006) with no associated linear correlation.

We studied the main pathologies motivating admission using the DRGs provided by the Hospital records and clinical documentation service. Table 1 shows the mean weight and number of discharges of the 20 most frequent DRGs. The sum of these represented 55% of all patients admitted. The order of frequency of these DRG showed little annual variation. Likewise, 21 of the 25 most frequent DRGs coincided each year. Mean weight per DRG was 1.18 (1.17 in 2003, 1.16 in 2004, 1.22 in 2005, 1.17 in 2006; $p = \text{NS}$). Mean stay was 1.9 (SD 1.4) days, which decreased from year to year (2.1 in 2003, 1.8 in 2004, 1.9 in 2005 and 1.7 in 2006; $p < 0.001$). Analysis of the relation between mean stay and mean weight of the 20 most frequent DRG showed a positive but non-significant correlation between these two variables ($r = 0.26$; $p = 0.269$; Figure 2).

The total number of discharges was 10,942, without significant differences in annual percentages (linear tendency $p = 0.872$). The mean daily discharge rate was 6.3 (5.9 in 2003, 6.1 in 2004, 6.5 in 2005 and 6.5 in 2006; $p = 0.234$). Weekend discharges represented 20.2% of the 4-year total, and this remained constant from year to year (21.6% in 2003, 19.5% in 2004, 20.6% in 2005 and 19.3% in 2006; linear tendency $p = 0.1082$). Table 2 shows the distribution of discharges per year during the study period. Analysis of each reason for discharge (internal transfer, external transfer and exitus) showed no significant differences in yearly distribution during the study period.

In the group of patients with external discharge (Table 2), we observed significant differences in distribution of all types from year to year ($p < 0.001$), with a significant increase in home-care discharge, outpatient consultation and discharge to other centres, and a significant decrease in referral to primary healthcare.

With respect to reasons for internal transfer, we found a significant annual decrease in the per-

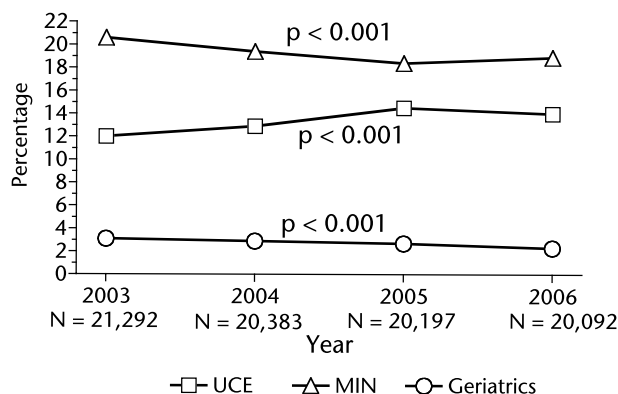


Figure 1. Evolution of the percentage of admissions to the SSW, the Department of Internal Medicine (DIM) and the Geriatric department by year of study. The value of N corresponds to the total number of admissions from ED.

centage of patients with poor evolution of the disease motivating initial SSW admission ($p < 0.001$), and significantly increased transfers due to new diagnoses made in the SSW which required hospitalization for further study ($p < 0.001$) (Table 2). In this latter group, the reasons for hospital admission were: lower gastrointestinal bleeding 129 (35.0%), bowel obstruction 127 (34.5%), cardiopulmonary pathology 45 (12.2%), syncope 25 (6.8%) and other reasons 42 (11.4%). The distribution of these reasons during the study period showed significant differences ($p = 0.032$).

The percentage of re-admissions for all hospital discharges was 5.4% (7,551). A breakdown of this by year of study (5.4% in 2003, 5.4% in 2004,

