Impact of the premature discharge on hospital mortality after a stay in an intensive care unit

M. Rodríguez-Carvajal,* D. Mora, A. Doblas, M. García, P. Domínguez, A. Tristancho, M. Herrera

Unidad de Cuidados Intensivos Polivalente, Hospital Juan Ramón Jiménez, Huelva, Spain

Received 12 August 2010; accepted 13 January 2011

Abstract

Objective: To determine the frequency and to evaluate the relationship between premature discharge and post-ICU hospital mortality.

Design: A prospective registry was made for patients admitted during six consecutive years, performing a retrospective analysis of the data on the first admission of ICU survivors.

Setting: A 10-bed general ICU in a 540-bed tertiary-care community hospital.

Patients: 1,521 patients with an ICU stay longer than 12 hours, discharged alive to wards with known hospital outcome.

Interventions: None.

Main variables: We recorded the patient data, including types of ICU discharge, normal or premature, and studying their relationship with post-ICU hospital mortality. The types of ICU discharge were also evaluated versus ICU readmission rate and post-ICU length of stay.

Results: There were 165 patients (10.8%) with premature discharge. Mortality rate was 11.6% (176 patients). The factors related with mortality were withdrawal and limitation of life-sustaining treatments (OR=14.02 [4.6-42.6]), readmissions to ICU (OR=3.46 [1.76-6.78]), premature discharge (OR=2.6 [1.06-4.41]), higher organ failure score on discharge from the ICU (OR=1.16 [1.01-1.32]) and age (OR=1.03 [1.01-1.05]). Readmission rates and post-ICU length of stay were similar among patients with premature and normal discharge (7.3% vs. 8.2%, P=.68 and 16.7±16.7 days vs. 18.7±21.3 days, respectively, P=.162).

Conclusions: Premature discharges appear to be common in our setting and have a significant impact on mortality. Types of ICU discharge do not seem to be related with other outcome variables in the hospital care of critically ill patients.

© 2010 Elsevier España, S.L. and SEMICYUC. All rights reserved.

KEYWORDS
Intensive care unit; Patient discharge; Withdrawing treatment; In-hospital mortality; Patient readmission; Outcome

*Corresponding author.
E-mail address: mjrcarvajal@gmail.com (M. Rodríguez-Carvajal).
Introduction

Critical patients who for different reasons do not gain admission to an Intensive Care Unit (ICU) have a poorer short-term prognosis than those patients who do gain admission to such Units.\(^1,2\) ICU admission and discharge policies are not only important for correct management of the available resources, but are also crucial to the outcome of critical patient care. The patient admission and discharge recommendations included in the clinical guides are not based on consistent evidence and must be adapted to the particular situation of each ICU and hospital.\(^3,4\) The decision to discharge a concrete patient from the ICU is generally fundamented upon clinical considerations regarding a favorable patient course in which special vigilance or treatment is no longer considered necessary, and were the required care is believed to be available in the area or destination of patient discharge. In situations of maximum occupation or saturation, and in the case of priority admission, intensivists, following due evaluation of the patients, must decide which individual should be discharged in order to make room for the new priority admission patient. This decision, although fundamented upon objective circumstances, always involves an important subjective component. Regardless of the intervening factors, non-programmed discharge of this kind may fall within the concept of premature or inappropriate discharge, considering the persistence of patient seriousness and organic dysfunction at the time of taking the decision - thereby conditioning the final outcome of the patient affected by discharge.\(^5,6\) Recently, a subjective scale has been validated that could help in the taking of such decisions and in minimizing the risks.\(^7\)

Non-programmed discharge of this type has not been specifically investigated, though some studies on nocturnal or weekend discharges mention that the great majority are determined by the need for a new admission.\(^8,9\) In a study carried out in the United Kingdom\(^9\) comprising 16,756 discharges from Intensive Care, 7.2% were seen to be due to the lack of a bed needed to accept a new admission and were thus considered premature. These situations in turn represented 42.6% of the nocturnal discharges and 5% of the diurnal discharges, and were associated to post-ICU hospital mortality (PICHM)(odds ratio [OR] = 1.35 [1.10-1.65]). In contrast, other authors have reported no relationship between the time of discharge and hospital mortality.\(^10,12\)

Based on the hypothesis that premature or non-programmed discharge influences the post-ICU results, the present study was designed to evaluate the frequency of this type of discharge and its impact upon PICHM.

