ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 11, Issue, 11, pp.8197-8199, November, 2019

DOI: https://doi.org/10.24941/ijcr.37225.11.2019

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

AN AUDIT ON SHORT TERM READMISSION AT THE MEDEOR INSTITUTE OF EMERGENCY MEDICINE

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ARTICLE INFO

Article History:
Received 04th August, 2019
Received in revised form
28th September, 2019
Accepted 15th October, 2019
Published online 26th November, 2019

Key Words:

Readmission, Avoidable Readmission, Short term Readmission, Emergency Readmission.

ABSTRACT

Emergency departments (ED) care for patients with a diversity of requirements that decide their disposition and revisit to the ED. Furthermore, readmissions to the hospital are often used as a quality indicator. However, caution must used since readmissions are complex in nature and only the avoidable readmission need to be dealt with improvements. Thus, we undertook an audit at the Medeor Institute of Emergency Department (MIEM) to gauge the readmissions within 72 hours. Therefore, all patients presenting to the ED within 72 hours of their admission to the hospital were prospectively included from June through September 2019. Each of these patients were further categorized hierarchically and exclusively into 5 categories as: (I) Avoidable readmissions – (IA) readmissions due to inadequate care/misdiagnosis, (IB) readmission due to poorly managed transitions during discharges; (II) Unavoidable readmission – (IIA) readmissions due to complication/disease progression, (IIB) readmission due to recurrence of symptoms; (III) Unrelated readmission (different organ system involvement); (IV) Readmission due to planned procedure or admission; and (V) Readmission after leaving against medical advice (LAMA). This categorization was based on our earlier study[2]. It was observed that the short term readmission rate at MIEM was 0.48%. A fifth of these readmissions were avoidable. Moreover, one (6.7%) patient returned to the ED due to poorly managed transitions during discharges due to poor understanding of instruction to return to ED, while two (13.3%) patients received inadequate care as a result of misdiagnosis. Hence, ED discharge summary with written discharge instructions, in addition to verbal explanation, and mandatory co-signature of every ED initial assessment by Emergency Consultant are introduced to address these lacunae.

Citation: Dr. Dolly C Yadav, Dr. VGR Shastry and Dr. Tamorish Kole. **2019.** "An audit on short term readmission at the Medeor Institute of Emergency Medicine", *International Journal of Current Research*, 11, (11), 8197-8199.

INTRODUCTION

Emergency Departments (ED) care for patients with a diversity of requirements that decide their disposition and revisit to the ED. Readmissions are multifaceted and are more and more used to measure patient outcome in healthcare systems. Moreover, avoidable readmission is often utilized for quality benchmarking (Halfon, 2006). Sometimes, readmission to the ED may be unavoidable. However, remedial actions are deemed necessary only for avoidable readmission. Furthermore, classifying short term readmission may throw light on the causes of readmission and therefore aid development of strategies to reduce them (Yadav, 2015; Van Walraven, 2012; Donze, 2013; Hesselink, 2012).

Aim: To assess the status of short term readmissions (within 72 hours of discharge) at the Medeor Institute of Emergency Medicine

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MATERIALS AND METHODS

The audit was carried out at the Medeor Institute of Emergency Medicine, Medeor Hospital, Gurgaon, Haryana, India, from 1st June 2019 through 30th September 2019. During this period, all patients that returned to the ED within 72 hours of their admission from the ED or the hospital were included, and data was prospectively collected from patient record. Thereafter, each of these patient were exclusively categorized by the authors into 5 categories as:

(I) Avoidable readmissions – (IA) readmissions due to inadequate care/misdiagnosis, (IB) readmission due to poorly managed transitions during discharges; (II) Unavoidable readmission – (IIA) readmissions due to complication/disease progression, (IIB) readmission due to recurrence of symptoms; (III) Unrelated readmission (different organ system involvement); (IV) Readmission due to planned procedure or admission; and (V) Readmission after leaving against medical advice (LAMA).

