

ADMISSION UNIT IN UN DIPARTIMENTO D'EMERGENZA

Anna Maria Ferrari

NAPOLI 19_11_2016



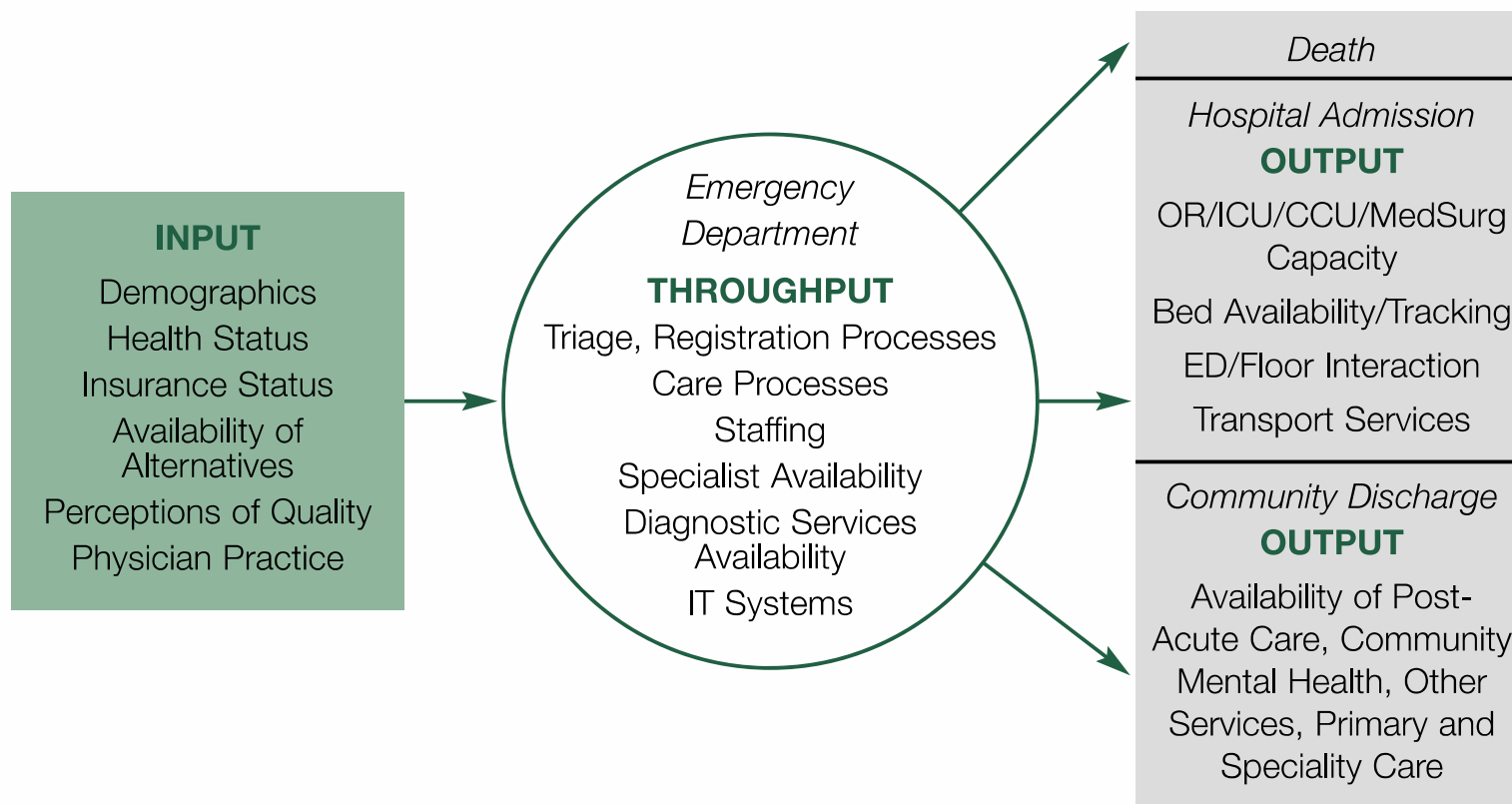
Urgent Matters

The George Washington University Medical Center
School of Public Health and Health Services
Department of Health Policy
SEPTEMBER 2004

BURSTING AT THE SEAMS

Improving Patient Flow to Help America's Emergency Departments

Urgent Matters Input/Throughput/Output Model



Emergency Department Crowding: High-Impact Solutions

April 2008

High-Impact Solutions—the following solutions would have significant impact on reducing boarding and improving the flow of patients through emergency departments

- Move emergency patients who have been admitted to the hospital out of the emergency department to inpatient areas
- Coordinate the discharge of hospital patients before noon.
Research shows that timely discharge of patients can significantly improve the flow of patients through the emergency department by making more inpatient beds available to emergency patients
- Coordinate the scheduling of elective patients and surgical patients



REGIONE TOSCANA

GIUNTA REGIONALE

ESTRATTO DAL VERBALE DELLA SEDUTA DEL 01-12-2008 (punto N. 31)

Delibera

N .1010

del 01-12-2008

Proponente

ENRICO ROSSI

DIREZIONE GENERALE DIRITTO ALLA SALUTE E POLITICHE DI SOLIDARIETA'

Pubblicità'/Pubblicazione: Atto soggetto a pubblicazione su Banca Dati (PBD)

Dirigente Responsabile: Valtere Giovannini

Estensore: Ilaria Lombardi

Oggetto:

Interventi ed iniziative per il miglioramento della efficacia ed efficienza nelle attività dei Pronto Soccorso delle Aziende Sanitarie toscane secondo i modelli della Discharge room e delle Agenzie/Servizi per la continuità ospedale-territorio.

Altre indicazioni

RESEARCH

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Using Data To Drive Emergency Department Design: A Metasynthesis

Shari J. Welch, MD

Dr. Welch is a Research Fellow, Intermountain Institute for Health Care Delivery Research, a practicing physician with Utah Emergency Physicians in Salt Lake City, UT, and a board member of the Emergency Department Benchmarking Alliance

Abstract

Objective: There has been an uptick in the field of emergency department (ED) operations research and data gathering, both published and unpublished. This new information has implications for ED design. The specialty suffers from an inability to have these innovations reach frontline practitioners, let alone design professionals and architects. This paper is an attempt to synthesize for design professionals the growing data regarding ED operations.

Methods: The following sources were used to capture and summarize the research and data collections available regarding ED operations: the Emergency Department Benchmarking Alliance database; a literature search using both PubMed and Google Scholar search engines; and data presented at conferences and proceedings.

Results: Critical information that affects ED design strategies is summarized, organized, and presented. Data suggest an optimal size for ED functional units. The now-recognized arrival and census curves for the ED suggest a department that expands and contracts in response to changing census.

Operational improvements have been clearly identified and are grouped into three categories: input, throughput, and outflow. Applications of this information are suggested.

Conclusion: The sentinel premise of this meta-synthesis is that data derived from improvement work in the area of ED operations has applications for ED design. EDs can optimize their functioning by marrying good processes and operations to good design. This review paper is an attempt to bring this new information to the attention of the multidisciplinary team of architects, designers, and clinicians.

Key Words: *Emergency department, emergency department operations, triage, throughput, design, efficiency, quality, safety*

Using Data To Drive Emergency Department Design: A Metasynthesis

Shari J. Welch, MD

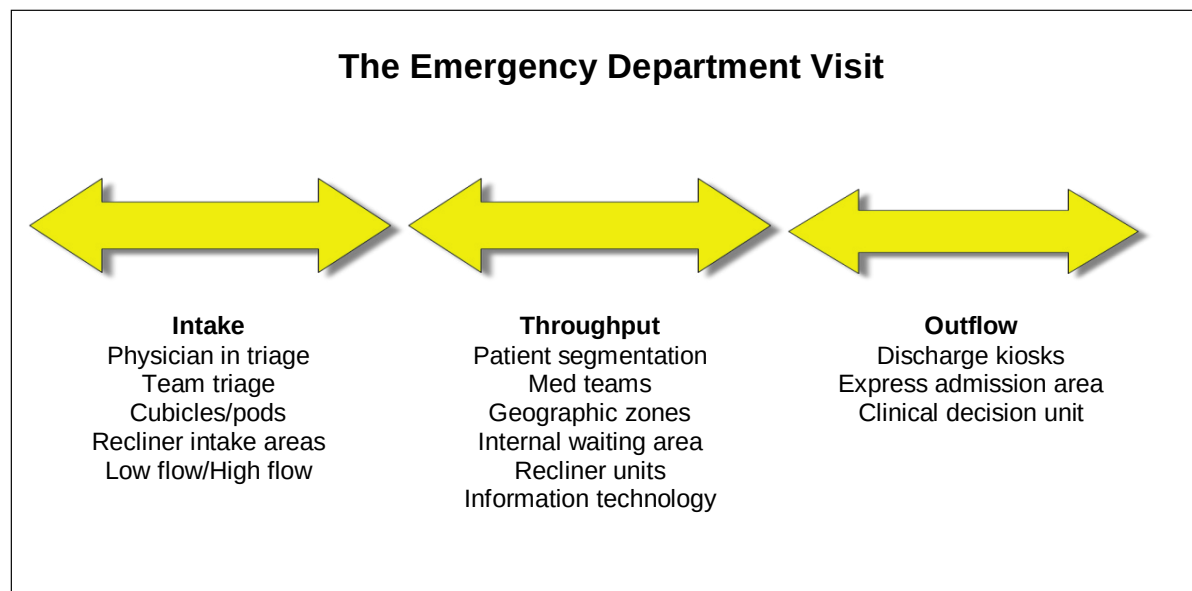


Figure 3. Emergency Department operational innovations.

