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ORIGINAL ARTICLE

PROFILE OF READMISSION PATIENTS IN A STATE HOSPITAL OF RIO DE JANEIRO

PERFIL DE PACIENTES READMITIDOS EM HOSPITAL ESTADUAL DO RIO DE JANEIRO

PERFIL DE PACIENTES READMITIDOS EN UN HOSPITAL ESTADUAL DE RIO DE JANEIRO

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ABSTRACT

Objective: to describe the profile of readmitted patients in the state hospital in Rio de Janeiro. ***Method***: documental descriptive study with a quantitative approach. Data were obtained from primary sources of discharge orientation service and the hospital information system (Clinikos), from June to November 2011, processed and analyzed in Bioestatic software. The study project was approved by the Research Ethics Committee CAAE 0268.0.258.000-11. ***Results***: it was found that most were female, with a predominance of elderly patients with an average age of 66.4 years old, 83% represent readmission in clinical medicine and readmission time average was equal to 63.4138. ***Conclusion***: in addition, the study found that 65.52% of patients were aiting for appointment in primary care and were readmitted during this period, indicating a large gap between discharge and continuity of treatment in primary health care. ***Descriptors***: Hospital Readmission; Discharge Planning; Service Structure.

RESUMO

***Objetivo*:** descrever o perfil dos pacientes readmitidos no hospital estadual do Rio de Janeiro. ***Método*:** estudo descritivo documental com abordagem quantitativa. Os dados foram obtidos a partir de fontes primárias do serviço de orientação de alta e do sistema de informação do hospital (Clinikos), de junho a novembro de 2011, processados e analisados no software Bioestatic. Este estudo teve aprovado o projeto pelo Comitê de Ética em Pesquisa CAAE 0268.0.258.000-11. ***Resultados*:** identificou-se que a maioria era do sexo feminino, com predomínio de pacientes idosos com média de idade de 66,4 anos, 83% representam as readmissões na clínica médica e a média do tempo de readmissão foi igual a 63,4138. **Conclusão:** além disso, o estudo identificou que 65,52% dos pacientes aguardavam a marcação de consulta na atenção primária e foram readmitidos nesse período, apontando uma grande lacuna entre a alta e a continuidade do tratamento na atenção primária de saúde. ***Descritores*:** Readmissão Hospitalar; Planejamento da Alta; Estrutura de Serviços.

RESUMEN

***Objetivo*:** describir el perfil de los pacientes readmitidos en el hospital estadual de Rio de Janeiro. ***Método*:** estudio descriptivo documental con enfoque cuantitativo. Los datos fueron obtenidos a partir de fuentes primarias del servicio de orientación de alta y del sistema de información del hospital (Clinikos), de junio a noviembre de 2011, procesados y analizados en el software Bioestatic. Este estudio tuco su proyecto aprobado por el Comité de Ética en Investigación CAAE 0268.0.258.000-11. ***Resultados*:** se identificó que la mayoría era del sexo femenino, con predominio de pacientes ancianos con media de edad de 66,4 años, 83% representan las readmisiones en la clínica médica y la media del tiempo de readmisión fue igual a 63,4138. **Conclusión:** además de eso, el estudio identificó que 65,52% de los pacientes aguardaban la marcar una consulta en la atención primaria y fueron readmitidos en ese período, apuntando una grande laguna entre el alta y la continuidad del tratamiento en la atención primaria de salud. ***Descriptores*:** Readmisión Hospitalaria; Planeamiento del Alta; Estructura de Servicios.

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INTRODUCTION

The Unified Health System (SUS) was created in 1988 by the Brazilian Federal Constitution. Supported by an expanded concept of health, it meets all the population in a full, universal and free way, covering outpatient care and complex care such as organ transplants and treatment for cancer.

The principle of comprehensiveness in SUS proposes to organize policies and health services, linking promotion, prevention, treatment and rehabilitation through the integrated actions of health services.[1] Thus, expanding the idea of comprehensiveness, there are two dimensions focused on the needs of health. The first one is "focused comprehensiveness" about the effort of the multidisciplinary team, located spatially in health services (Basic Health Units, Family Health Program, Hospital etc.). In the second dimension, the author proposes the macro comprehensiveness, joining each health service with a more complex center of services and institutions, not necessarily of the "health sector".[2]

SUS represents advances and achievements in the Brazilians´ health. However, it faces some challenges constantly, highlighting the qualification of management and social control, strengthening and qualification of primary care as the organizing strategy of care health centers, difficult to access health actions and services, the fragmentation of health policies and programs, the organization of a regionalized and hierarchical network of actions and health services, the recognition of the autonomy of federal entities, among others[3].

In this context, seeking to improve the quality and integration, and observing the need of the population, a pioneering service was created in May 2010 within the state health, high guidance to patients hospitalized in which these patients at the time of discharge, are referred to the service and guided by a multidisciplinary team in order to optimize the homecare. In addition, patients are sent to medical care in the primary care network in order to continue the treatment initiated an emergency basis during hospitalization.