Patients and method

Study setting

The study was carried out in the Polyvalent ICU of Juan Ramón Jiménez Hospital in Huelva (Spain), which has 10 beds for non-coronary critical adult patients. This is a closed clinical-surgical ICU attended 24 hours a day by intensivists, with four staff intensivists, two residents in training in
Critical Care Medicine (fourth and fifth year of training), and a nurse/patient ratio of 1/2. The hospital has 540 beds serving a fixed population of 230,000 inhabitants, and possesses a coronary ICU with 6 beds and a neonatal ICU. The center has no intermediate care or dependency discharge unit, as a result of which the patients discharged from the ICU are moved directly to normal nursing wards, with nurse/patient ratios of between 1/8 to 1/32, depending on the wards and shifts. There is an awakening room, but no post-surgery resuscitation unit. The hospital has Departments for dealing with a broad range of clinical and surgical diseases, though it has no heart surgery or solid organ transplant facilities.

The admission and discharge policies of this ICU are documented in general lines and are established on a consensus basis with the rest of the hospital. It is a general policy of the ICU not to discharge terminal patients or patients subjected to invasive mechanical ventilation or intravenous vasoactive drug perfusion. In the daily staff meeting of the Unit (physicians and nurses), all the patients, including those subjected to some limitation of therapeutic effort (LTE), are classified on the basis of clinical and physiological appraisal, and according to medical and nursing criteria, as either dischargeable or non-dischargeable individuals. In the case of the dischargeable patients, a discharge report is prepared and the patient is moved to the ward as soon as a bed becomes available. Those patients not regarded as dischargeable remain in the ICU. The final decision on the admission or discharge of patients is made by the intensivist, and the purpose of this classification is to always have beds available for those critical patients that need them.

Data acquisition and definition of premature discharge

The demographic data and information related to the disease of all admissions during 6 consecutive years (2000-2005) were prospectively entered (adopting consensus-based criteria) in a Microsoft Access database by the four physicians in the Unit, in a rotational and monthly manner. The intensivist in charge of data collection recorded as normal discharge all cases of discharge affecting dischargeable patients, regardless of the time of day of discharge. These cases were registered as type I discharges in the database, while premature discharge corresponded to the discharge of patients regarded as non-dischargeable. These discharges were registered as types II to IV, depending on whether the patients were receiving intensive treatment (e.g., mechanical ventilation, artificial airway or the titration of vasoactive drugs, etc., in the case of type IV) or not, and on the time during which they had been without this type of treatment (under 24 h in type III discharge or over 24 h in type II discharge). These premature discharges in all cases occurred at times when the ICU was saturated and a new patient had to be admitted. During weekends and on holidays, in which there was only one intensivist on duty and there were no joint staff meetings, premature discharges were taken to be exclusively those discharges decided to leave a bed vacant for another patient. Therefore, premature discharge means discharge not foreseen or agreed, and conditioned by the need for a new patient admission - with no associated time connotations (weekend, night shift, etc.).

Study variables and patients

Of all the patients admitted in the study period, the data analysis excluded those cases relating to readmissions to the ICU within the same hospitalization period, patients who died in the ICU, those with a stay of under 12 hours, and patients discharged to some other hospital and who were lost to follow-up.

The database variables included in the analysis were: age; sex; origin upon admission to the ICU; hospital stay before admission to the ICU, in the ICU and post-ICU; patient category (clinical or surgical); emergency or elective surgery; presence of chronic disease and acute physiological score (APS) according to the APACHE II in the first and last 24 h of stay in the ICU; evaluation of organ failure according to the SOFA (sequential-related organ failure assessment score) upon admission, the maximum reached during the course of stay and at discharge from the ICU; assessment of the nursing workload in the first 24 h of admission and at discharge from the ICU using the NEMS (nine equivalents of nursing manpower use score); the presence or absence of mechanical ventilation and its duration; the existence of any written instructions in the clinical history relating to LTE; the type of discharge (normal or type I in the database, and non-programmed or types II, III and IV); and readmissions to the ICU within the same hospitalization interval. According to definitive destination at the time of hospital discharge, the patients were classified as survivors if sent home, or as deceased patients if death occurred anywhere in the hospital - including the ICU if the patient had been readmitted to the Unit.

