

La dimissione dopo Osservazione: come evitare la riospedalizzazione

L. Morelli OBI, Pronto Soccorso, Med Urgenza, Osp San Paolo, Napoli

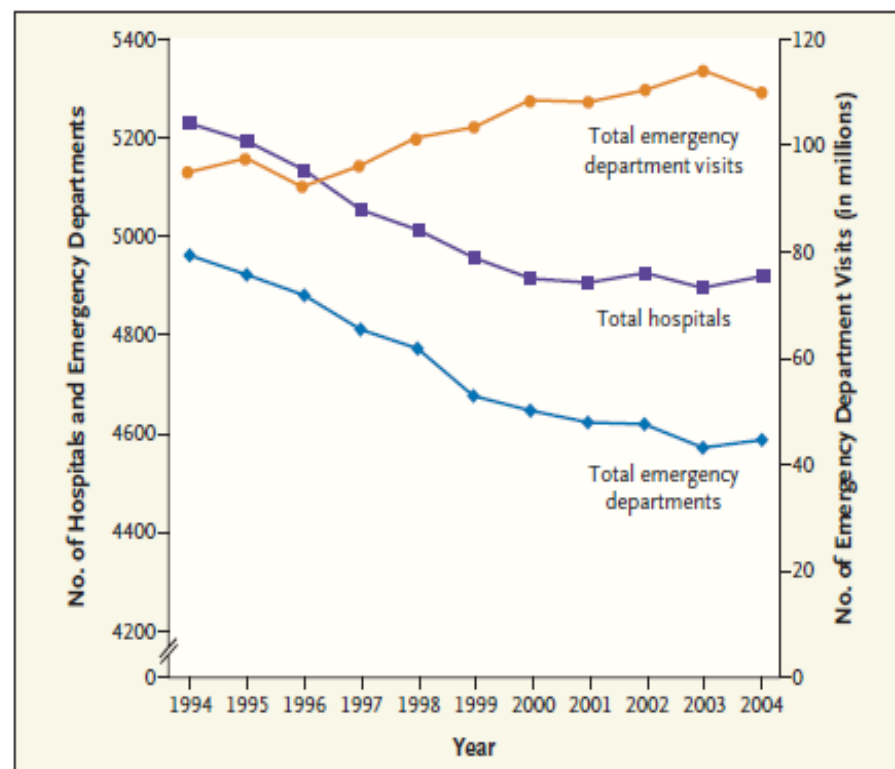


Crisis in the Emergency Department

Arthur L. Kellermann, M.D., M.P.H.



tion to address these concerns, the federal government has



Trends in Emergency Department Visits, Number of Hospitals, and Number of Emergency Departments in the United States, 1994–2004.

L'AREA CRITICA come MOTORE del sistema

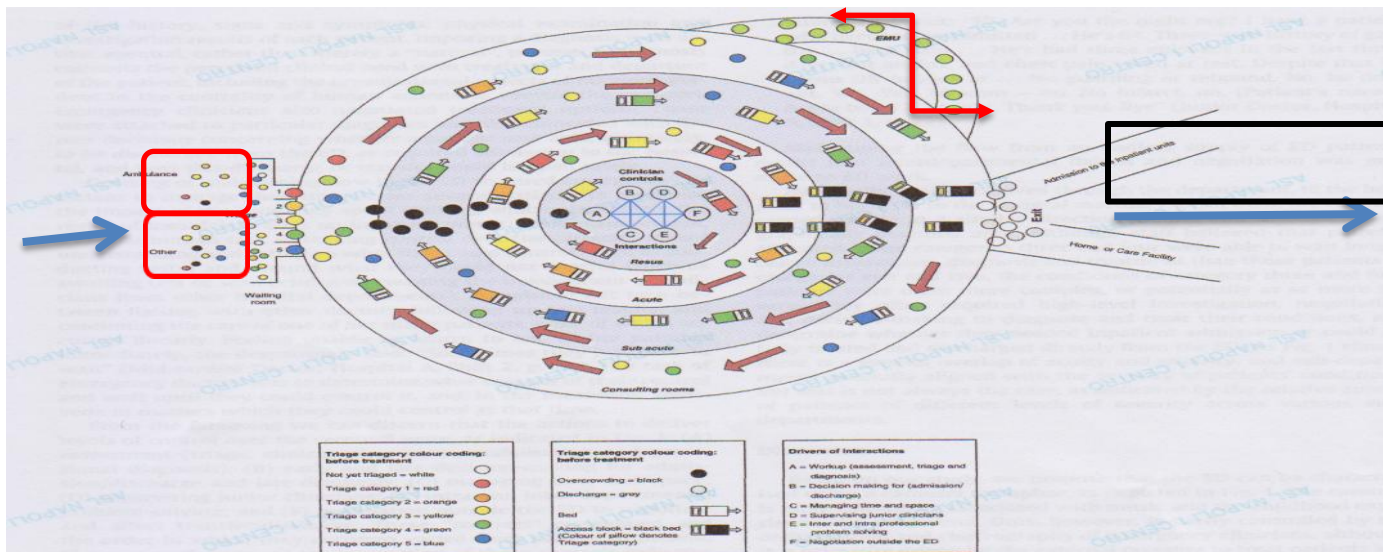


Fig. 1. The carousel model of the emergency department.

depending on their need and on numbers and skill of staffing ("skill-mix"). The sub-departments were distinguished as separate spaces by doorways and corridors. This is represented by the concentric circles in the carousel (Fig. 1).