Most of the operational research done in emergency medicine has focused on patient intake (also known as the *front end*) because improvements in the intake process can have a dramatic and immediate impact on patient satisfaction, door- to-physician times, and LWBS

Using Data To Drive Emergency Department Design: A Metasynthesis

Shari J. Welch, MD

Improvements at Outflow



- *Discharge Kiosks*
- *Express Admission Unit*
- *Clinical Decision Unit*

Administration of Emergency Medicine

IMPACT OF AN EXPRESS ADMIT UNIT ON EMERGENCY DEPARTMENT LENGTH OF STAY

Byron J. Buckley, MD, Edward M. Castillo, PhD, MPH, James P. Killeen, MD, David A. Guss, MD, and
Theodore C. Chan, MD

Department of Emergency Medicine, University of California, San Diego, School of Medicine and Medical Center, San Diego, California
Reprint Address: Theodore Chan, MD, Department of Emergency Medicine, UCSD Medical Center, 200 W. Arbor Dr., #8819, San
Diego, CA 92103

Abstract—Background: Express admit units (EAUs) have been proposed as a way to expedite patient flow through the Emergency Department (ED). **Objectives:** We sought to determine the effect of opening a five-bed EAU unit for temporary placement of admitted patients on our ED length of stay (LOS) and waiting room times (WT). **Method:** This was a before-and-after interventional study of the 3-month period immediately before (pre-EAU) and after opening (post-EAU) of the EAU. We compared ED LOS and WT for patients admitted and discharged from the ED for both time periods, controlling for daily census and patient acuity. **Results:** During the post-EAU period, 386 patients (26.2% of total admits) were admitted through the EAU. Overall LOS decreased from 8:21 (interquartile range [IQR] 6:02–11:20) to 7:41 (IQR 5:22–10:16) for all admitted patients ($p < 0.001$), and from 3:41 (IQR 2:05–5:58) to 3:35 (IQR 2:00–5:55) for the discharged patients ($p = 0.025$). After controlling for census and acuity, the LOS decreased an average of 10% (95% confidence interval [CI] 6%–14%; $p < 0.001$) for admitted patients and 4% (95% CI 2%–7%; $p = 0.001$) for discharged patients. These changes represented a decreased LOS of about 50 and 9 min, respectively. There were no significant differences in WT (0:44; IQR 0:09–2:07 vs 0:50; IQR 0:11–2:20 for admitted patients and 0:41; IQR 0:09–1:50 vs 0:41; IQR 0:10–1:47 for discharged patients). However, after controlling for census and acuity, WT decreased 9% (95% CI 1%–16%; $p = 0.022$) for discharged patients, which represented a decrease of about 4 min. **Conclusions:** With an EAU, there was a modest improvement in ED LOS despite

an overall increase in daily ED volume. © 2010 Elsevier Inc.

Keywords—express admit unit, emergency department, patient flow

INTRODUCTION

In the past two decades, Emergency Department (ED) use in the United States has risen dramatically to over 110 million visits annually (1). Along with this increase, factors such as the lack of available inpatient beds for admitted patients boarding in the ED, as well as the inability of patients to access regular outpatient care, have contributed markedly to the growing problem of ED crowding nationwide (2). As a result, patients often have to wait longer and have prolonged lengths of stay (LOS) to receive medical care in the ED, with potentially deleterious consequences on their outcomes and health (3,4).

Efforts to ameliorate ED crowding and its consequences have attempted to address the myriad of factors contributing to the problem, with the goal of improving overall patient flow in the ED (5). Some hospitals have turned to opening express admit units (EAUs) to facilitate movement of admitted patients to temporary holding areas in order to open ED beds (6). However, there are few data on the impact of EAUs on ED patient flow and lengths of stay. We performed a before-and-after inter-

Impact of an acute medical admission unit on length of hospital stay, and emergency department ‘wait times’

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From the ¹Division of Internal Medicine St. James’ Hospital and ²Department of Therapeutics and Pharmacology, Trinity College Dublin, Trinity Centre at St. James’ Hospital, Dublin, Ireland

Received 13 August 2004 and in revised form 21 December 2004

Summary

Background: While many UK hospitals have introduced an acute medical admissions unit (AMAU) to facilitate an efficient emergency admission process and reduce length of hospital stay (LOS), there is a lack of such data in the Republic of Ireland

Aim: To determine the impact of an AMAU on emergency department (ED) wait times for a hospital bed, consultant practice, and LOS.

Design: Retrospective analysis of data recorded in the hospital in-patient enquiry (HIPE) system.

Methods: We studied all emergency medical patients admitted to St James’ Hospital Dublin between 1 January 2002 and 31 December 2003. In 2002, patients were admitted directly to a variety of wards, many of which were not affiliated with a medical specialty, under the care of a named

consultant physician. In 2003, two centrally located wards were re-configured to function as an AMAU, and all emergency patients were admitted to this unit.

Results: For all physician teams, median LOS shortened significantly from 2002 to 2003 (6 vs. 5 days, $p < 0.0001$). Overall, patients seen by general physicians had a shorter LOS (5 days) than that of those seen by sub-specialists (6 days) ($p < 0.0001$). The number of patients waiting in the ED for a hospital bed was reduced by 30% from 2002 to 2003 ($p < 0.001$). Extrapolated cost savings for the hospital with the introduction of the AMAU were estimated at approximately 4039 bed-days and €1 714 152.

Discussion: Introduction of the AMAU speeded access to acute medical service and reduced costs.

BRITISH JOURNAL OF
HOSPITAL
MEDICINE

MMC
Modernising Medical Careers

MODERNISING MEDICAL CAREERS

The survivors' guide to working in the medical admission unit

Faraz Imran, Mohamed Y Yousuf,
Swapan Bhaumick

NHS jargon buster

SV Vamadeva

Making the most of the doctors' mess: a guide for the foundation year doctor

Rachel Hooke

A guide to assisting at surgical operations 1: general principles

Comus Whalan

Addison's disease: a diagnostic challenge

Daniel A Jones, Alex Miras, Jennifer R Tringham

So you want to be ... a paediatrician

Alan Cado

IN NEXT MONTH'S MMC SUPPLEMENT

Frequently used investigations:
amylase

Prescribing diuretics

A guide to assisting at surgical
operations 2: handling surgical
instruments

So you want to be... a paediatrician

The survivors' guide to working in the medical admission unit

Introduction

The medical admission or assessment unit is a relatively new specialty in the NHS which has been developed to cope with the demands of the accident and emergency department. It provides a practical hub for the flow of emergency medical patients into the hospital. The principal aims of the medical admission unit are two fold: first to direct patients who require inpatient care to the most appropriate facility and second to provide high quality care through a multidisciplinary team focused on achieving a clear diagnosis and management plan, which will either enable patients to return home or to access specialist care.

Working in the medical admission unit as a foundation year doctor

Medical admission unit is an exciting posting for foundation year doctors. Although it might be a bit challenging in the beginning, there is a lot to learn here, from managing acutely unwell patients to performing invasive procedures.

It certainly meets the principle of the foundation years to prepare junior doctors to manage the acutely unwell patient. The medical admission unit senior house officer and the house officer usually form the basis of the cardiac crash team. This is a very good opportunity to practice skills learnt on basic and advanced life support courses.

What to expect

Medical admission unit is an acute admission unit for medical patients. It is therefore a busy ward, with lots of opportuni-

ties to learn and present cases to seniors. *Figure 1* gives some idea of a typical day on the medical admission unit. There are three main jobs:

1. The ward round (including morning and evening post-take ward round) with the consultant
2. Clerking patients and presenting them to a senior
3. To take away (TTA) prescriptions or discharge letters.

The ward round

Ward rounds are sometimes considered less exciting than clerking patients, but they are a very good way of learning, especially if you are working with an enthusiastic consultant. Even if not, you can still learn a lot just by seeing and observing how the seniors approach, communicate with, take a specific history from and examine patients.

Preparation and documentation are both vital for an efficient ward round or post-take ward round.

Preparation

Have at hand an up-to-date patient list with their bay or bed locations. Unlike the general wards new patients are admitted all the time so it is necessary to make a fresh list every day, which may mean coming in to work a bit early.

Share the roles among your colleagues so that one person writes in the patient's notes while the other carries out requests and investigations, i.e. filling forms for blood requests, radiological requests and referrals. Other colleagues can start doing discharge letters for those patients deemed fit to go home during the ward round.