Statistical analysis

The main objective of this study was to compare post-ICU hospital mortality (PICHM) according to the type of discharge (normal or premature). A sub-analysis was made to assess the characteristics of premature discharge. The secondary objectives were to compare the frequency of readmissions to ICU and post-ICU hospital stay according to the types of discharge involved.

The statistical analysis was carried out using the SPSS version 14.0 statistical package. The values are reported as means ± standard deviation (SD) for continuous variables or as percentages of the corresponding group in the case of categorical variables.

Statistical significance was assessed using the Student t-test for variables with a normal distribution, as determined by the Kolmogorov-Smirnov test, and the Mann-Whitney U-test for variables with a non-normal or skewed distribution. Categorical variables were analyzed using the chi-squared test or Fisher exact test. A probability of \( Z < 0.05 \) was considered significant. Factors found to be significant in the univariate analysis were entered as independent variables in the step-by-step additive binary logistic regression analysis for estimating their influence upon post-ICU hospital mortality (PICHM), expressed as the odds ratio (OR) with the corresponding 95% confidence interval (95%CI).
Results

A total of 2584 admissions to the ICU were registered during the study period. Mean occupation, assessed on a daily basis (number of patients x 100/10) at 8:00 a.m., during the study period, was 80%.

The analysis included the data corresponding to the first admission of 1521 patients discharged live from the ICU.

Table 1 Characteristics of the 1521 patients and their relation to post-ICU hospital mortality

<table>
<thead>
<tr>
<th>Variables</th>
<th>Survivors (n = 1345)</th>
<th>Deceased (n = 176)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>54.9 ± 18</td>
<td>64.9 ± 14</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Sex (% males)</td>
<td>64.7</td>
<td>73.4</td>
<td>0.02</td>
</tr>
<tr>
<td>Pre-ICU hospital stay (days)</td>
<td>5.1 ± 13</td>
<td>5.5 ± 9.1</td>
<td>0.22</td>
</tr>
<tr>
<td>Origin (%)</td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>37</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Clinical wards</td>
<td>14</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Surgical wards</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Operating rooms</td>
<td>35</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Other hospitals</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Type of patients (% clinical)</td>
<td>56.6</td>
<td>57.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Type of surgery (% elective)</td>
<td>61.9</td>
<td>55.3</td>
<td>0.22</td>
</tr>
<tr>
<td>APACHE II (score)</td>
<td>15.7 ± 7.4</td>
<td>21 ± 6.6</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>APS (score)</td>
<td>11.9 ± 6.3</td>
<td>15.4 ± 6.4</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Chronic disease (%)</td>
<td>16.4</td>
<td>31.6</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>SOFA (score upon admission)</td>
<td>3.7 ± 3.18</td>
<td>5.1 ± 3.3</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>NEMS (score first 24 h)</td>
<td>26.2 ± 7.9</td>
<td>28.8 ± 7.1</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Mechanical ventilation (%)</td>
<td>36.6</td>
<td>50.5</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Duration of mechanical ventilation (days)</td>
<td>6.4 ± 13.3</td>
<td>10.1 ± 14.9</td>
<td>0.003</td>
</tr>
<tr>
<td>Stay in ICU (days)</td>
<td>4.8 ± 9.7</td>
<td>8.1 ± 12.4</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>SOFA maximum (score)</td>
<td>4.7 ± 3.8</td>
<td>7.1 ± 4.1</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>LTE (% patients)</td>
<td>0.74</td>
<td>19.9</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Premature discharge (% patients)</td>
<td>8.4</td>
<td>29.5</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>APS (score at discharge from ICU)</td>
<td>7.2 ± 4.4</td>
<td>9.9 ± 5.6</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>SOFA (score at discharge from ICU)</td>
<td>1.8 ± 1.9</td>
<td>3.3 ± 2.3</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>NEMS (score at discharge from ICU)</td>
<td>18.3 ± 2.7</td>
<td>18.7 ± 3.4</td>
<td>0.083</td>
</tr>
<tr>
<td>Readmissions to ICU (%)</td>
<td>6.1</td>
<td>23.3</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Post-ICU hospital stay (days)</td>
<td>16.9 ± 16.3</td>
<td>16.9 ± 23.3</td>
<td>0.98</td>
</tr>
</tbody>
</table>