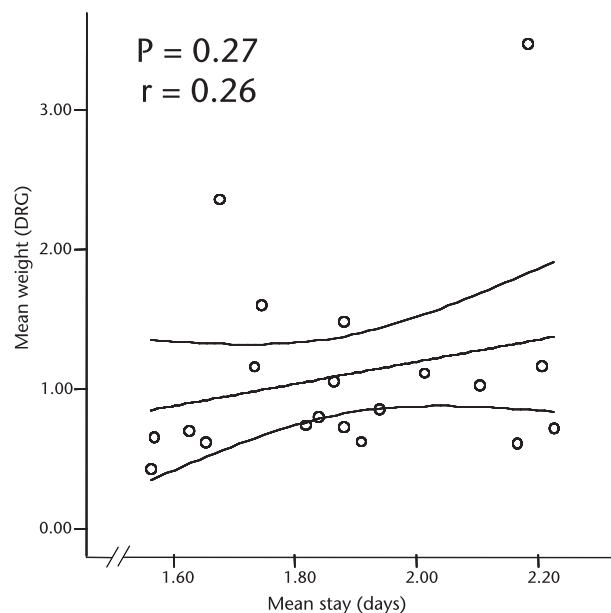


Figure 2. Scatter plot: relation between mean stay (days) and mean weight of the 20 most frequent diagnosis-related-groups (DRGs) during the study period.

5.3% in 2005 and 5.4% in 2006) revealed no significant differences (Linear tendency $p = 0.740$). Total re-admissions in patients discharged from the SSW were 410 (3.7%), significantly lower than those for the rest of the hospital ($p < 0.001$).

No significant changes were observed in the rate of SSW re-admissions throughout the study period. However, there was a significant increase in the percentage of re-admissions to hospital

Table 1. Relation between mean weight and number of discharges from the Short-Stay Ward according to the 20 most frequent Diagnosis-Related Groups

Diagnosis-Related Groups	MW	N° discharges
127 (heart failure and shock)	1.485	632
541 (respiratory disorders excluding infections. bronchitis. asthma with major complications)	2.365	617
321 (renal and urinary infections in patients aged >17 years, without complications)	0.660	556
175 (bowel haemorrhage without complications)	0.803	388
183 (esophagitis. gastroenteritis & varied GI disorders in patients aged >17, without complications)	0.774	359
142 (syncope & collapse without complications)	0.722	347
88 (Chronic obstructive pulmonary disease)	1.166	329
814 (non-bacterial gastroenteritis & abdominal pain in patients aged >17, without complications)	0.430	323
139 (cardiac arrhythmia & conduction disorders, without complications)	0.735	302
181 (GI obstruction, without complications)	0.611	237
97 (bronchitis & asthma in patients aged >17, without complications)	0.703	232
138 (cardiac arrhythmia & conduction disorders, with complications)	1.171	199
544 (congestive heart failure & cardiac arrhythmia, with major complications)	3.479	150
320 (renal and urinary infections in patients aged >17 years, with complications)	1.071	177
87 (lung edema & respiratory failure)	1.603	191
141(syncope & collapse, with complications)	1.070	171
813 (non-bacterial gastroenteritis & abdominal pain in patients aged >17, with complications)	0.860	150
189 (other GI disorders in patients aged >17, without complications)	0.629	159
102 (other respiratory disorders without complications)	0.636	146
182 esophagitis. gastroenteritis & varied GI disorders in patients aged >17, with complications)	1.157	121

MW: mean weight; GI: Gasrointestinal.

Table 2. Final destination of patients admitted to the ED Short-Stay Ward, total and by year of study period

Destination after discharge	Total (N = 10 942) n (%)	2003 (N = 2,553) n (%)	2004 (N = 2,639) n (%)	2005 (N = 2,923) n (%)	2006 (N = 2,827) n (%)	linear tendency p
External discharges	9,811 (89.67)	2,282 (89.39)	2,412 (91.40)	2,609 (89.26)	2,508 (88.72)	0.10
Internal transfers	1,116 (10.19)	265 (10.38)	225 (8.53)	308 (10.54)	318 (11.16)	0.07
Exitus	15 (0.14)	6 (0.23)	2 (0.07)	6 (0.20)	1 (0.12)	0.14
External discharges	N = 9,811	N = 2,282	N = 2,412	N = 2,609	N = 2,508	
Homecare program	1,218 (12.42)	112 (4.91)	306 (12.69)	368 (14.11)	432 (17.23)	< 0.001
External consultation	2,638 (26.88)	368 (16.13)	723 (29.98)	822 (31.50)	725 (28.91)	< 0.001
Support centres	293 (2.99)	5 (0.22)	21 (0.87)	42 (1.61)	225 (8.97)	< 0.001
Primary Care	5,662 (57.71)	1,797 (78.75)	1,362 (56.47)	1,377 (52.78)	1,126 (44.89)	< 0.001
Internal transfers	N = 1,116	N = 265	N = 225	N = 308	N = 318	
Poor evolution	748 (67.02)	188 (70.94)	169 (75.11)	198 (64.28)	193 (60.69)	< 0.001
SSW diagnoses	368 (32.98)	77 (29.06)	56 (24.89)	110 (35.71)	125 (39.31)	< 0.001