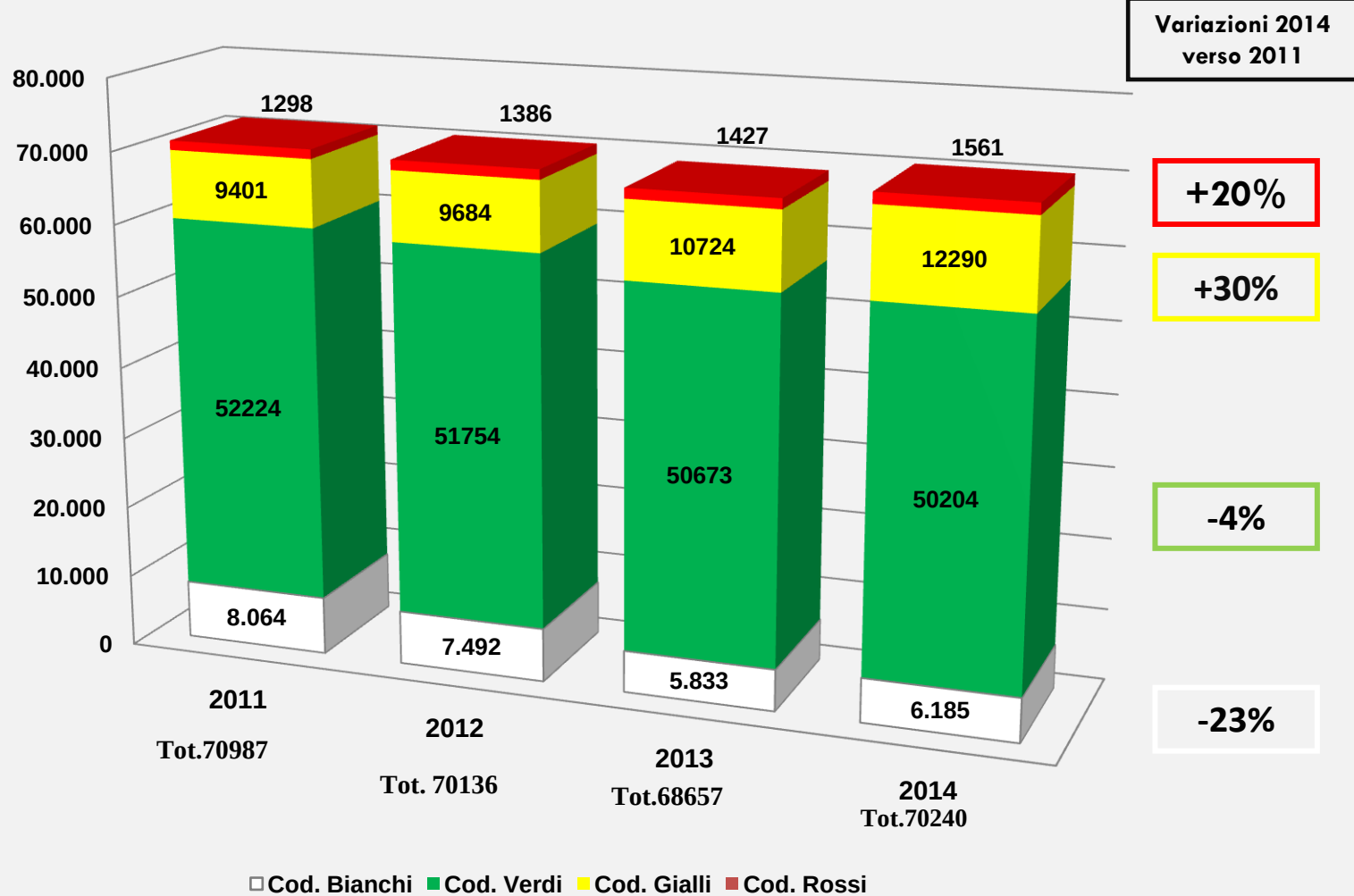
It is advisable to carry with you a folder with everything that you might need during the ward round such as spare papers, investigation forms and pens. Do not forget your stethoscope. Have a list of phone numbers that you need every day such as pathology, radiology or porters. This is especially important out of hours when you may need to bleep on-call technicians.

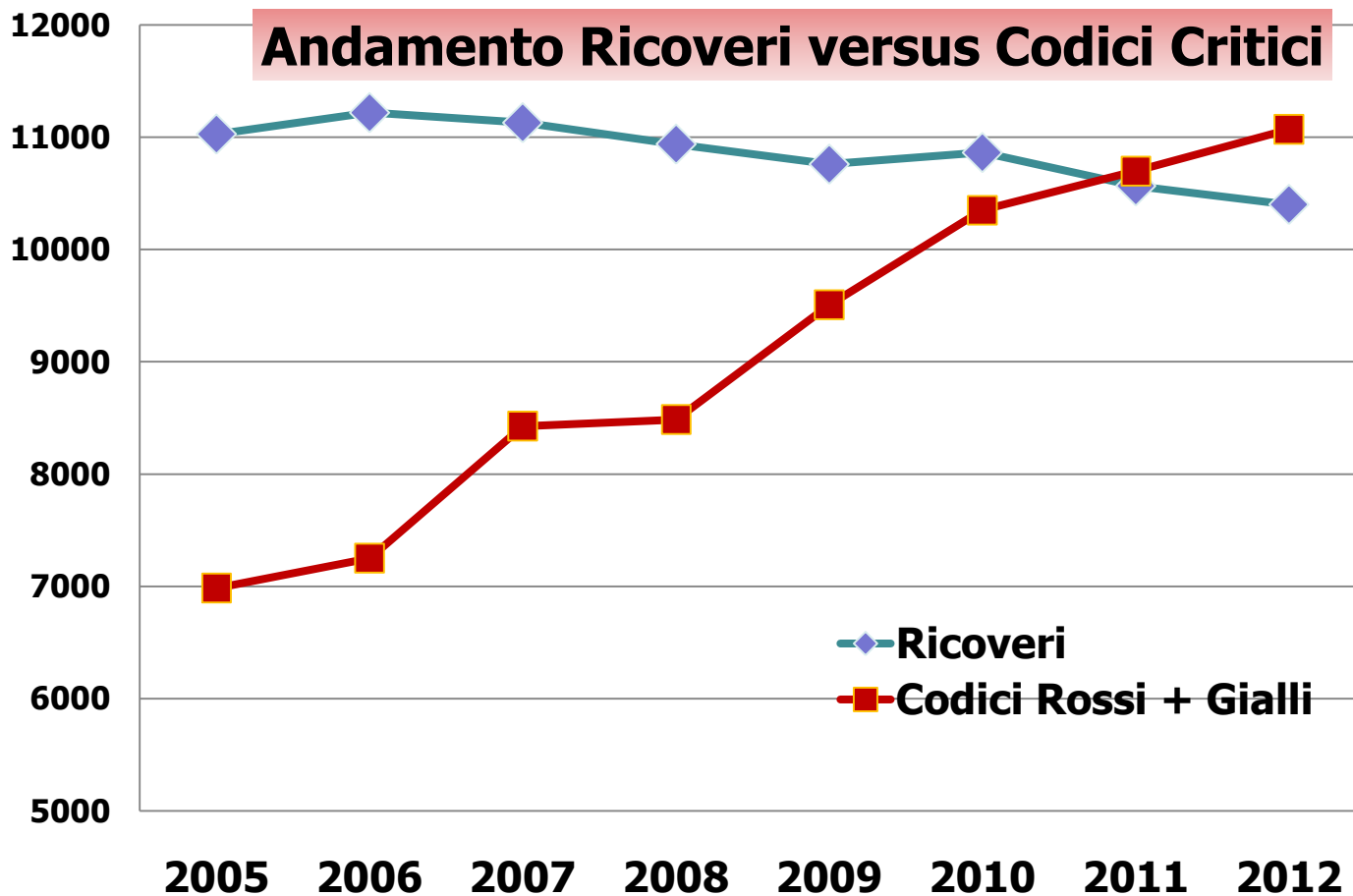
Dr Faraz Imran is Foundation Year 1 Doctor, **Dr Mohamed Y Yousuf** is Specialist Registrar and **Dr Swapan Bhaumick** is Consultant in the Medical Admission Unit, Northern Devon Hospital, Barnstaple, Devon

Correspondence to: Dr F Imran, Accident and Emergency Department, Hemel Hempstead General Hospital, Hemel Hempstead, Hertfordshire HP2 4AD