The discharge service orientation arose from the unit manager´s linking with municipal health representatives, developing orientation activities at admission and discharge, performed by a multidisciplinary team consisting of a nurse, physical therapist, social worker, psychologist and administrative technician, responsible for consultations appointments on Regulation System (SISREG) on an outpatient.

As service goals, there is a continuity of care after discharge, reducing readmissions, resoluteness of referrals and patients´ responsibility and their families in need of treatment.

Since the project began in 2010 and there were no units in previous studies about readmissions, this study aims to describe the profile of the readmitted patients at the state hospital in Rio de Janeiro.

METHODOLOGY

Article elaborated from the dissertation Service Actions of the Discharge Orientation of the State Hospital of Rio de Janeiro: a case study, presented to the Post-Graduate Program, at Aurora Afonso Costa Nursing School, Federal University Fluminense/UFF. Niterói, RJ, Brazil, in 2013.

Single case study, representative or typical, retrospective and descriptive with quantitative approach from the reports of care provided in Discharge Orientation Services of the State Hospital in Rio de Janeiro from June to November 2011. Data were collected in primary sources of information in discharge orientation service and also in secondary computerized database hospital.

The scenario of this study was a large state hospital in the West Zone of Rio de Janeiro that provides emergency care in the following specialties: clinical medicine, orthopedics, pediatrics, maternity, nursery, adult ICU and pediatric ICU, dentistry, general surgery. Generally, these services evolve to clinics hospitalization, creating situations of distress, anxiety, uncertainty, misinformation, among other disorders to the patient and their families.

Thus, the data found in the service records have been clearly described and systematically organized, aiming at a coherent interpretation of the profile to use the service aimed at the proposed objectives.

After encoding, there was a normality test of Shapiro-Wilk in Bioestatic® 5.0 software, since the sample is less than 50 patients, followed by descriptive analysis using the SAS® System software, version 9.3.1 for Windows (SAS Institute, Inc., Cary, North Carolina) using tables for data observed, expressed by frequency (n) and percentage (%) for categorical data and average and ± SD (or median ± IQR) for numerical data.

The study project was approved by the Ethics Committee in Research of the University Hospital of the city of Niterói, in

compliance with Resolution 196/96 (No. CAAE: 0268.0.258.000-11), and respected all ethical aspects of confidentiality and legitimacy, informing about the reality exposed in order to generate improvement to quality of health care.

RESULTS AND DISCUSSION

To characterize hospital readmissions, we found that patients who were discharged from June to November 2011, 1,036 were from medical and surgical clinic, and only 29 were readmitted to the hospital, presenting an indicator of hospital readmission equivalent to 2.8%. Of these, 24 (83%) represented readmissions in the medical clinic and five (17%) represented readmissions in the surgical clinic and four of all patients evolved to death on readmission.

The incidence of readmissions found in this study was considered low, compared to other literature studies that found that the readmission rates ranging from 5 to 25%.[4,5,6]

Regarding the demographic characteristics of the readmitted patients, there is a prevalence in hospital readmissions of adults and elderly patients, as shown in Table 1, with an average age of 66.4 years old and standard deviation of 14.0065 that is there is no great variation from the average indicating that the data tend to be near average. Among the elderly, females were the most prevalent (66.7%).

Table 1. Distribution of hospital readmissions according to age group (n= 29), HEAS. Rio de Janeiro, June-November 2011.

		N	%
Age group	34-45	2	6.9%
	45-56	4	13.7%
	56-67	9	31.0%
	67-78	9	31.0%
	78-89	4	13.7%
	89-100	1	3.4%
	Average 66.4 SD ± 14.0065		

SD – Standard Deviation.

It was found that the average of time between discharge and readmission is 64.36 days, so the minimum period between discharge and hospital readmission was 0 days, less than 24 hours, being readmitted in the medical clinic and the maximum period of 153 days with a standard deviation of 52.6074. That is, there is great variation between the average length of readmission and other data indicating that the data tend to be spread across a range of values, such as shown in Table 2.

Table 2. Distributions of hospital readmissions according to readmission time characteristics (n=29) HEAS. Rio de Janeiro, June to November 2011.

Readmission Time	%
0-7 days	10.34%
8-30 days	24.14%
31 days to 12 months	65.52%
Average 63.4138 SD ± 52.6074	
Total 100% (29)	

Study of patients profile readmitted in a philanthropic hospital in São Paulo showed that 12.6% were readmitted and the admission diagnosis and its relation to the diagnosis of readmissions influenced the frequency of readmissions, that is chronic illness and cerebrovascular accident sequelae had more than one readmission within one year.[4]

With regard to readmission time, it was found in the study that 10.34% were readmitted between zero to seven days, two of which were readmitted to the medical clinic and a surgical clinic, in less than 24 hours of discharge. Early readmission may highlight gaps in assistance, as the patient being readmitted within a short period, showing that the problem that led to hospitalization has not been resolved, causing them to return to the clinic.