wards and a corresponding decrease in re-admission to the SSW itself (Table 3).

Discussion

Our hospital SSW is an alternative to conventional hospitalization units, which has established itself with a clearly defined role within the hospital (Figure 3). It has functioned not only as a therapeutic unit but also as a diagnostic one. Criteria for admission have been respected and mean stay has been lower than expected (less than 72 hours). Regarding final destination, the majority were extra-hospital, with or without other resources (homecare, outpatient visits, and transfer to other hospitals). The rest were transferred to other departments in the hospital (for lack of improvement or new diagnoses) and exitus. All this has maintained the rate of re-admission lower than that of the rest of the hospital.

The current situation of EDs in tertiary hospitals has required a re-appraisal of ED activity and highlighted their care protocols. The factors underlying ED saturation, both internal and external, are difficult to modify from within. For this to be accomplished, the levels of attention external to the tertiary hospital would have to be increased and, within the hospital itself, optimized. EDs have not only worked to ensure equal and adequate quality treatment but they have also gener-

ated alternatives to conventional hospitalization, notably SSWs. Tertiary hospitals are the final link in the healthcare chain. They offer the most sophisticated technical and human resources. Their objective is to achieve health, stabilization and recovery in the most complex cases. Thus, they are also the most expensive health centres for the administration. Apart from these hospitals, our health system has secondary hospitals, long-stay units, community and primary health centres.

In line with Barbado et al²⁴, we believe that most medical services continue to implement hospitalization until the correct diagnosis and treatment are obtained without considering that, at times, the patient may be appropriately treated in an ambulatory manner. Hospitalization in tertiary centres is recommended for those more complicated cases requiring diagnostic and therapeutic (medical and/or surgical) resources that cannot be offered by primary or secondary health centres. An "early adequate" discharge from a tertiary hospital entails a series of benefits, not only from the viewpoint of economic management but also for the patient: reduced hospital-related complications, increased social integration and less limited functional impact.

The data presented in our study are not easily compared with those of other previously published studies which mainly deal with ED observation units¹⁸ or SSW in departments of Internal Medicine¹⁹, not EDs.

Table 3. Distribution of re-admissions to the ED Short-Stay Ward, total and by year of study period

Re-admissions to SSW	Total n (%)	2003 n (%)	2004 n (%)	2005 n (%)	2006 n (%)	linear tendency p
Re-admissions to SSW	132 (32.20)	33 (37.93)	40 (37.04)	33 (28.21)	26 (26.53)	< 0.001
Re-admissions to a hospital ward	278 (67.80)	54 (62.07)	68 (62.96)	84 (71.79)	72 (73.47)	< 0.001
Total	410 (100)	87 (100)	108 (100)	117 (100)	48 (100)	NS

NS: non-significant.