The need to manage the relationship between the department-wide motion of the ED and its sections was evident when the field researcher asked a junior nurse what the role of the Clinical Initiatives Nurse (CIN) was. Unprompted by any knowledge of what we were observing exactly, she explained: "To save time; they speed things up, especially in sub-acute" (Junior Nurse, Hospital B, Shift 2, p. 4). This role exemplifies the active leadership undertaken by individuals to coordinate patient flow. The boundaries between acute and sub-acute sections in both EDs were relatively fluid and negotiated internally depending on patient need and flow. However, they were bounded by corridors or doorways, defining the various sections geographically as distinctive spaces.

The ED of each hospital was located on the bottom floor of the hospital, literally constituting a "front door" so that it was easily accessible for self-presentation and access by ambulance and other emergency services. The resuscitation bays in the acute area of one of the hospitals were, on rare occasions, used for overflow of acute patients rather than exclusively for those needing resuscitation. Specifically, beds were allocated across various sub-departments by the nursing team coordinator to manage the workload of the

nurses. Nurse workload was equalised with the planning of future bed availability in determining bed occupancy; that is, if possible, patients were staggered along different sub-departments creating bed availability in the department. A senior nurse in Hospital B explained: "We have to keep at least one bed free for a real resus (resuscitation)" (Senior Nurse, Hospital B, Shift 1, p. 11). Staff were actively managing time and space, helping control patient flow, as represented by the clinician controls in the centre of Fig. 1.

Emergency specialists generally only allocated patients to the EMU (green dots in the carousel) under two conditions: first was if the patients required a limited period of intervention for an identified condition with the expectation that they would be able to be discharged within 24 h; or second, if emergency specialists were awaiting confirmation that the patients were safe to be discharged. The significance of the EMU (green dots) for illuminating the carousel-character of the ED is that it allows emergency clinicians to take blocked patients (black dots) off the carousel and circulate them through the EMU. The role of the EMU was to gain "breathing space" on the carousel.

In the central processes described in the carousel model, assessment, stabilisation and diagnosis represented important aspects in the management of time and space. In the accomplishment of these aspects, clinicians exercised control over the carousel. Clinicians identified a recognised medical condition on the basis

INTERN EMERG NURS: 2014, 22:3-9

...from home to...



...a good start...

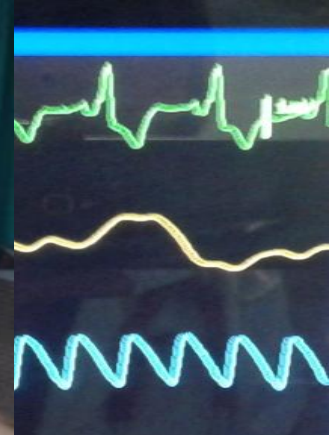
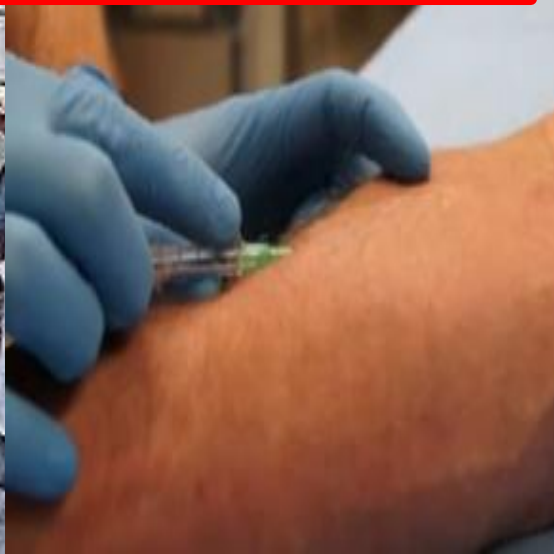


...Red room

Finally.....
OBI



Test *"point of care"*



45 FC 120

Clinical

Drugs

ECG

ABG

ProBNP(HS)

Bedside US

(Xray)

...few minutes



Circulation

JOURNAL OF THE AMERICAN HEART ASSOCIATION



Circulation. 2010;122:1975-1996:

Acute Heart Failure Syndromes: Emergency Department Presentation, Treatment, and Disposition: Current Approaches and Future Aims: A Scientific Statement From the American Heart Association