ANDAMENTO DEI CODICI COLORE 2011-2014

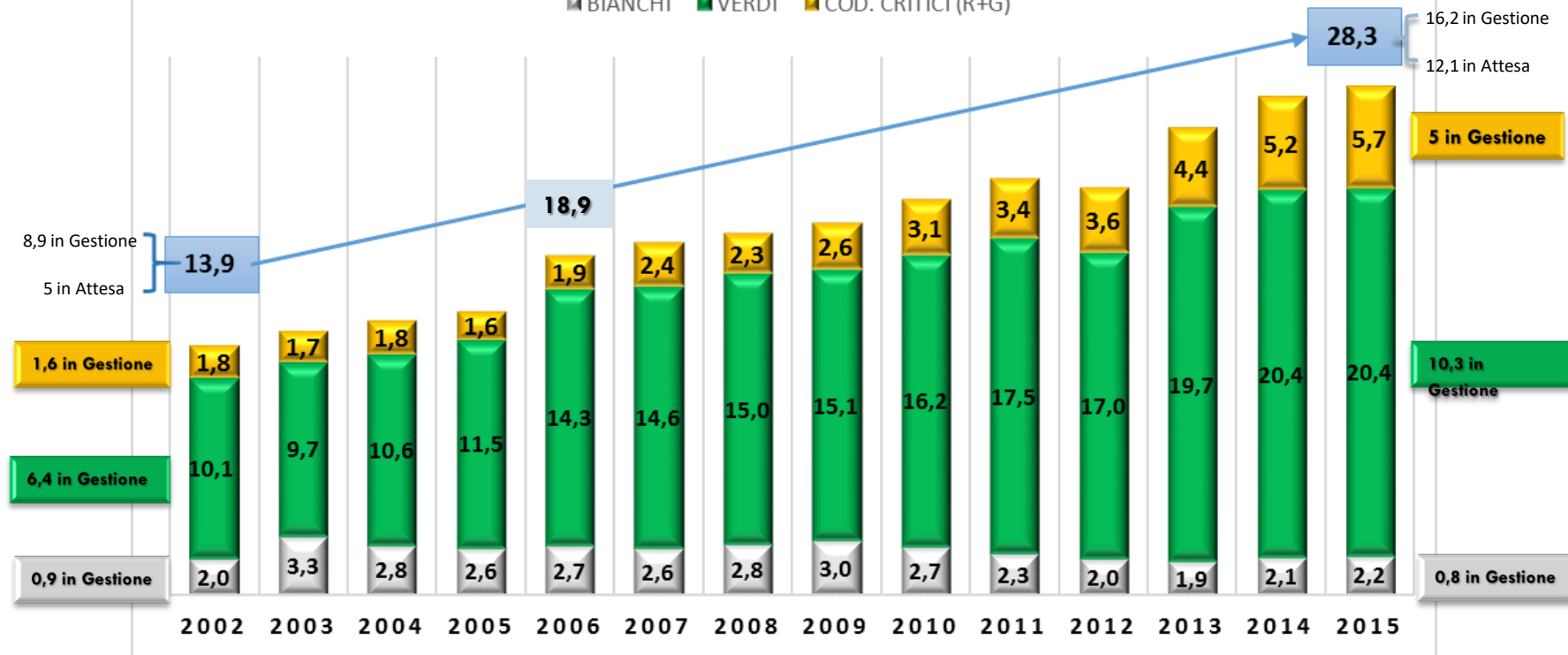




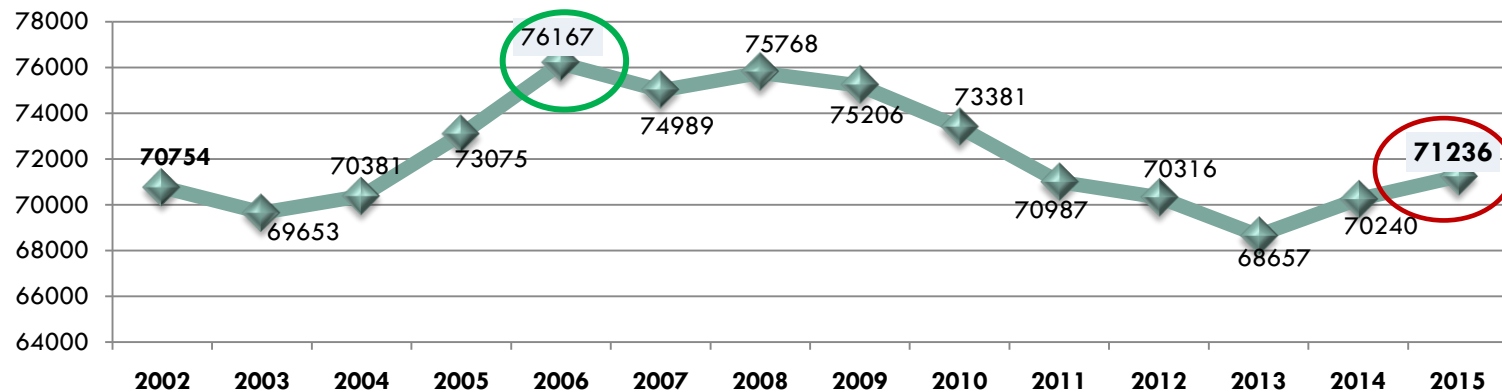
	2005	2006	2007	2008	2009	2010	2011	2012
Ricoveri	11028	11220	11131	10939	10761	10865	10.567	10.401
Codici Rossi + Gialli	6986	7252	8428	8486	9508	10353	10.699	11.070

N° PAZIENTI PRESENTI IN MEDIA IN PS OGNI ORA SUDDIVISI PER CODICE COLORE

■ BIANCHI ■ VERDI ■ COD. CRITICI (R+G)



ACCESSI TOTALI in PS





Area Ricoveri nel DEU

Razionale

- Il **tempo di attesa per il posto letto** rappresenta una criticità per la maggior parte dei Pronto Soccorso.
- Una delle cause di sovraffollamento, universalmente riconosciuta come la più importante, è il fenomeno del **boarding**, cioè l'attesa in Pronto Soccorso di quei pazienti che, necessitando di ricovero ospedaliero, in assenza di posto letto attendono il ricovero nei locali del PS stesso.
- I Pronto Soccorso, progettati per fornire cure tempestive in emergenza urgenza, si trovano quindi a dovere assistere per svariate ore i pazienti in attesa di posto letto, in una situazione definita dalla letteratura anglosassone di “**access block**” .



Area Ricoveri nel DEU

I pazienti in attesa di ricovero sostano negli ambienti di PS (rientranze, corridoi) con le seguenti ricadute:

- aumento del **rischio clinico** (aumento mortalità ospedaliera, ritardo inizio terapie, etc..)
- **allocazione inadeguata** in situazione di scomodità (su barelle)
- assistenza prestata da **personale** occupato negli ambulatori di visita, quindi non dedicato ai pazienti in attesa di ricovero
- **rallentamento** di tutte le altre attività di PS.

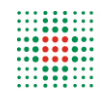
Da ultimo, le lunghe attese per il posto letto, riducono le possibilità di collocazione appropriata del paziente: il paziente che attende da più tempo si destina spesso al primo posto letto che si rende disponibile, indipendentemente dall'**appropriatezza di questa collocazione**.



Area Ricoveri nel DEU

Obiettivi

- ❑ Perseguire l'appropriatezza dei ricoveri in area medica
- ❑ Migliorare il setting assistenziale dei pazienti in attesa di una collocazione definitiva
- ❑ Utilizzare il tempo in attesa ricovero per iniziare il percorso diagnostico-terapeutico dei pazienti con soluzione di continuità dalla fase della stabilizzazione in emergenza.
- ❑ Perseguire una reale continuità assistenziale condividendo strumenti, metodi e procedure con le altre unità operative coinvolte dalla riorganizzazione aziendale, sia nella fase di accoglienza che di ricovero nelle unità operative di assegnazione
- ❑ Incrementare le competenze infermieristiche



Area Ricoveri nel DEU

Risultati attesi

- ❑ Ricovero del paziente nella Unità Operativa appropriata alla patologia e non nel primo letto disponibile.
- ❑ Tempo di attesa del “posto letto” gestito in modo attivo secondo protocolli condivisi
- ❑ Ambiente confortevole per il paziente e tutela della privacy
- ❑ Riduzione del rischio clinico legato al sovraffollamento del Pronto Soccorso e all’attesa di questi pazienti
- ❑ Riacquisizione di tempo e spazi da parte degli operatori di Pronto Soccorso, che non debbono più dedicare parte della propria attività ad assistere i pazienti in attesa di ricovero



Area Ricoveri nel DEU

CRITERI DI ESCLUSIONE PAZIENTI NELL'AREA RICOVERI

- ❑ Pazienti che non hanno terminato l'iter diagnostico in PS o in OBI non è ancora stato deciso la necessità di ricovero
- ❑ Paziente critico con parametri vitali instabili che deve trovare rapida collocazione nelle aree ad alta intensità di cura
- ❑ Paziente con sospetto di malattia infettiva contagiosa
- ❑ Contestualmente a questi criteri, si sottolinea che il medico dell'Area Ricoveri è in possesso di un mandato di ricovero inappellabile che potrebbe superare l'appropriatezza di collocazione e che sarà indispensabile che le unità operative rispettino gli accordi sulla disponibilità dei p.l. nei tempi previsti.