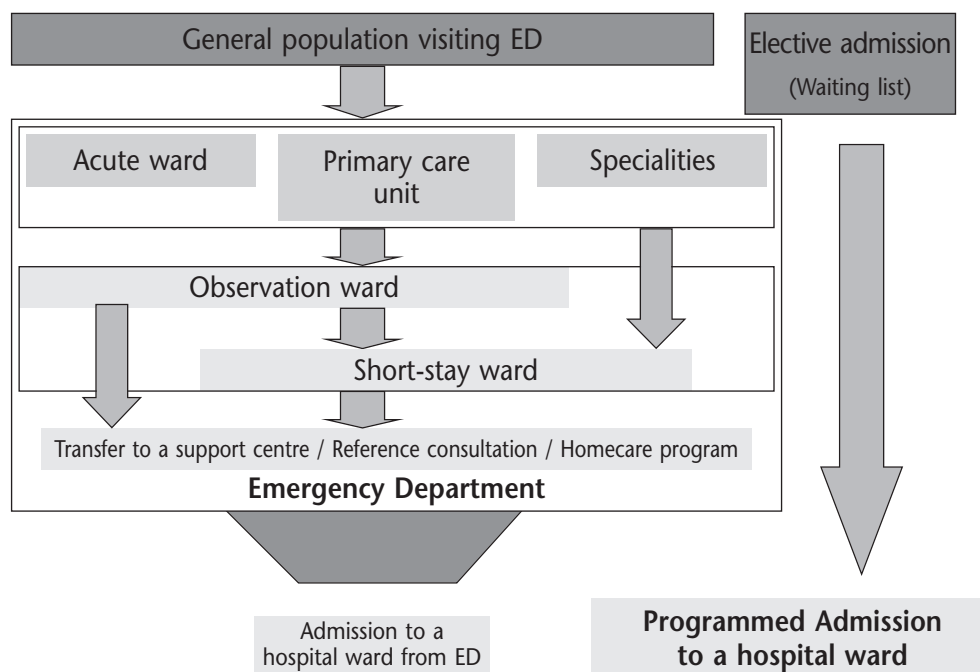


Figure 3. Flow chart of ED patients.

Despite increasing pressure on ED services, the SSW has increased the number of its admissions, thus reducing those in Internal Medicine and Geriatric departments. In 2003, the number of patients admitted to the SSW was approximately half that in these other two departments, whereas in 2006 this number reached two thirds. The number of beds in our SSW is similar to that in other SSWs (20 in Barcelona²⁰, 18 in Toledo, 16 in Leganés²¹, A Coruña²² o Montreal²³ and 15 in Valladolid²⁴), which is considered adequate in terms of occupation, approximately 90%.

Regarding the profile of patients admitted, a notable finding was the presence of elderly women, which is a reflection of the surrounding population with the highest mean age of the Community of Madrid. In other SSWs, mean age was lower except for Hospital La Fe SSW (Valencia) with a mean age of 76.1 (SD 7.0) years.

The most frequent pathologies underlying SSW admission were: exacerbation of chronic disease (heart failure, obstructive lung disease), infection (respiratory, urinary), syncope, arrhythmia, diarrhoea, GI haemorrhage and bowel obstruction. Of the 75 DRGs, 25 predominated, including those numbered as 127, 541, 88, 97, 544, 101, 102, 90, 814 and 542. Other SSWs report similar results, especially regarding acute phases of chronic disease and acute uncomplicated infection^{25,26}. Gaspoz et al describe a more specific SSW for

chest pain²⁷. Mean stay was lower than expected (< 2 days), and has decreased since inception, without variation in DRG mean weight. Other SSWs show longer mean stay times, which may be related with fewer formal support resources. In addition, it is notable that our SSW has been able to discharge patients during non-working hours (weekday afternoons, Saturdays, Sundays and holidays), in contrast to the rest of the hospital. In this study, 20% of the discharges were given over weekends. Destination at discharge remained stable, with almost 90% being external to the hospital. A striking finding was the increase in the homecare program formed by our ED staff, the creation of emergency reference consultation and the relation established with other specialists for consultation, such as cardiologists (consulted in certain cases of heart failure). Discharge to other centres of support to continue treatment occurred on some occasions, after symptom diagnosis and initial stabilization. The remaining discharges were internal transfers, with minimal mortality rates as expected. The percentage of these internal transfers remained stable.

Data published on other SSWs indicate both lower rates of internal transfer (6% reported for the Toledo SSW and 8.5% for the SSW of L'Hospitalet de Llobregat) and higher rates (32% in La Coruña)²⁸. But on evaluating the reasons for transfer, our data showed increased transfer for diag-

nostic reasons (notably GI bleeding and bowel obstruction) and decreased transfer due to poor clinical evolution. This latter point is important, since it indicates generally correct type of admission to the SSW.