AHFS

transient
event



Systolic dysfunction

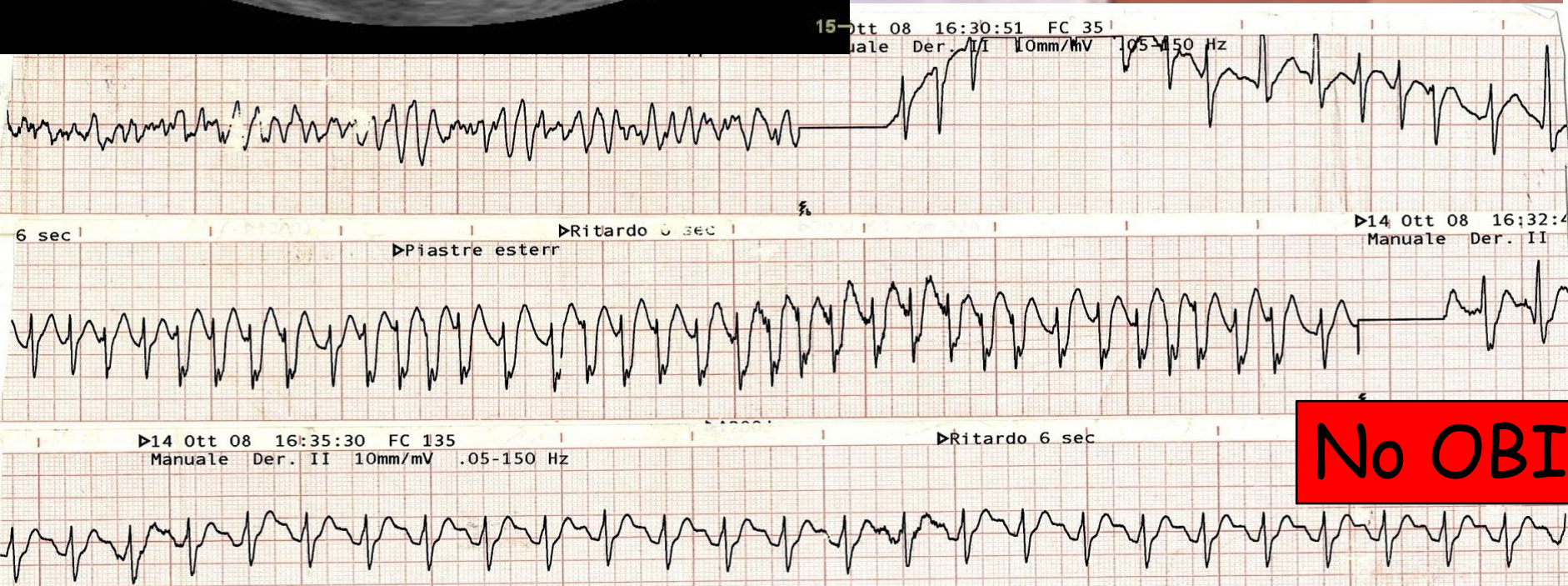
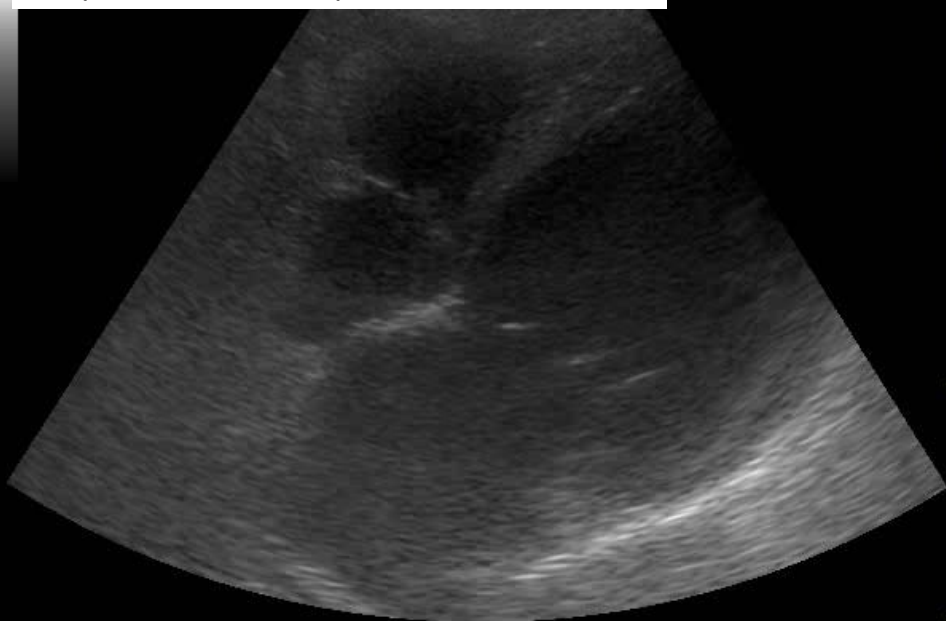


