EDITORIAL

Short-stay units: a safe, winning bet for hospitals

Unidad de corta estancia: una apuesta ganadora y segura para el hospital

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Short-stay units (SSUs) appeared in Spain in the mid-1990s and are undoubtedly a clear example of the adaptive capacity of the emergency services (EMS) in situations of high levels of care[1,2]. Its appearance responds to a demand for hospitalization not covered by conventional hospitalization and has turned the professionals who worked in them into real experts in the management of acute chronic pathologies and non-complex acute processes, usually infectious, requiring hospitalization to ensure a correct evolution. However, the implementation of SSUs in hospitals is still low. The REGICE1 study conducted a survey of 591 Spanish hospitals registered by the Ministry of Health, Social Services and Welfare, to determine the degree of implementation of these units. Only 67 (11.3%) had SSUs[3]. It is true that there are communities that have more implantation of these units, and thus in Catalonia their presence increases to 35.4% as shown in the data from SUHCAT study[1,4]. Another interesting fact shown by the REGICE1 study is the organic unit of the SSUs, and highlights that 65% of them depend on the EMS. This dependence on the EMS is logical, since in many cases it has been the EMS themselves that have created the unit as a response to the demand for care. The other service involved in the management of the SSUs is internal medicine, which has always created a debate about who does it best. The fact that a SSUs depends on emergencies is not better or worse, it is simply different[3]. But the scientific evidence generated in these emergency-dependent SSUs is increasing, and demonstrates their safety with different processes such as pneumonia, acute heart failure (AHF) or chronic obstructive pulmonary disease (COPD), and in the elderly[6-10], with a high degree of satisfaction on the part of patients[11]. The main characteristic of the SSU is its high care activity, thanks to an approximate stay of 3 days, a percentage of home discharge of around 80% and a hospital mortality of 2.8%[12]. To achieve these results it is necessary to strictly comply with a series of selection criteria, in the patients who are going to enter. Fundamentally, they must be patients with an acute process already diagnosed and stable, with a predictable stay of less than 72 hours, with minimum complementary testing needs and that can be discharged at home or benefit from by hospitalization control equipment at home or in the center of subacutes[13]. The main reasons for admission to the SSUs are therefore HF (8.2%), exacerbation of COPD, asthma or bronchitis (6.5%), infectious disease of the kidney and urinary tract (5.5%) and respiratory infection (4.8%).

A subjective critique to these units has been the possible increase in inappropriate or inadequate admissions, according to the generosity of criticism, which can generate the presence of a SSU, which results in an increase in hospital admissions and, resulting in worse overall hospital outcomes. In recent years there have been studies that provide scientific evidence regarding the impact of the SSU in managing the rest of hospital resources. In this regard, we have objective data in a process of high prevalence in the SSU which is the AHF. An analysis of EAHFE[14] data showed two interesting things. The first was that the presence of a SSU was associated with an increase in hospital admissions for AHF with an adjusted absolute increase of 8.9% (95% CI, from 6.5% to 11.4%). However, it was also associated with a significant decrease in AHF re-emergence at 30 days with an adjusted absolute difference of -10.3% (95% CI -16.9% to -3.7%). Therefore, the existence of a SSU allows the emergency physicians to have a resource that increases the safety in the decision making, not having to discharge patients inappropriately or with a high risk of re-visit. The second was that there was a significant decrease in hospital stay in hospitals with SSU, with an adjusted absolute difference of -2.2 days (95% CI -2.7 to -1.7 days), which has repercussions on better overall hospital outcomes. It should be added that this decrease in hospital stay was not accompanied by negative results in terms of clinical safety, since there were no significant differences in mortality and re-emergence at 30 days, with an adjusted absolute difference -0.5% (95% CI of -2.6% to 1.6%) for the first and 1.3% (95% CI -1.9% to 4.5%) for the second.

The study by Richard Espiga et al. gives us more scientific evidence as to what contributes to the creation of an SSU to a hospital. This interesting work, with a quasi-experimental design, studies the impact of setting up a SSU in a third-level hospital in terms of indicators of clinical management and quality of care of the hospital and of conventional hospitalization units. In order to carry out this work, the authors compare two

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periods of time before (year 2012) and after (years 2013 to 2015) of the implementation of the SSU. The results of this study coincide with the aforementioned results: a decrease in the mean hospital stay after the start of the SSU, without an increase in in-hospital mortality or re-visits by the same main diagnosis after discharge at 30 days. In this study we find a result that draws much attention, and is the fact that despite an increase in the number of visits to the ED of close to 8%, there is a decrease in the percentage of hospital admissions from the emergency room, which was 16.6% in 2012 and 14.9% in 2015, following the opening of the SSU.

Regarding the patients' opinion of the SSU, the authors complete the study with a satisfaction survey, with very positive results, in consonance with other studies[11]. It is necessary to emphasize the good valuation that is done of the respect to the intimacy in the SSU. The authors do not make it clear if they make reference to the corporal intimacy or the right to the privacy of the patient, which is based, essentially, in the confidentiality about certain aspects of their lives that they do not want to be made public without authorization. But without a doubt, the fact that the rooms are single, facilitates both, a situation more difficult to meet in most hospitals, where the rooms are double.

The current evidence makes clear all the positive results offered by the opening of the SSU, so we must work to implement a SSU in all Spanish hospitals.

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