

Area of admission and short-term care: is it still possible after the COVID pandemic?

Francesco Serafini, Elia Vettore, Fabio Presotto

Complex Operating Unit of Internal Medicine, Department of Medicine and Onco-Hematology with Urgent Care character, Ospedale dell'Angelo, Mestre (VE), Italy

Dear Editor,

Since 2011, the Internal Medical Unit of Ospedale dell'Angelo, Mestre, has been equipped with an area of eight beds which served as a short-stay unit called *area di accoglimento e degenza breve* (area of admission and short-term care, ADB). All patients coming from the emergency room (99%) passed through the ADB area. Here, doctors and nurses carried out an initial clinical care triage to identify patients with features that made the discharge possible within 72 hours (Table 1). Doctors and nurses in the ADB area made use of two major tools: clinical care pathways and bedside ultrasounds. The results achieved with this organization were in line with the expectations. In particular, discharges within three days increased, the average length of stay decreased, and hospital returns after 90 days did not increase.¹

The COVID-19 pandemic has strongly impacted health organizations: in particular, hospitals experienced a rearrangement of the workflow, hospital floors were shifted from elective to intensive care units, and healthcare workers were tasked with new roles and responsibilities. In the

Italian reality, many internal medicine wards had to change their structure and organization to treat patients and limit contagion. This was particularly frequent in internal medicine wards rather than in infectious diseases and pneumology wards. The ADB unit of Ospedale dell'Angelo experienced a dramatic transformation with two major changes. The first was structural: beds were transformed into small protected rooms where it was possible to accommodate patients with SARS-CoV-2 infection. The second change was functional, so only selected patients could access the structure following a single pathway. All of this distorted the original function of the ADB area where patients were characterized by low-intensity-of-care diseases and rapid presumed discharge.²

Another consequence of the pandemic was the reduction of non-COVID hospitalizations. There was a significant reduction in the number of admissions for acute decompensated chronic conditions like heart failure, diabetes, kidney disease, oncological disease, and other conditions that could benefit from a short hospitalization. Furthermore, when admissions for these diseases were possible, they turned out to be more complicated and needed a longer stay before recovery.³

During the third and fourth waves of the pandemic, the average age of hospitalized patients was eighty years, many of the patients came from retirement homes or had lost self-sufficiency and their caregivers were no longer able to assist them at home. Therefore, also patients admitted to the ADB unit could not be moved out and the average hospital stay became longer.⁴

Today, the pandemic is under control but we should ask ourselves what we have learned from it and how we can change the activity in the internal medicine ward. Moreover, we should analyze whether it is possible to continue with the experience of the ADB unit.

The first important aspect to consider is the improvement of the flexibility of the beds. In particular, it would be necessary to quickly change their function depending on the needs. Moreover, the ABD unit should not consist of a specific area but rather a dedicated number of beds within the internal medicine ward, where patients should be admitted following clinical pathways shared with the emergency department.

A second aspect we would like to stress is the need for a case manager nurse in the internal medicine ward. Elderly and complex patients who are admitted to the Medicine ward need a 360-degree clinical care vision. The presence of a case manager nurse in the medical wards would help to

Correspondence: Francesco Serafini, Department of Medicine and Onco-Hematology with Urgent Care character, Ospedale dell'Angelo, Mestre (VE), Italy.
E-mail: francesco.serafini@aulss3.veneto.it

Conflict of interest: the authors declare no potential conflict of interest.

Received: 16 May 2024.
Accepted: 6 June 2024.

Publisher's note: all claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article or claim that may be made by its manufacturer is not guaranteed or endorsed by the publisher.

©Copyright: the Author(s), 2024
Licensee PAGEPress, Italy
Italian Journal of Medicine 2024; 18:1746
doi:10.4081/ijm.2024.1746

This work is licensed under a Creative Commons Attribution NonCommercial 4.0 License (CC BY-NC 4.0).

Table 1. Eligible patients for short-term care (max. 72 hours).

Long-lasting transient ischemic attack at risk medium low
Concussive head trauma (even with small hemorrhage subarachnoid)
Rib trauma even fracture without contusion pulmonary
Syncope preceded by prodromes
Abdominal colic, non-surgical intestinal subocclusion
Atrial fibrillation (both for rhythm control and for rate control)
Chest pain with high thrombolysis in myocardial infarction score
Fine class III community pneumonia
Chronic bronchitis with mild exacerbation (saturation oxygen >90%)
Alterations in the hydroelectrolyte balance
Heart failure (class I-II of Killip upon discharge from the emergency room)
Suspicion of gastrointestinal hemorrhage with score of Rockall <6
Deep vein thrombosis and pulmonary thromboembolism minor (in compensation with negative troponin and brain natriuretic peptide)
Hyperglycemia

better understand the patients' social and clinical problems improving the outcome and reducing the length of stay in hospital. This would be especially useful for short-stay beds in the medicine ward.

A third aspect we consider fundamental is the increasing investments in technology and healthcare training. The presence of monitors for hemodynamic parameters, portable machines for point-of-care ultrasound, and computers at the patients' beds for connecting to the intra-hospital and extra-hospital network would improve both diagnostics and patient care. This is true both in semi-intensive beds and in short-stay beds in the medicine ward.

A fourth aspect we consider extremely important is planning a discharge pathway for fragile patients towards the territory. In particular, discharge procedures should be quick and easy, streamlining as much as possible the bureaucratic difficulties that slow down any initiative. In addition, the territory should have a certain number of *ad hoc* structures to receive patients from the hospital who have overcome the acute phase but who cannot yet return home ("intermediate care"). The short-stay beds could also take the patient back if the clinical conditions deteriorate.

In conclusion, the current COVID-19 pandemic has given us evidence that, rather than ruling out the possibility of a hospital short-stay unit, calls for redefining its parameters. The internal medicine ward should ideally have

all of the short-stay beds. There, the emergency room admissions, treatment, and community discharge could be coordinated by the internal medicine specialist and the case manager nurse. Health professionals should have effective, high-performing tools for communicating with the territory in order to carry out this task.

References

1. Serafini F, Bonanni L, Zancanaro A, et al. Area of admission and short-term care: an integral part of the internal medicine ward organized to intensive care. *Ital J Med* 2012;6:242-7.
2. Shuster SM, Lubben N. The uneven consequences of rapid organizational change: COVID-19 and healthcare workers. *Soc Sci Med* 2022;315:115512.
3. Dati Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS), Istituto Nazionale di Statistica (ISTAT). Impatto dell'epidemia COVID 19 sul sistema ospedaliero italiano. 2022. Available from: <https://www.agenas.gov.it/comunicazione/primo-piano/2112-agenas-e-istat-impatto-dell'epidemia-covid-19-sul-sistema-ospedaliero-italiano-anno-2020> (in Italian)
4. Perrotta F, Corbi G, Mazzeo G, et al. COVID-19 and the elderly: insights into pathogenesis and clinical decision-making. *Aging Clin Exp Res* 2020;32:1599-608.