Progetto di riorganizzazione per intensità di cura e complessità assistenziale



SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Ospedaliera di Reggio Emilia
Arcispedale S. Maria Nuova

Istituto in tecnologie avanzate e modelli assistenziali in oncologia
Istituto di Ricovero e Cura a Carattere Scientifico

dal 4 aprile 2013



attivazione
ADMISSION UNIT E DISCHARGE ROOM

4 aprile

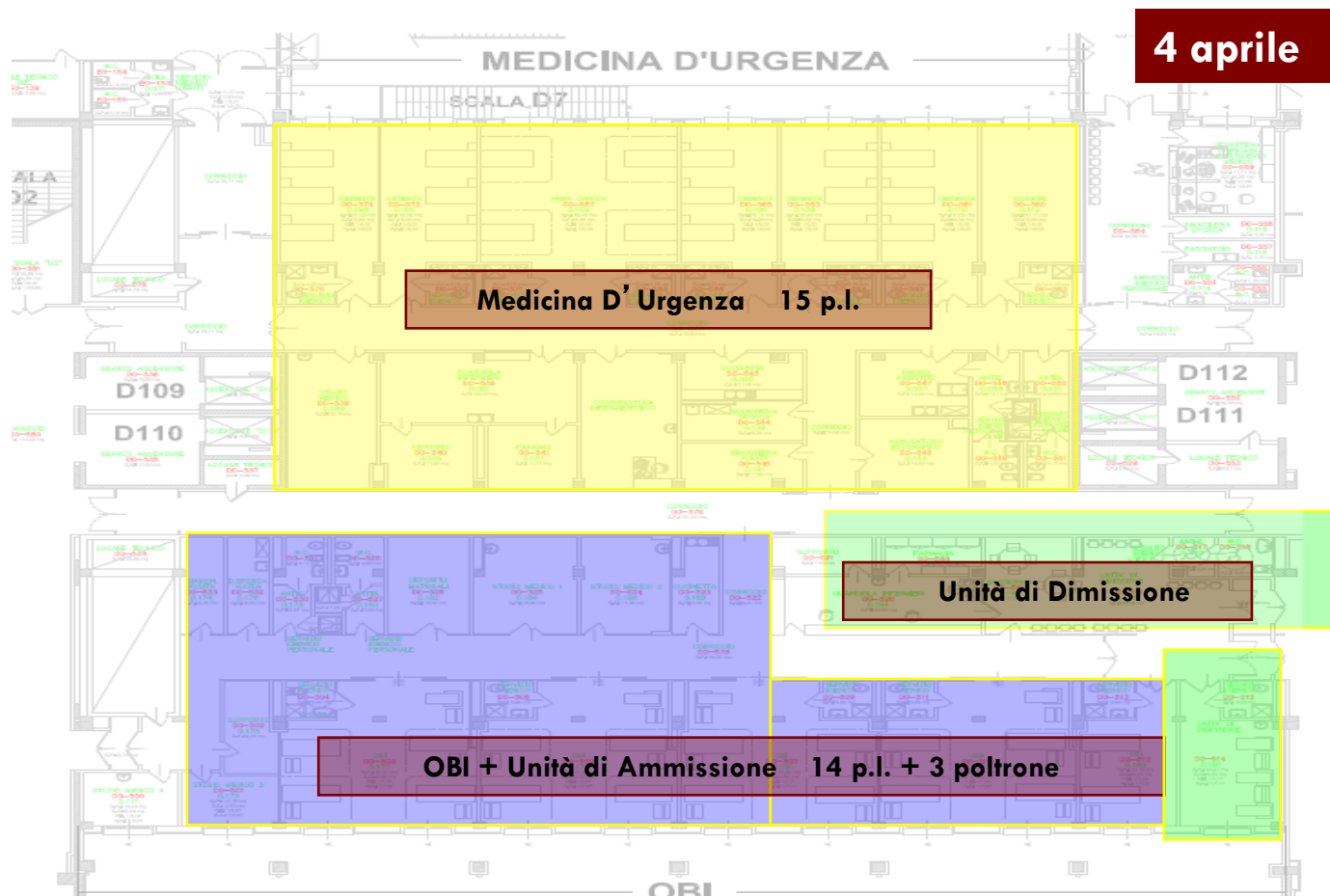


4 aprile

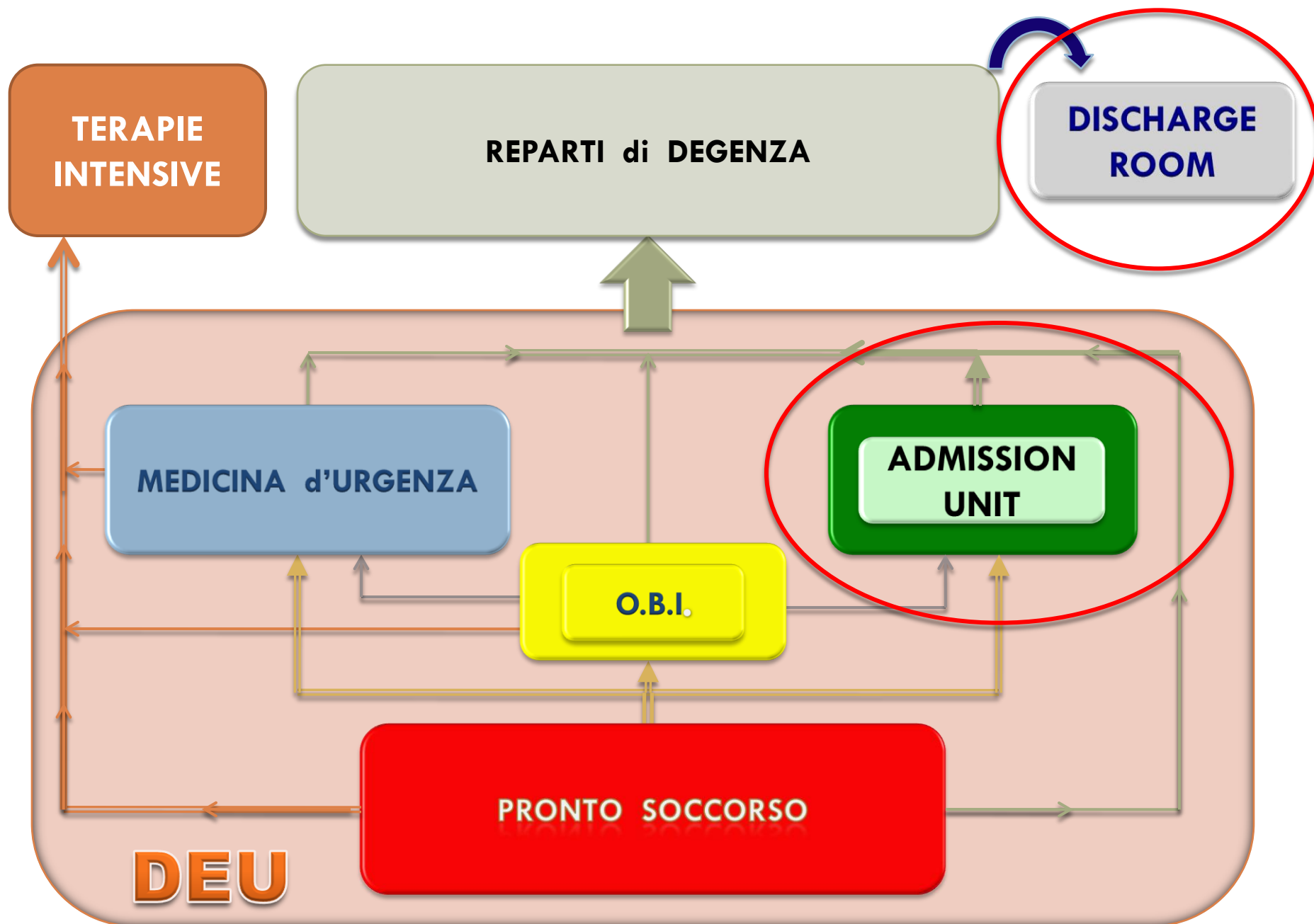
Riorganizzazione **DIPARTIMENTO MEDICINA INTERNA**
e attivazione **MEDICINA ONCOLOGICA**

Progetto di riorganizzazione per intensità di cura e complessità assistenziale

Area Emergenza Urgenza



FLUSSI - RICOVERI IN URGENZA DAL DEU Reggio Emilia



Area Ricoveri/OBI

Area Ricoveri

- 8 postazioni con TMT
- Permanenza 12h (18 ore max)
- Protocolli di gestione e trattamento
- Flessibilità con postazioni OBI
- Nò pazienti critici

OBI

- 9 postazioni con TMT
- Max 24 ore
- Protocolli di gestione e trattamento
- Flessibilità con postazioni Area Ricoveri
- Nò pazienti critici

17 postazioni in 5 stanze di degenza

Attivazione 3 Aprile 2013



Contiguità con Pronto Soccorso e
Medicina d'Urgenza



Postazione Lavoro
Medico - Infermieristica

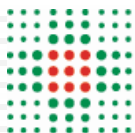
Area Ricoveri+ OBI

- 1 Medico h 24 (guardia notturna anche Medicina d'Urgenza) + il Medico Responsabile diurno
- 2 Infermieri ore diurne
- 1 Infermieri turno notturno

