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P008 -Superior performance status in haemodialysis inpatients does not always translate into a shorter length of stay.

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Introduction: Performance status is widely acknowledged to compound the length of inpatient hospital stay and has been quantified reliably by multiple indices, including the Charlson Comorbidity Index. In renal patients - and particularly haemodialysis patients – the co-existence of multiple morbidities is widely recognised. With this in mind, we postulate that of the haemodialysis patient admissions to our tertiary renal unit, those admitted with better performance status would have shorter, and hence more economical, inpatient stays.

Methods: Retrospective analysis of haemodialysis inpatient admissions to a tertiary renal centre over the course of one month was undertaken. This analysis collated note-based data on the length of stay (LoS) of haemodialysis patients admitted; the performance status of those patients; their demographic factors; and the primary reason for their admission on clerking to the unit. Performance status was measured using the Charlson Comorbidity Index (CCI). Subsequent screening of inpatient notes for relevant management and any changes to diagnosis post-clerking was also undertaken. These factors were also addressed by dividing our patient cohort into those that required input from multiple specialties post admission and those that required only renal specialty input.

Results: HD patient admissions (n=27) in a single calendar month period were analysed with 13 males and 14 females in the age range 21-86 years-old identified (\bar{x} = 63.1 ; Med= 69). For the full cohort, length of stay (LoS) ranged from 1-101 days (\bar{x} = 21.3 ; Med= 11). Of those with length of stay >7 days, median performance status was lower (CCI 8) than those who stayed <7 days (CCI 6). 37 % of patients admitted required only renal physician input as opposed to those requiring one or more other specialties for their inpatient management. On closer observation, those patients requiring multiple specialty input had longer LoS despite their better performance status (median LoS=19 ; median CCI 5) when compared to those patient requiring only renal input (median LOS=5d ; median CCI 7.5).

Discussion: In summary, this retrospective analysis showed that the majority of haemodialysis patients admitted to our tertiary centre were for causes unrelated to their on-going renal pathology, subsequently requiring input from one or more specialties other than renal medicine. This patient sub-group had greater lengths of stay, even in spite of their notably higher performance status as measured by the Charlson Comorbidity Index. This data supports the perspective that specialty connectivity, even in tertiary renal centres, is essential for efficient delivery of care. The results also evidence the fact that improved multi-disciplinary referral strategies might be required for transfer of inpatients to tertiary renal centres where other inpatient specialties are not primarily based, as in the case of our renal unit.