APS: acute physiology score of the APACHE II classification; LTE: instructions relating to limitation of therapeutic effort of any modality, reflected in the clinical history of the patient; NEMS: nine equivalents of nursing manpower use score; SOFA: sequential-related organ failure assessment score; ICU: Intensive Care Unit.
after a stay in the latter of 12 hours or more, and with a
known final destination (in-hospital death or discharge
home) (Fig. 1). Of these patients, 176 (11.6%) died in
the hospital before discharge home - this representing a
little over one quarter (26%) of the total deaths of pa-
tients admitted to the ICU. The differential characteris-
tics between these patients and the survivors (Table 1)
basically indicate older age, seriousness and organic dysfunc-
tion between these patients and the survivors (Table 1)
basically indicate older age, seriousness and organic dysfunc-
tion between these patients and the survivors (Table 1)
between these patients and the survivors (Table 1)
between these patients and the survivors (Table 1)
between these patients and the survivors (Table 1)

Discussion

In this study 11% of all discharges from the ICU were not
programmed. We consider this figure to be high, and it
confirms the scant usefulness of mean occupation as an
isolated measure of bed availability at specific points in
time. In the study published by Goldfrad and Rowan,8
involving somewhat lower figures and different definitions,
nighttime discharges were used as a surrogate marker of
pressure upon the ICU; as this was a study comprising the
temporal division of cohorts, the situation was viewed as a
growing problem attributable to a lesser availability of beds
for critical patients. The same results have been obtained in
other studies,7,17,18 and although our definition of premature
discharge is unrelated to temporality or to the moment in
which it occurs, the findings of the present study likewise
illustrate this same problem.

In our hospital, patients with premature discharge from
the ICU present on average a two-fold greater probability of
dying in hospital than those with normal discharge. The
post-ICU hospital mortality (PICHM) recorded in this study
coincides with the observations of other authors,7,12,17-19
and is conditioned not only by the type of discharge involved
but also by other factors relating to discharge. Accordingly,
the greater organ dysfunction seen among patients with
premature discharge reflects incomplete resolution of the
disease processes affecting these patients20 with an
increased nursing workload,4 and indicates that this type of

Table 2 Factors related to post-ICU hospital mortality in
the multivariate logistic regression analysis

<table>
<thead>
<tr>
<th>Factors</th>
<th>OR (95% confidence interval)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (per additional year)</td>
<td>1.03 (1.01-1.05)</td>
<td>0.001</td>
</tr>
<tr>
<td>LTE</td>
<td>14.02 (4.6-42.6)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>SOFA (per score point at discharge from ICU)</td>
<td>1.16 (1.01-1.32)</td>
<td>0.003</td>
</tr>
<tr>
<td>Premature discharge</td>
<td>2.16 (1.06-4.41)</td>
<td>0.033</td>
</tr>
<tr>
<td>Readmission to ICU</td>
<td>3.46 (1.76-6.78)</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

LTE: instructions relating to limitation of therapeutic eff ort of any modality, reflected in the clinical history of the patient; OR: odds ratio; SOFA: sequential-related organ failure assessment score; ICU: Intensive Care Unit.

Table 3 Characteristics of the types of discharge in relation to the factors associated to post-ICU hospital mortality

<table>
<thead>
<tr>
<th>Factors</th>
<th>Normal discharge (n = 1356)</th>
<th>Premature discharge (n = 165)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>55.5 ± 18.5</td>
<td>60.7 ± 16.4</td>
<td>0.001</td>
</tr>
<tr>
<td>LTE</td>
<td>25 (1.8%)</td>
<td>20 (12.1%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>SOFA (score at discharge from ICU)</td>
<td>1.8 ± 1.18</td>
<td>3.76 ± 2.56</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Readmission to ICU</td>
<td>111 (8.2%)</td>
<td>12 (7.3%)</td>
<td>0.68</td>
</tr>
</tbody>
</table>