In patients readmitted within 8 to 30 days, there was a higher incidence of readmission in the surgical clinic (57.1%). It is also observed that the largest number of patients was readmitted with more than 31 days after discharge (65.52%), this fact can be understood with the increase in chronic diseases and the difficulty of maintaining the evolution of their disease under control. However, it cannot be confirmed by the lack of data in the information system to the principal diagnosis and the presence or absence of comorbidities.

It is important to note that the adoption of the Family Health Strategy as a priority policy

of primary health care, for its configuration and work process include the most favorable conditions for access to the multi-sectoral and integrated measures that the approach of chronic non-communicable diseases (NCDs) requires. However, knowing the profile of the service and hospital readmissions provide basis for improving operations within the discharge orientation of service from the multidisciplinary team.[7]

It can be seen in the data that most readmitted patients were waiting by the outpatient care since 65.52% of them were waiting at home the medical consultation appointment by the central (CMC), that is, patients had discharge from the unit and could not continue the treatment in primary care due to waiting time for consultation and then they were readmitted.

Several studies show the discharge planning as a key action for nursing care, emphasizing the work of nurses in several aspects of teaching and learning in the discharge period and[4,8,7] show that nursing needs guidance during the disease acute phase are not met efficiently by the nursing team, which was confirmed through readmissions as a result of the patient and the family unprepared for the post-discharge.[9]

CONCLUSION

As regards to the time between discharge and readmission, it was shown that the average days were equal to 63.4138 and 52.6074 ± SD, with minimum of zero and maximum of 153 days, most of them, 65.52% of patients readmitted in the period up to 31 days and may indicate a chronic disease and not control of the symptom at home.

Regarding the actions of discharge service orientation, it was shown that 65.52% of the readmitted patients were waiting the consultation appointment by SISREG. However, due to the delay, they were readmitted to the unit. This points out a big gap between discharge and continuity of care in primary health care, and the cardiology and neurology specialties represented the largest number of referrals.

REFERENCES

1. Batista, CSD, Silvino, ZR. Implantação do serviço de orientação de alta em um Hospital Estadual: relato de experiência. J Nurs UFPE on line [Internet] 2014 Mar [cited 2014 Dec 15];8(3):780-3. Available from: http://www.ufpe.br/revistaenfermagem/index.php/revista/article/view/746

2. Cecílio, LC. As necessidades de saúde como conceito estruturante na luta pela integralidade, equidade na atenção em saúde. In R Pinheiro & RA Mattos (Eds.), Os sentidos da integralidade na atenção e no cuidado à saúde (pp. 39-64). Rio de Janeiro, RJ: Abrasco, 2001.

3. Souza, GC de A; Costa, I do CC. O SUS nos seus 20 anos: reflexões num contexto de mudanças. Saúde Sociedade. São Paulo. 2010.19 (3):509-17.

4. Borges FK, Soliman F, Pires DO, Seligman R. Reinternação Hospitalar precoce: avaliação de um indicador de qualidade assistencial. Rev. HCP. 2008; 28(3): 147-52.

5. Fraçois P, Bertrand D, Beden C, Fauconnier J, Olive F. Early readmissionas an indicator of hospital quality of care. Rev Epidemiol Sante Publique. 2001; 49(2): 183-92.

6. Zamir D, Zamir M, Reitblat T, Polishchuk I. Readmissions to hospital within 30 days of discharge from the internal medicine wards in southern Israel. European Journal os Internal Medicine. 2006; 17: 20-3.

7. Andradade AM, Brito MJM, Silva KL. Montenegro LC, Caçador BS, Freitas LFC. Organização das redes de atenção à saúde na perspectiva de profissionais da atenção domiciliar. Revista Gaúcha de Enfermagem [Rev Gaúcha Enferm] 2013;34(1): 111-17.

8. Suzuki VF, Carmona EV, Lima MHM. Planejamento da alta hospitalar do paciente diabético: construção de uma proposta. Rev Esc Enferm USP [Internet] 2011 [cited 2014 Dec 15];45(2):527-32. Available from: http://scielo.br/scielo.php?pid=S0080-62342011000200032&tscript=scri_arttext

9. Barreto LCL, Cardoso MHCA, Villar MAM, Gilberto ACB. Percepções dos profissionais de uma unidade de internação pediátrica sobre a alta de crianças ostomizadas. Rev Gaúcha Enferm [Internet]. 2008 [cited 2014 Dec 15];29(3):345-50. Available from: http://ser.ufrgs.br/RevistaGauchadeEnfermagem/article/view/6722

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