Low cardiac output

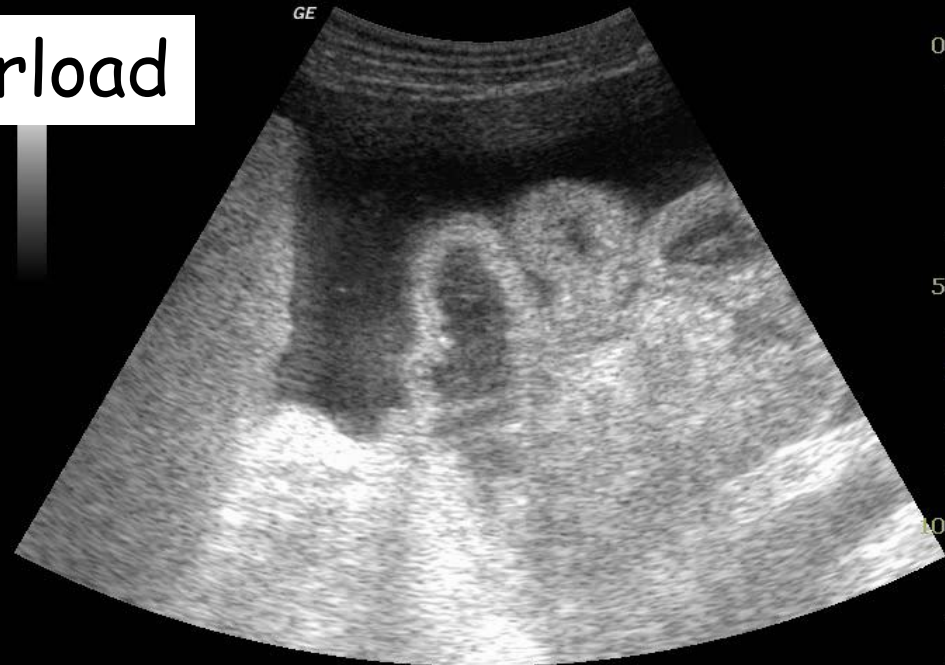
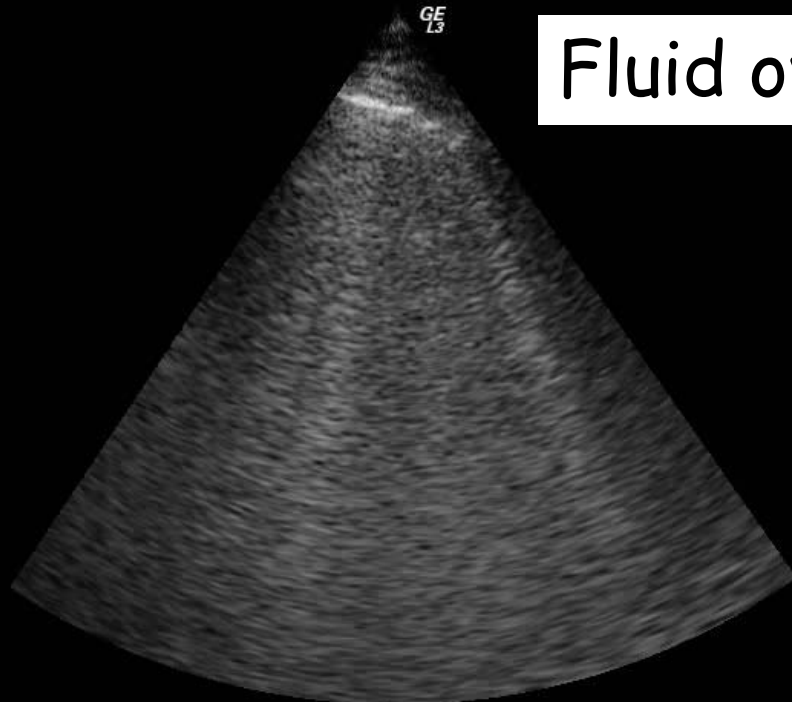