LTE: instructions relating to limitation of therapeutic effort of any modality, reflected in the clinical history of the patient; OR: odds ratio; SOFA: sequential-related organ failure assessment score; ICU: Intensive Care Unit.
discharge is inappropriate or even premature. Another factor, the limitation of therapeutic effort (LTE), is common practice in the ICU, and most of the patients subjected to LTE die in the Unit - contributing at least one-third of all deaths recorded in the ICU.15,20,21 Of the patients of our study, only 44 (3%) had one or more LTE instructions in their clinical history, and the preferential distribution of these patients among the cases of premature discharge probably reflects a logical preference on the part of the intensivists when it comes to having to decide which patients to discharge in order to gain a vacant bed in the Unit.

In coincidence with the study of Fernández et al.,7 readmissions to ICU were also found to be associated to PICHM. In the same way as nocturnal discharges in the study published by Goldfrad and Rowan,8 premature discharge did not imply increased ICU readmission rates. In other studies, however, nocturnal discharges were correlated to more readmissions.11,23,24 In our case, the older age of the patients with premature discharge, together with the higher LTE rates applied in the ICU and the organic dysfunctions may have contributed to non-consultation of the intensivists for the readmission of certain patients, or even to rejection by the intensivists themselves (“occult LTE”) - thus explaining the lack of a relationship between this type of discharge and readmission.

As in the case among survivors and patients who died in hospital, the duration of hospital stay after discharge from the ICU did not vary according to the type of discharge involved.

Reducing premature discharge with a view to reducing PICHM appears complicated. Keeping patients longer in the ICU has been found to be effective in some studies,6 though it is impossible with our current hospital structure, and would lead to increased mortality among other patients who probably would stand to benefit more from admission to the ICU than those in which the stay is prolonged in order to facilitate recovery from organ dysfunction. In our study, however, we did not study those patients who were admitted and caused premature discharge, or those who remained in the ICU when such discharge occurred. Consequently, both the ethical aspects of the decisions taken by the intensivists and the results of the other possible alternatives are limited to the field of speculation. Contemplating structural and functional changes to improve critical patient care at discharge from the ICU is an attractive idea, but neither the design of the study nor the results obtained allow us to identify those patients amenable to special follow-up in other increased dependency units or by a special healthcare team, or to know whether such a measure would effectively reduce PICHM. In this sense, the recently validated Sabadell score2 could prove to be a useful instrument.

Our study has important limitations that must be taken into account when interpreting the results obtained. Firstly, it has been carried out in a single institution, and the case mix, the functional structure, application of LTE, and the policies relating to admission, discharge and readmission may all be very different from those of other hospitals and ICUs. Secondly, we included no information on the diagnoses or reasons for patient admission, which could have modified the mortality model20 but which also would have posed complications for the logistic regression analysis due to multiplication of the number of variables and the addition of further heterogeneity. Nevertheless, the APACHE II-based mortality risk prediction model includes the reasons for admission, and we have seen that performance as assessed by standardized mortality according to this model is poorer in premature discharge. On the other hand, we did not examine the timing of discharge, and it is feasible that non-programmed discharge occurred more often in the course of shifts in which there are fewer ward personnel members, thereby accounting for poorer performance with this type of discharge6,11 - though neither the readmission rates nor posterior hospital stay appear to justify this assumption. Another limitation is that the information relating to discharge on weekends or holidays was obtained from the different intensivists on duty at the time, and in such situations the discharge criteria used when needing to gain a bed for another patient are not as homogeneous as when these decisions are taken in the context of the joint staff meetings of the Unit. Thus, some of these discharges might have been classified as normal if the decision had been taken in the mentioned routine joint staff meetings. In any case, it is unlikely that this would have modified our primary study endpoint.

Lastly, the present study is conditioned by the bias inherent to retrospective analyses, even if the data were collected prospectively.

In conclusion, premature discharge is relatively frequent in our setting and significantly contributes to post-ICU hospital mortality, without significantly affecting other outcomes of critical patient hospital care such as ICU readmission rate or post-ICU hospital stay.

Conflict of interest

The authors declare no conflict of interest.

References