After hospital discharge, any re-admission must be carefully analyzed. Rates of re-admission are accepted as indicators of hospital healthcare quality, especially early re-admission²⁹. However, this has not been consistently demonstrated³⁰. Lack of uniformity reduces the value of these rates³¹. Most re-admissions are associated with indicators of sub-optimal care, such as failure to resolve the reason for initial admission, incorrect treatment on discharge or deficient out-of hospital attention. In our case, the rate of re-admission remained stable and below that for the rest of the hospital. This suggests that the SSW was efficient without compromising its quality of care.

Other SSWs report somewhat higher rates of re-admission: (5% in Toledo and Leganés, 6% in Montreal and 9.3% in Valladolid).

This study has certain limitations, in accordance with any such retrospective "case series" study. The lack of a control group prevents comparisons and establishing associations. In this case, the comparisons with other SSWs presented here are merely for orientation. Future studies should be designed to prospectively compare different care units. In any case, we believe that the SSW represents a complementary and alternative approach to conventional hospitalization in a tertiary hospital. The SSW has acted as care unit admitting patients according to DRGs, maintaining mean stay time below 2 days and with minimal mortality (0.14%). Most discharges (89.7%) were external to the hospital, with almost half of these (42.3%) assigned to other care resources (home-care programs, support centres or outpatient specialist consultation). Finally, the SSW has acted as a high resolution unit, not only therapeutically (especially in exacerbation of chronic cardio-respiratory processes and acute infection), but also in diagnostic functions (especially in certain pathologies such as syncope, bowel obstruction and GI bleeding).

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Actividad de una unidad de corta estancia en urgencias en un hospital terciario: cuatro años de experiencia

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Objetivos: La Unidad de Corta Estancia es una alternativa a la hospitalización vinculada al servicio de urgencias (SU) operativa las 24 horas los 7 días de la semana. Se describen las características de la actividad asistencial de la Unidad de Corta Estancia de Urgencias (UCEU) del Hospital Clínico San Carlos (HCSC).

Método: Estudio de una serie de casos de todos los pacientes ingresados en la UCEU del HCSC durante cuatro años (2003-2006), dotada de 16 camas para cada caso se obtuvo información de forma retrospectiva de la base de datos de archivos y documentación clínica y del informe de alta.

Resultados: Se incluyeron un total de 10.942 pacientes (13,2% del total ingresos realizados desde urgencias), con una edad media 78,8 (DE 18,5) y un 62,5% mujeres. El índice de ocupación fue 14,6 (DE 1,5) (87% del total de camas). Los motivos principales de ingreso fueron la reagudización de procesos crónicos (insuficiencia cardiaca y enfermedad pulmonar obstructiva crónica), las infecciones (focos respiratorio y urinario), el síncope, las arritmias, la diarrea, la hemorragia digestiva y la obstrucción intestinal. Los grupos relacionados de diagnóstico (GRD) principales fueron el 127, el 541 y el 321 (la suma de 20 GRD representa el 55% ingresos). El peso medio por GRD fue de 1,18 (DE 0,02) y la estancia media de 1,91 (DE 1,39) días. El destino final fue alta externa en 9.811 casos ($p < 0,001$ para todos ellos) (20,10% en sábados o domingos), de los cuales 2.638 (26,9%) con cita en consultas, 1.218 (12,4%) con hospitalización a domicilio, y 293 (3,0%) fueron derivados a centros de apoyo. Se observa una tendencia ascendente estadísticamente significativa en la evolución de altas con hospitalización a domicilio, a consultas externas y a centros de apoyo (89,7%). Se realizaron 1.116 (10,9%) traslados internos, 368 (32,98%) tras nuevo diagnóstico y el resto por ausencia de mejoría de la patología que motivó el ingreso en la UCEU. Se detecta una tendencia ascendente significativa en el porcentaje de nuevo diagnóstico en UCEU ($p < 0,001$). La tasa de mortalidad fue del 0,14% y la de reingresos del 3,7%.

Conclusiones: La UCEU representa una alternativa a la hospitalización convencional. Es un modelo de alta resolución diagnóstica y terapéutica. [Emergencias 2009;21:87-94]

Palabras clave: Urgencias. Unidad de corta estancia. Gestión. Organización.