Fluid overload

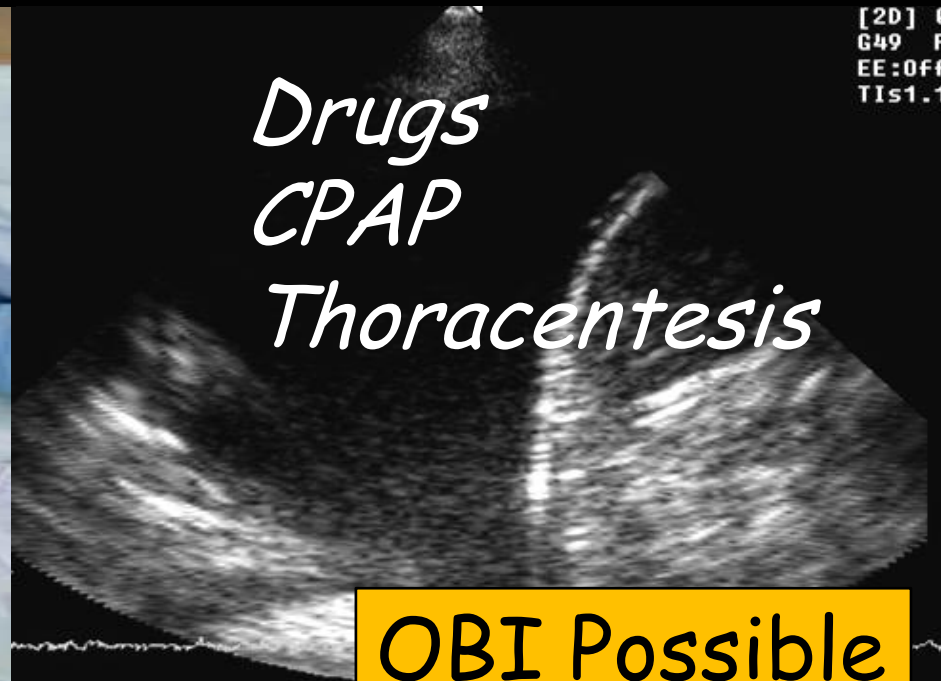
Systolic dysfunction



Fluid overload



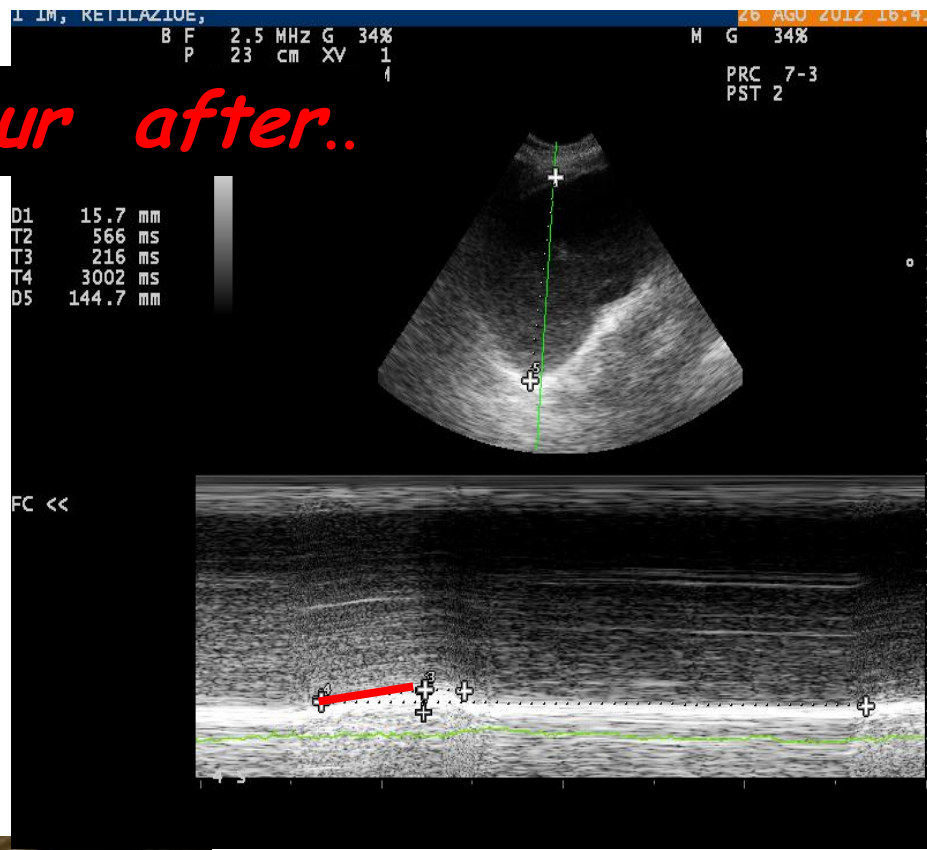
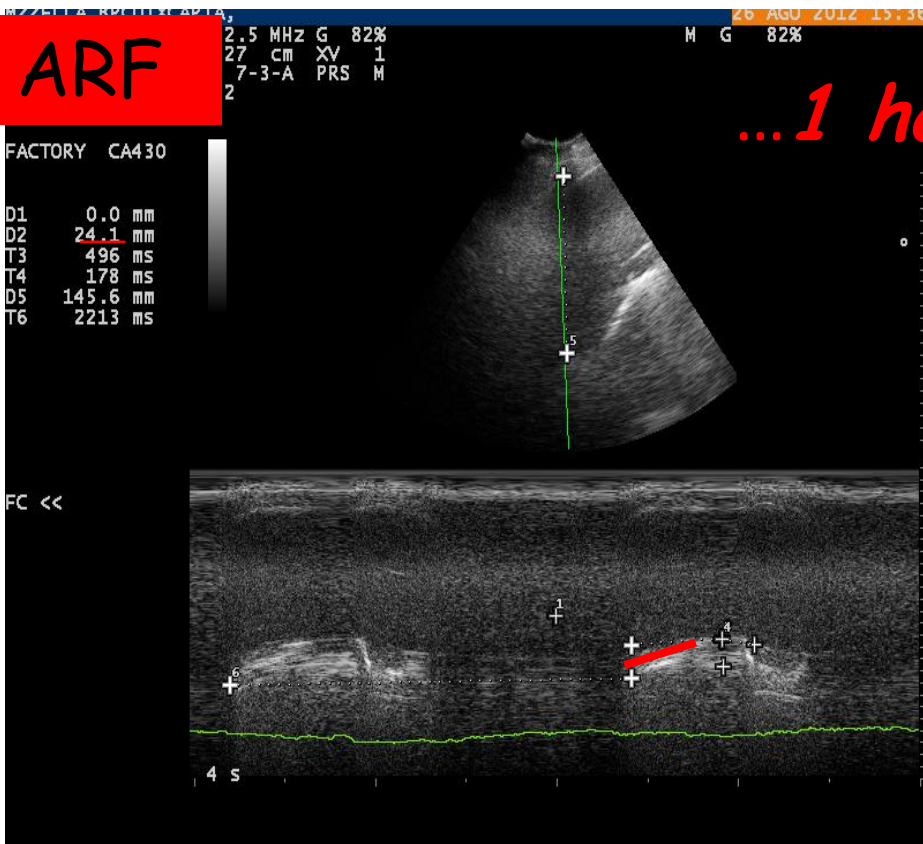
Drugs
CPAP
Thoracentesis