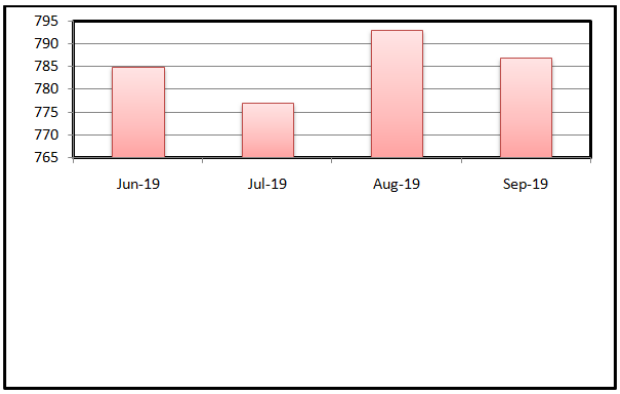


Figure 1. Total number of Emergency Department registrations

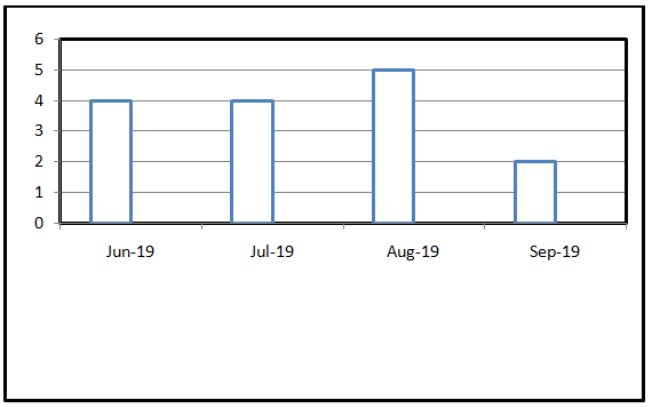


Figure 2. Readmission within 72 hours of hospital admission

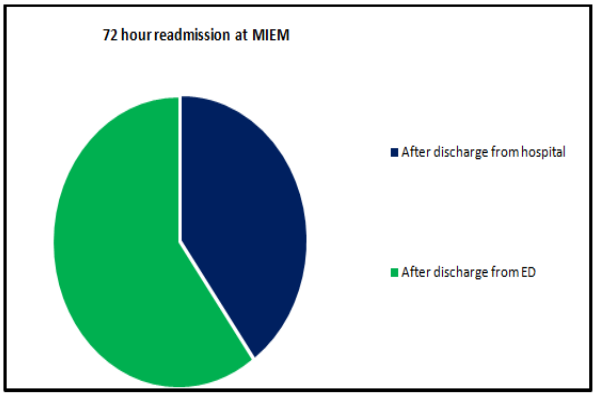


Figure 3. Classification of Short term readmissions

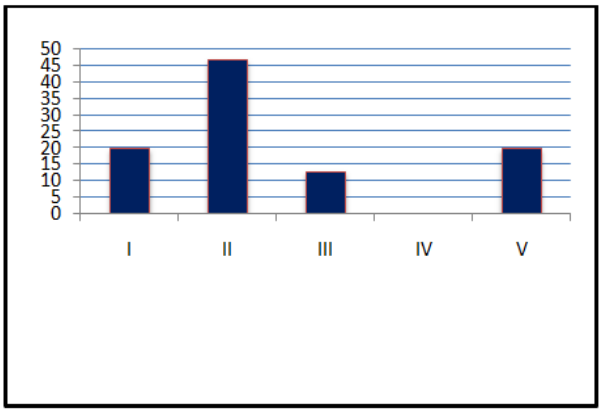
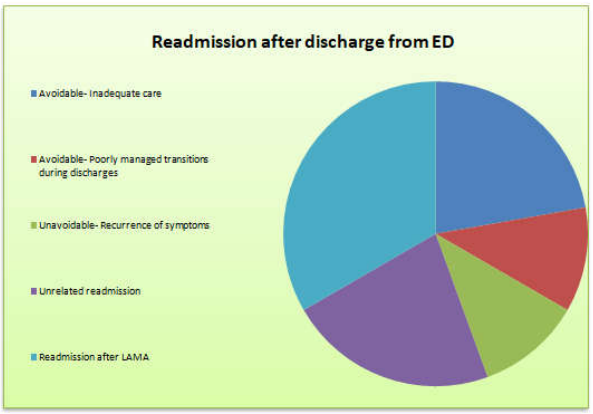
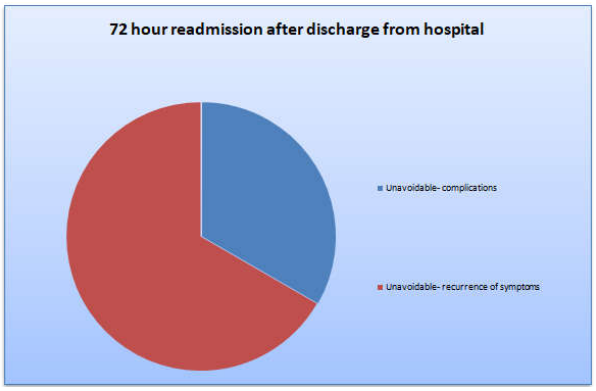


Figure 4. Short term readmission at MIEM





RESULTS

At MIEM, a total of 3142 patients were registered from 1st June 2019 through 30th September 2019. Of these, 15 patients revisited the ED within 72hours of being discharged. Thus, the short term readmission rate at MIEM was 0.48%. The average age of patients, who returned to the ED within 72 hours of discharge, was around 47 years. And only 1 of them was female. A fifth of the short term readmissions were avoidable; about 47% were unavoidable; a little over a tenth were unrelated readmissions; and a fifth returned to the ED after LAMA. Of the unavoidable short term readmission, two thirds were due to recurrence of symptoms & rest due to complication/disease progression. On the other hand, 1 (6.7%) patient returned to the ED due to poorly managed transitions during discharges- - poor understanding of instruction to return to ED while 2 (13.3%) patients received inadequate care as a result of misdiagnosis. Amongst the readmissions after LAMA, majority had left the ED for financial reasons. A single death was observed amongst readmitted patient due to poorly managed transitions during discharges. About a third of the short term readmission was after hospital discharge - all due to unavoidable causes. However, two thirds of readmission after discharge from the ED were avoidable, a third after patients left against medical advice, and a fifth were unavoidable. Almost half of readmitted patients had government panel as their mode of payment, a fifth were cash paying, while the rest were insured.

Conclusion

As evidenced by literature, short term readmissions are multi-factorial and classifying them assist in exploring causes and discovering solutions (Yadav, 2015; Van Walraven, 2012; Donze, 2013).

At MIEM, about half of the short term readmissions were unavoidable. And avoidable readmissions were as a result of misdiagnoses, and poor understanding of instruction to return to ED. A 2012 systematic review found that many types of interventions, including medication reconciliation, structured electronic discharge summaries, discharge planning, and facilitated communication between hospital and community providers, improved patient outcomes and readmission rates (Hesselink, 2012). Thus, the introduction of ED discharge summary with written discharge instructions, in addition to verbal explanation, and mandatory co-sign of every ED initial assessment by Emergency Consultant hopes to address these lacunae.

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