

SHORT REPORT

Unplanned readmission to hospital: a comparison of the views of general practitioners and hospital staff

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Abstract

Objective: to compare the views of general practitioners and hospital staff on the reasons for unplanned readmission of older people.

Methods: we studied 124 patients aged 65 years or over who were readmitted within 28 days of discharge. We determined the views of hospital staff and the patient's general practitioner on the reasons for readmission and compared them using McNemar's test.

Results: the crude readmission rate was 13.2%. The commonest agreed reason for readmission was a relapse or complication of the initial illness. Opinions differed most significantly when the reason was poor health or inadequate preparation on discharge.

Conclusion: hospital discharge policies should take into account general practitioners' views on the causes of unplanned readmission.

Keywords: *general practitioners, unplanned readmission to hospital, hospital staff, older people*

Introduction

Hospital readmissions of older people have increased substantially over the past 30 years [1]. About 15% of older patients have an unplanned readmission [2]. Such events are of concern to patients, carers and hospitals.

The unplanned readmission rate has been proposed as a surrogate marker for quality of clinical care [3], and high readmission rates are sometimes considered to be the price for shorter in-patient stays [4]. Rates for specific conditions (such as diabetes mellitus and bronchial asthma) may identify quality of care problems for that particular specialty [5]. However, if factors causing readmission are unavoidable, then global rates are not a useful qualitative measure.

Studies have found no link between readmission rates and age or sex [6], though there is an association with chronic disabling conditions [3]. Initial assessment of older patients by a more senior doctor has been shown significantly to lower 28 day readmission rates [7].

Williams and Fitton found that medical relapse, carer problems, medication problems and poor communication between hospital and general practitioners (GPs) are contributing factors [8].

The aim of this study was to elucidate GPs' views on the causes of readmission and to compare them with those of hospital staff.

Methods

Over 3 months, we studied patients aged 65 years or over readmitted to the integrated Directorate of Medicine, having been discharged from the same directorate within the previous 28 days. We used a questionnaire based on the factors shown by Williams and Fitton to be associated with readmission (Table 1) to determine the views of hospital staff (senior nurse or doctor) caring for the patients. The same questionnaire was then sent to the patients' GPs.

We used SPSS for Windows for statistical analysis. The readmission rate was defined as the ratio

Table 1. Factors contributing to readmission

	GPs' views <i>n</i> = 84	Hospital staff's views <i>n</i> = 84	Significance
Relapse or complication of initial illness	59 (70%)	68 (81%)	not significant
New problem	12 (14%)	19 (23%)	not significant
Problem with social services	5 (6%)	3 (4%)	not significant
Carer problem	25 (30%)	22 (26%)	not significant
Medication problem	1 (1%)	8 (10%)	<i>P</i> = 0.04
Poor health on discharge	23 (27%)	2 (2%)	<i>P</i> = 0.0001
Inadequate preparation for discharge	14 (17%)	2 (2%)	<i>P</i> = 0.002
Inadequate information given to GP	8 (10%)	0 (0%)	<i>P</i> = 0.008
'Avoidable' readmissions	18 (23%)	9 (11%)	not significant

GP, general practitioner.

(percentage) of the number of patients admitted aged 65 years or over discharged from the Directorate of Medicine within the previous 28 days, divided by the total number of patients admitted to the directorate in the three month study period. McNemar's test was performed to compare the views of hospital staff and GPs.

Results

We identified 124 patients who were readmitted over 3 months. The crude readmission rate was 13.2%. The GP response rate was 65% and complete data on the causes of readmission were available for 84 patients (51% male). The mean age was 78 years (± 7.2). The mean length of stay of the previous admission was 9.6 days (± 8.3) and the mean time until readmission was 10.1 days (± 7.7). Eight per cent of readmissions occurred from institutional care.

Patients judged by GPs to have 'avoidable' readmissions tended to be older: 82.6 years compared to 77.1 years for 'unavoidable' cases. Difference in means: 5.4 years (95% CI 1.7–9.0 years).

GPs' and hospital staffs' opinions about reasons for readmission are shown in table 1. The reasons for the readmission were not mutually exclusive.

Discussion

In the opinion of both GPs and hospital staff, a relapse or complication of the original illness was the commonest factor contributing to readmission. This is in keeping with the study of Williams and Fitton [8]. Carers' difficulties was the second commonest reason given. Surprisingly, problems with social services were not frequently mentioned.

Poor health, inadequate preparation and lack of communication on discharge were cited significantly more often by GPs as contributing to the readmission. These were often regarded as 'avoidable' factors.

Upon discharge, all our patients are given a letter to take to their GP. This contains diagnostic and

management details, a list of medication and arrangements for follow-up. A typed discharge letter follows usually within two weeks. Frail or housebound patients living alone may not be able to pass on a letter to their GP, or they may be readmitted before the GP receives a typed summary. This may be why GPs recognised drug problems much less frequently than hospital staff as reasons for readmission.

Studies from Canada have demonstrated the benefit of hand-written faxed discharge summaries [9], and consultation with GPs to agree what discharge information is essential [10]. Development of electronic information, discharge co-ordinators and specialist liaison nurses all have the potential to improve discharge procedures. A personal telephone call to the GP is often the best way to prevent difficulties with complex discharges.

The study has some limitations. Some patients were readmitted and discharged quickly before being identified, particularly over weekends. Readmission may have occurred to hospitals other than the study hospital. The GP response rate was 65% and non-responders were not pursued.

Despite these limitations, we have shown that both GPs and hospital staff regard relapse or complication of the original illness and problems with carers as the two main causes of readmission into hospital. A significantly higher proportion of GPs than hospital staff felt that poor health on discharge, inadequate discharge preparation and lack of communication contributed to some readmissions. Although the proportion of avoidable readmissions was relatively low, these data suggest that hospital discharge policies should take into account GPs views on the causes of unplanned readmissions.

Key points

- Most unplanned readmissions are due to the original illness or problems with carers.
- More general practitioners cite 'avoidable' failures in communication and discharge planning as reasons for readmission.

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