Osservazione Breve Intensiva
Area Ricoveri

Area Dimissioni

Area Dimissioni



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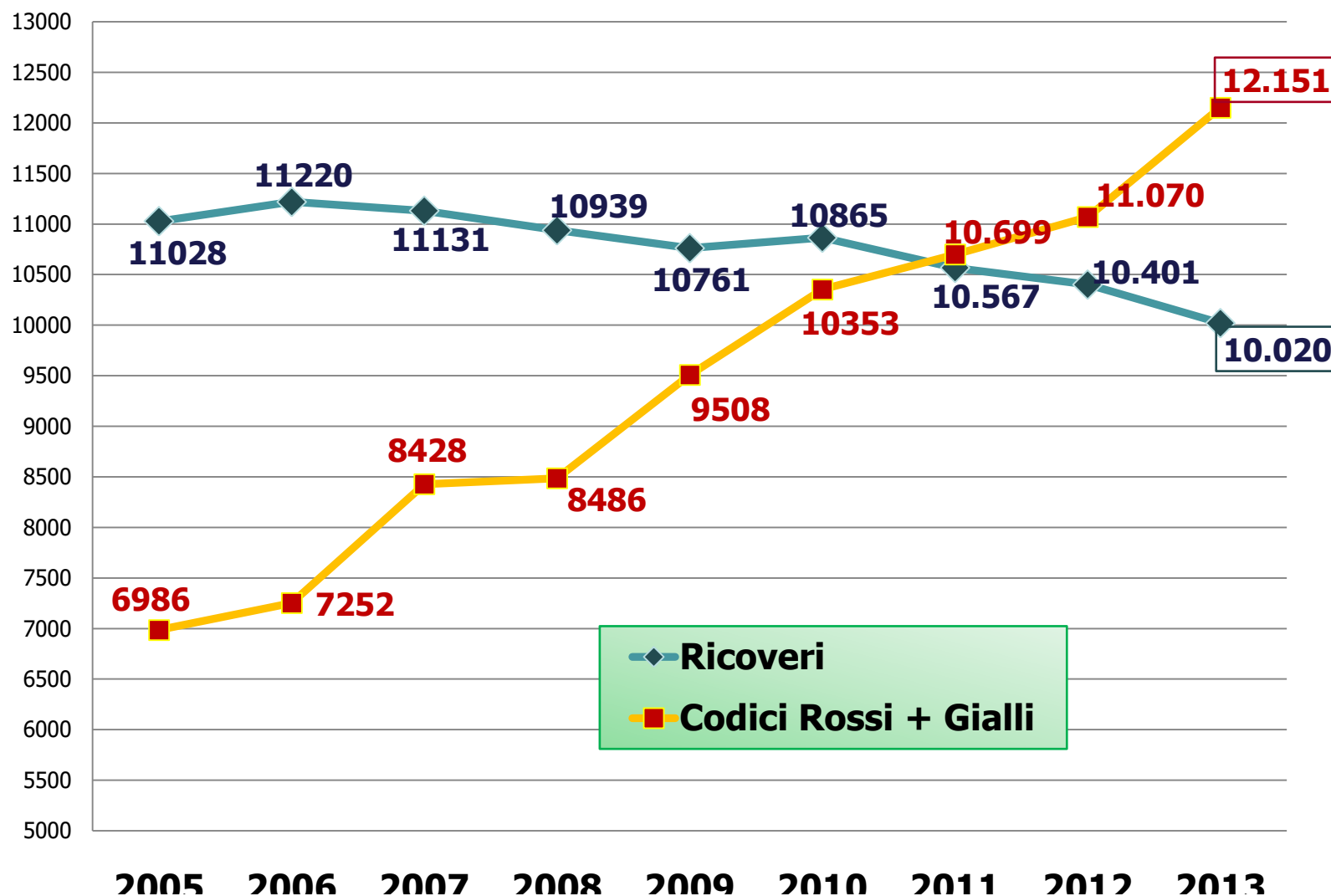
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Area Ricoveri

Risultati



ANDAMENTO RICOVERI PS VERSUS CODICI CRITICI



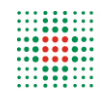


Anno 2013 (dal 3 aprile)

AR	N°	%
AL CURANTE	238	17,7%
TRASFERITO ALTRO OSPEDALE	60	4,5%
DECESSO	12	0,9%
RICOVERO	1030	76,6%
RIFIUTA RICOVERO	4	0,3%
Totale complessivo	1344	

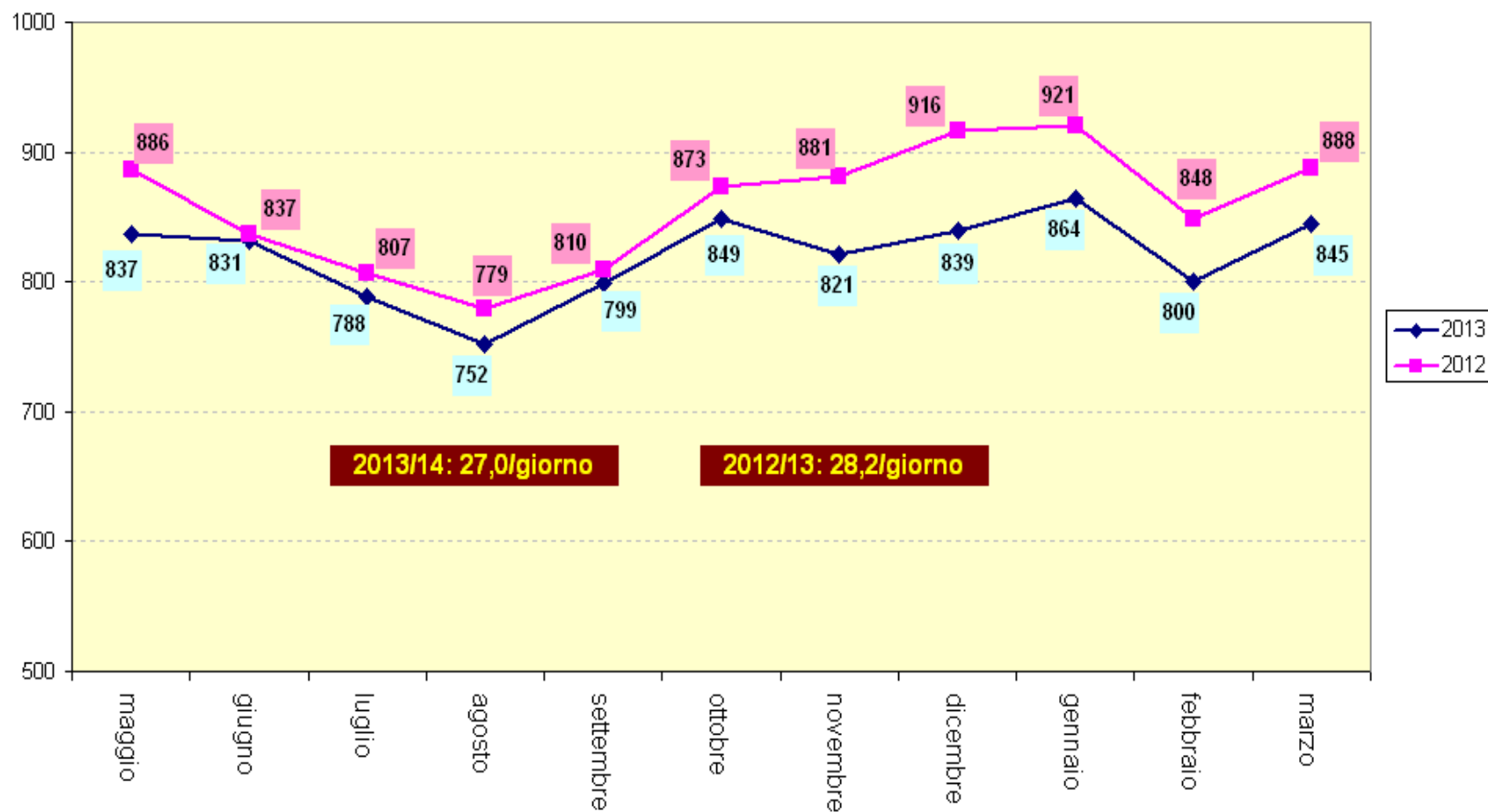
Tempo permanenza medio 16:15

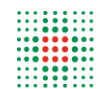
N°pz medio per giorno 5,02



Andamento ricoveri da PS (tutti i reparti)