OBI Possible

ARF

...1 hour after..



pH 7.28
pCO₂ 91
pO₂ 84
HCO₃ 39.9
Lact 1.9

RR 32
O₂ 4L/min



pH 7.35
pCO₂ 55
pO₂ 83
HCO₃ 35
Lact 0.4

NIV PSVST
IPAP 18 EPAP 6
O₂ 3L/min

OBI Possible

...enlarged OBI?



Acute Heart Failure Syndromes: Emergency Department Presentation, Treatment, and Disposition: Current Approaches and Future Aims: A Scientific Statement From the American Heart Association

Risk
stratification

Biomarkers (urea,crea

PproBNP,Trop,Na)

Clearance of lactate

Ischemic Ecg

Us parameters

Ultrasound Clinics

Volume 6, Issue 2 , Pages 261-276, April 2011

The Rapid Assessment of Dyspnea with Ultrasound: **RADiUS**

Acad Emerg Med.

2009 Mar;16(3):201-

10. Emergency thoracic ultrasound in the differentiation of the etiology of shortness of breath (**ETUDES**): sonographic B-lines and N-terminal pro-brain-type natriuretic peptide in

American Journal of Emergency Medicine 31 (2013) 1208–1214



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American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

The
American Journal of
Emergency Medicine

Original Contribution

Diagnosing **heart failure** among acutely dyspneic patients with cardiac, inferior vena cava, and lung ultrasonography☆☆☆★

...la nostra realtà

Territorio
30,72 Km²

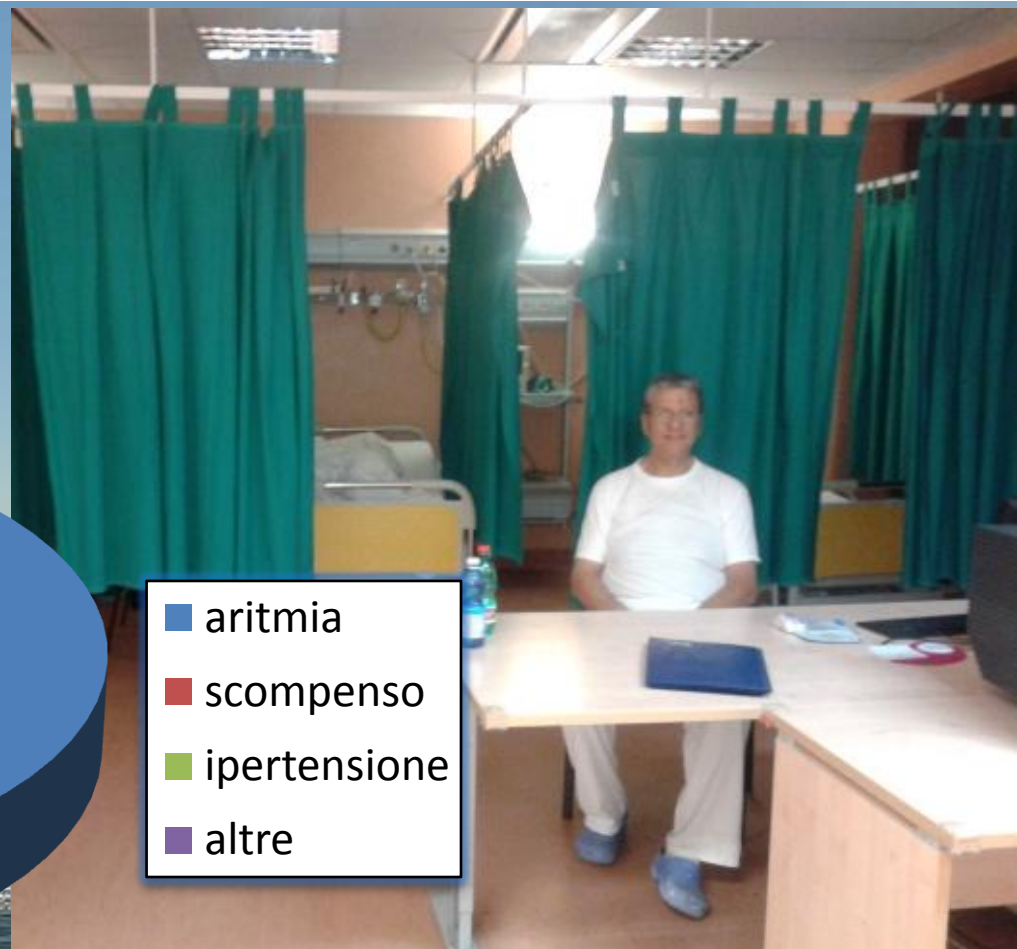
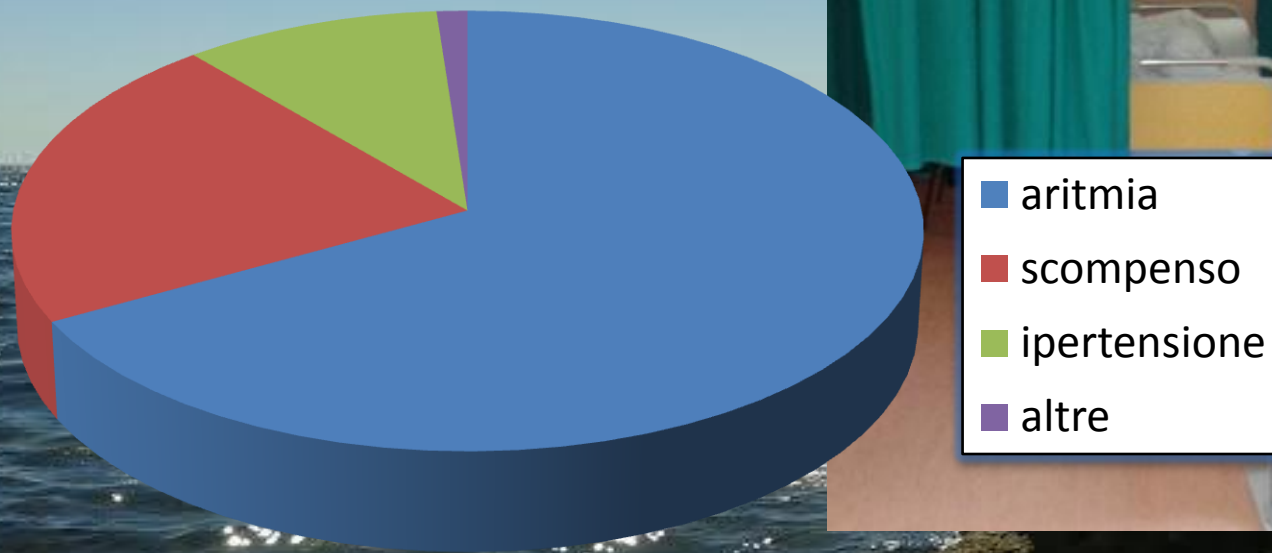
211.015 utenti
(20.57%
età > 65a)