2013/2014 vs 2012/2013

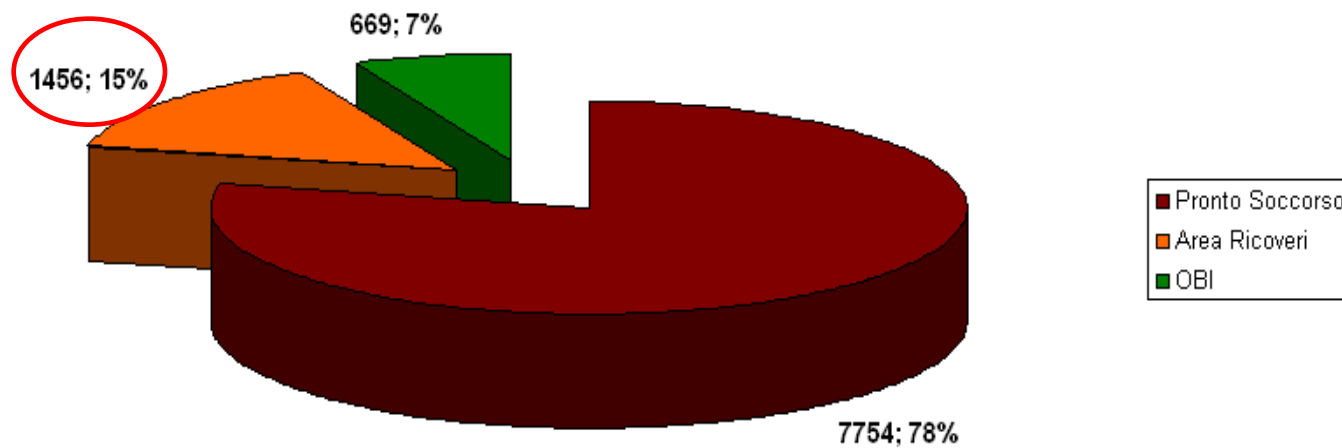


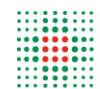


Ricoveri urgenti da Pronto Soccorso

8 aprile 2013 - 7 aprile 2014

9879 ricoveri urgenti da PS

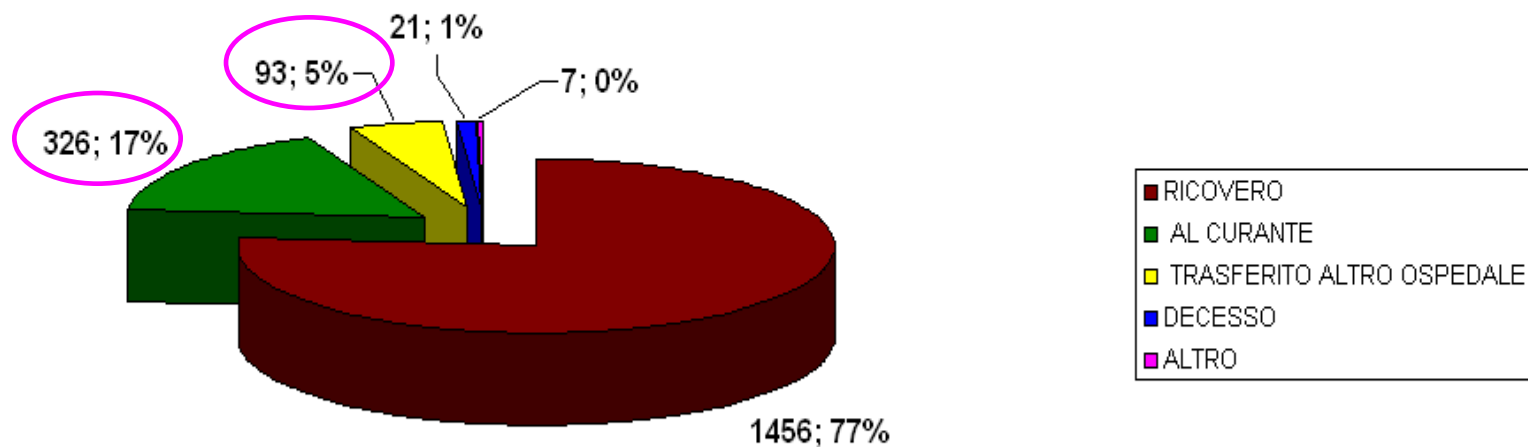




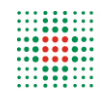
Area Ricoveri - modalità di dimissione

8 aprile 2013 - 7 aprile 2014

1903 pazienti: 5,2 pazienti al giorno



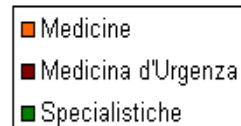
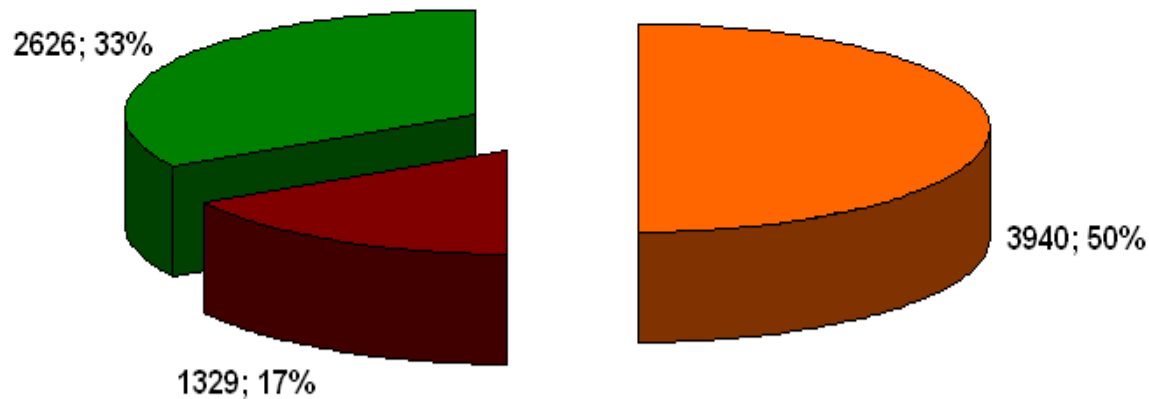
- 1,14 pl/die per ricoveri urgenti da PS



Ricoveri urgenti da PS

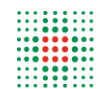
1 aprile 2012 - 31 marzo 2013

PRIMA DELLA RIORGANIZZAZIONE



Medicine: Medicina 1, Medicina 2, Medicina 3

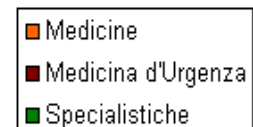
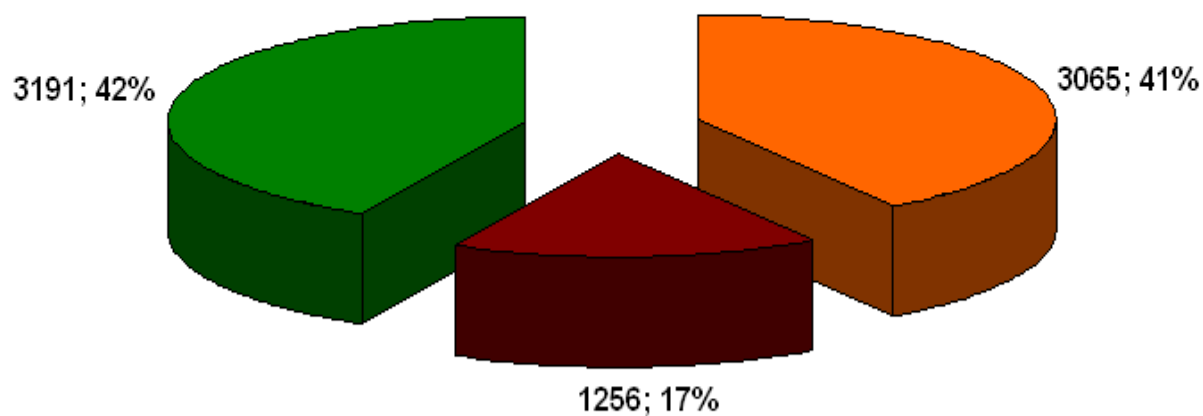
Specialistiche: Angiologia, Cardiologia, Geriatria, Malattie Infettive, Nefrologia, Neurologia, Pneumologia