170 PL con rapporto
PL/abit < 1/1000

60.000 accessi/anno



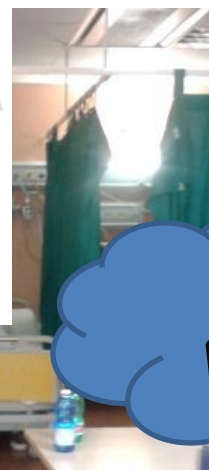


Ricoveri in OBI ultimo semestre



Ambulatorio
di followup

DIMISSIONE
CONDIVISA



DiProDi



Interviste

"discharge day"



Monitoraggio
remoto



Table 5**General Considerations Regarding Gaps in Transitions of Care in Heart Failure****Physician assessment**

Failure to recognize worsening clinical status prior to discharge from the hospital

Failure to identify or address comorbid conditions (underlying depression, anemia, hypothyroidism, and so on)

Medication errors and adverse drug events

Failure to recognize worsening clinical status prior to discharge from the hospital

No or inadequate provision of education to patient and family/caregiver

Failure to clarify whether patient and caregiver understood instructions and plan of care

Failure to address prior nonadherence in self-care, diet, medications, therapies, daily weights, follow-up, and testing

Providing information on broad themes without details on how to make it work for the individual patient based on lifestyle, economic constraints, social support, and other patient or process factors

Handoff communication

Lack of communication resulting in primary care provider not knowing patient admitted

Poor communication of the care plan to the nursing home team, home healthcare team, primary care physician, or family caregiver

Discharge instructions missing, inadequate, incomplete, or illegible

Lack of understanding by the healthcare receiver of information regarding heart failure medical and self-care management

Hospital to home and discharge planning**Medication errors**

Patient lack of adherence to self-care, e.g., medications, therapies, diet (sodium restriction), and/or daily weights because of poor understanding or confusion about needed care, how to get appointments, or how to access or pay for medications

No follow-up appointment or follow-up too long after hospitalization

Failure to provide phone number of physician/nurse patient should call if heart failure worsens

STATE-OF-THE-ART PAPER

Rehospitalization for Heart Failure

Problems and Perspectives

Mihai Gheorghiade, MD,* Muthiah Vaduganathan, MD, MPH,

Robert O. Bonow, MD, MS*

Chicago, Illinois; Boston, Massachusetts; and Los Angeles, California

DiPRODi nostri dati :



...1MEDICO
ed 1
INFERMIERE
1 AUTISTA
CARDIOLINE



Dal 2004 il PO San Paolo ASL NA1 Centro, ha attivato un servizio di assistenza domiciliare: Dimissione Protetta e Difficile (Di.Pro.Di.). Da gennaio 2009 a gennaio 2011, sono state reclutati **98 pz**(54 F), età 74 ± 5.8 affetti da scompenso cardiaco come controllo sono stati analizzati i dati di 42 pz (22 F), età 77 ± 4.3 non reclutati nel progetto ma anch'essi affetti da scompenso cardiaco cronico

Reospedalizzazioni a 3mesi

GRUPPO	TOTALE	%
CONTROLLO	42	47.61
TRATTATI	98	32.65



Decessi

GRUPPO	TOTALE	%
CONTROLLO	42	30.95
TRATTATI	98	28.57

Giornate degenza(risparmio economico)

	Contro llo	DpD
Pazienti	42	98
Giornate tot	244	383
Media	5.95	3.9
Dev. standard	2.07	1.59

I nostri dati : Ambulatorio di followup

330 pazienti a luglio 2014

Età media 73 anni

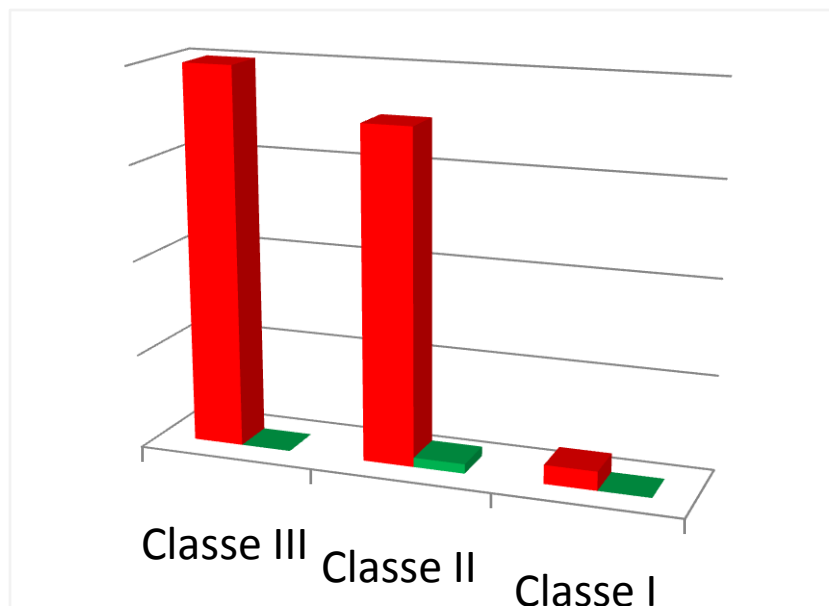
severità dell'angina con terapia tradizionale **Classe**

II-III(C.C.S.)

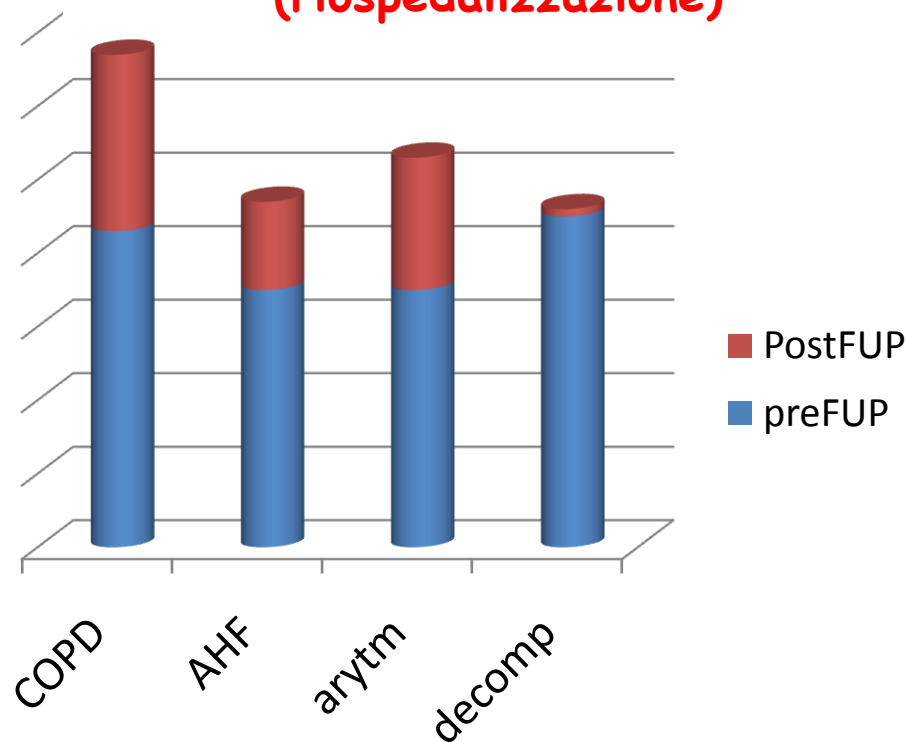
Clearance della creatinina: 55-65 ml /m (media),

70% diabete mellito, 4%epatopatia (CHILD A)

Follow-up a 6 mesi (Classe
angina)



Follow-up a 3 anni
(riospedalizzazione)



The Growing Role of Emergency Departments in Hospital Admissions

...lavoro di
squadra



SESSIONE V: Pronto Soccorso: un lavoro da professionisti

Moderatore: V. Procacci