Ricoveri urgenti da PS

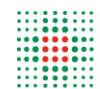
8 aprile 2013 - 07 aprile 2014

DOPO LA RIORGANIZZAZIONE

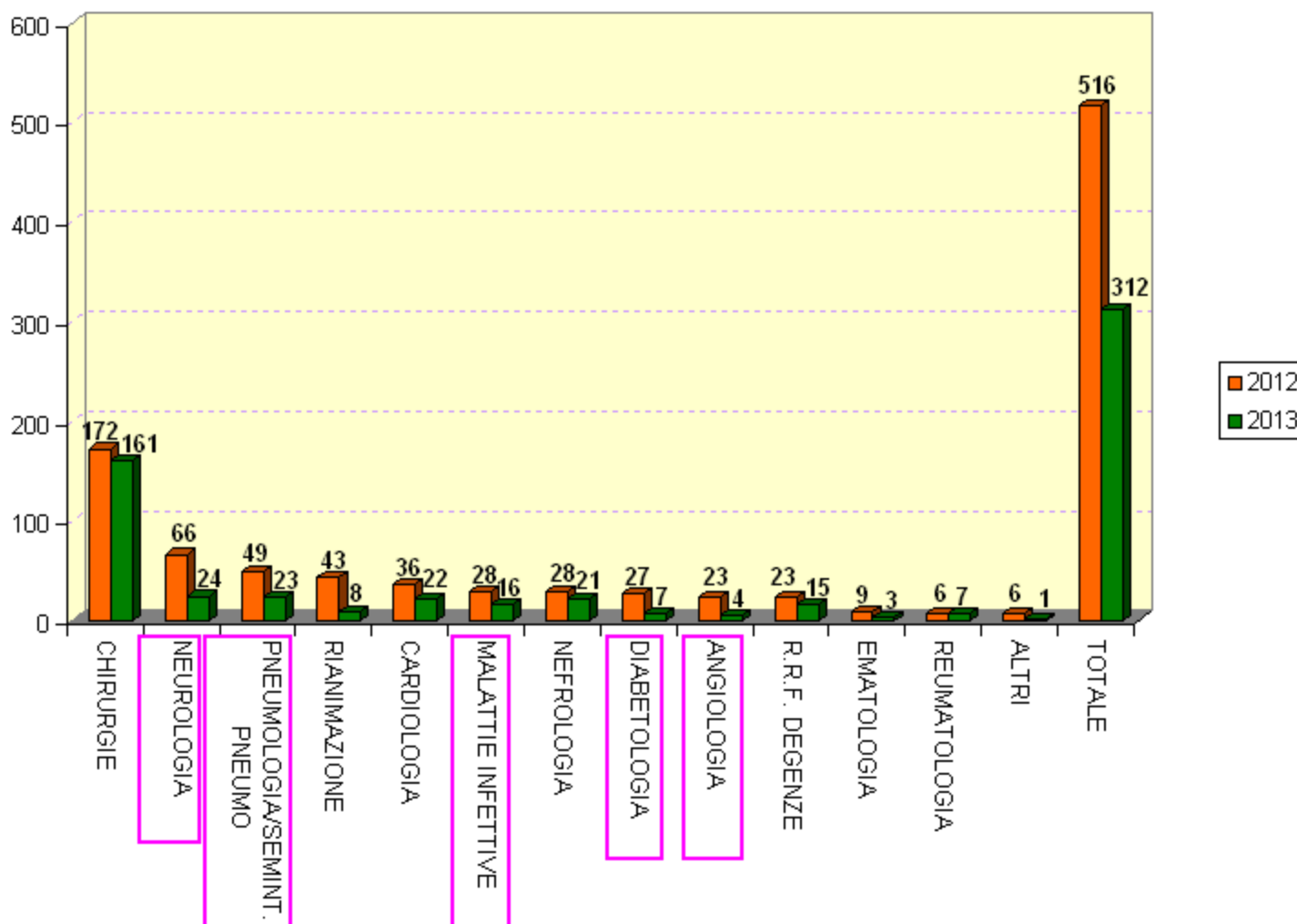


Medicine: Medicina 1, Medicina 1 HC, Medicina 2, Medicina 3, Medicina 3 WH, Medicina Oncologica

Specialistiche: Angiologia, Diabetologia, Cardiologia, Geriatria, Malattie Infettive, Nefrologia, Neurologia, Pneumologia



Trasferimenti da Medicine verso altri reparti





Tempi di permanenza pazienti in PS

	2012		2013	
> 6 ore	598	7,5%	365	4,8%
> 8 ore	225	2,8%	128	1,7%
> 10 ore	97	1,2%	59	0,8%

BLOCCO RICOVERI PROGRAMMATI

aprile – marzo

2013 vs 2012 e 2011



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2011/12	148 giorni
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2012/13	112 giorni
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→

2013/14	0 giorni
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~~In seguito alle difficoltà riscontrate in questi ultimi giorni nel garantire una disponibilità sufficiente di posti letto per ricoveri urgenti, si comunica la necessità di blocco dei ricoveri programmati, sia uomini che donne, **dalla data odierna fino a sabato 28 maggio compreso**, ad eccezione dei ricoveri di soggetti sottoposti a procedure diagnostiche ed interventistiche cardiologiche (coronarografie, PTCA, impianto device).~~

Area Ricoveri

Prime considerazioni

- Migliorata fin da subito l'appropriatezza di ricovero con riduzione dei trasferimenti successivi
- Possibilità di ricovero fin dal mattino
- Riduzione della sosta in Pronto Soccorso prima del ricovero
- Risparmio di ricoveri per secondo filtro
- Pazienti e parenti apprezzano la collocazione in questa area (anche nel momento dell'exitus)
- Gli infermieri di Pronto Soccorso, che ruotano per periodi limitati nell'area, ne apprezzano la qualità del lavoro

Area Ricoveri

Prime considerazioni

- L'azione di bed management è diventata cruciale e da formalizzare
- Nei momenti di aumentata richiesta di ricoveri e ridotta disponibilità di posti letto la gestione dell'area diventa più difficoltosa e deve essere autorevole
- Difficoltà a mantenere i tempi di permanenza entro le 12 ore
- Importanza della collaborazione tra professionisti



SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Ospedaliera di Reggio Emilia

Istituto in tecnologie avanzate e modelli assistenziali in oncologia
Istituto di Ricovero e Cura a Carattere Scientifico

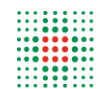
PROTOCOLLO PER LA GESTIONE DEI RICOVERI DAL PRONTO SOCCORSO

rev. Marzo 2013

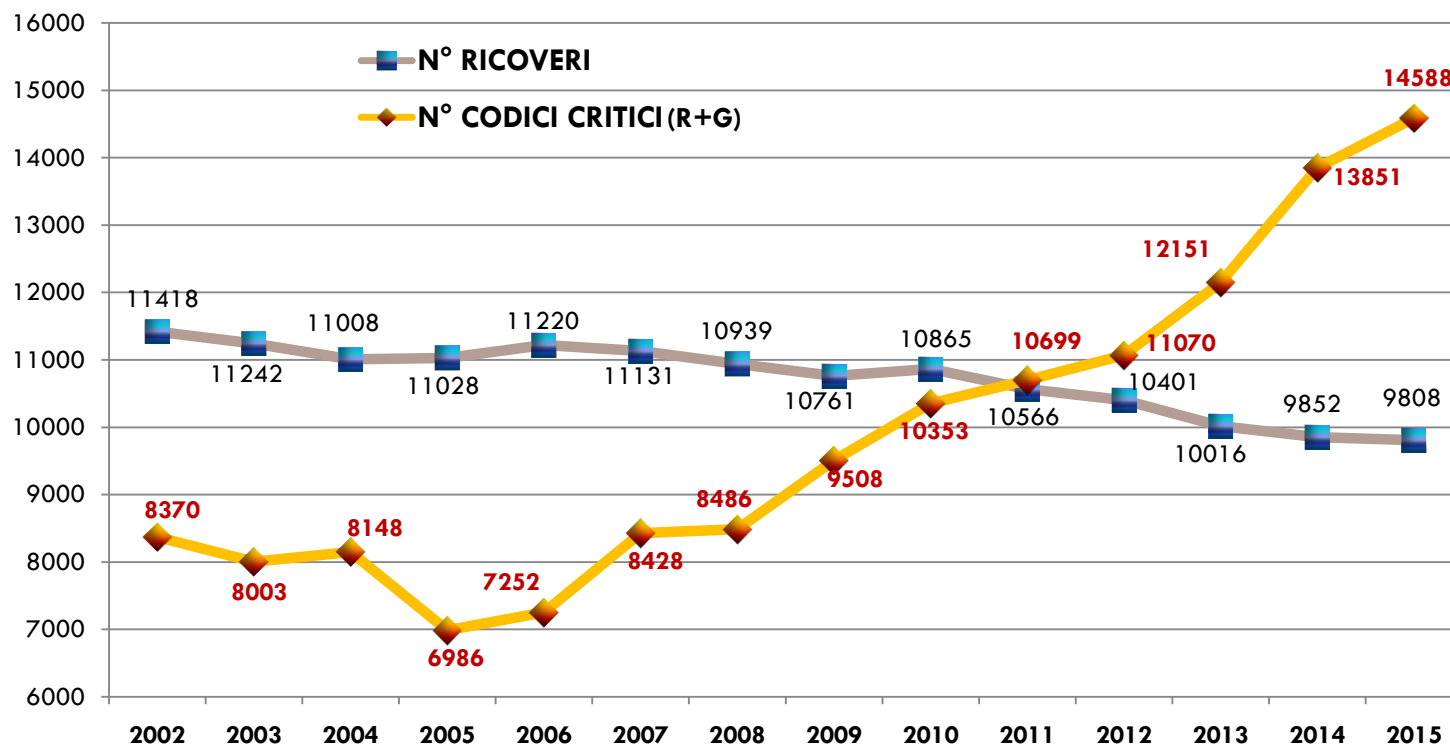


1. PREMESSA
2. NUOVA DOTAZIONE POSTI LETTO IN AREA MEDICA E IN AREA CHIRURGICA
3. ATTIVAZIONE AREA RICOVERI E AREA DIMISSIONE PRESSO DIPARTIMENTO EMERGENZA URGENZA
4. NUOVA ORGANIZZAZIONE ACCETTAZIONE RICOVERI DA PS
5. RICOVERI PRESSO REPARTI DI COMPETENZA
6. RICOVERO PAZIENTI VISITATI IN URGENZA IN REPARTO
7. VERIFICA DELL'APPLICAZIONE DEL PROTOCOLLO

Area Ricoveri	2013 (Da Aprile)		2014		2015		2016 (Fino a Settembre)	
Modalità di Dimissione	N°	%	N°	%	N°	%	N°	%
AL CURANTE	238	17,7%	368	18,1%	541	28,4%	341	25,0%
TRASFERITO ALTRO OSPEDALE	60	4,5%	102	5,0%	86	4,5%	63	4,6%
CONSULENZA ALTRO OSPEDALE	0	0,0%	3	0,1%	0	0,0%	0	0,0%
DECESSO	12	0,9%	29	1,4%	52	2,7%	35	2,6%
RICOVERO	1030	76,6%	1532	75,2%	1213	63,7%	923	67,6%
RIFIUTA RICOVERO	4	0,3%	3	0,1%	11	0,6%	3	0,2%
TOTALE	1344		2037		1903		1365	



CODICI CRITICI (CODICI ROSSI + GIALLI) E RICOVERI, CONFRONTO 2002-2015



Grazie dell'attenzione

Anna Maria Ferrari