

Penalties for hospital readmissions?

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Early June, Health Secretary Andrew Lansley announced an intention to reduce the half million annual hospital readmissions. Between 1998–99 and 2007–2008 the number of emergency readmissions in the UK has risen by 53%, from 359,719 to 546,354 (Peñaloza, 2010). The new Health Secretary argues that patients are being discharged too early to free up beds and this in turn undermines patient care. Under the new plans, hospitals would receive funding for the first hospital stay plus treatment for the 30 days post discharge, giving hospitals the responsibility for a patient's health and wellbeing following hospital treatment, not the GPs and primary care trusts (PCTS), as is currently the case.

Thus, the reduction of postoperative infections, and healthcare-acquired infections (HCAIs) arising within 30 days, is likely to make substantial savings in terms of healthcare costs — and patient suffering. Readmission within 30 days will result in financial penalties for acute trusts.

It is certain that a (large) proportion of these admissions are attributable to postoperative wound infections. It is also important to remember that one of the central domains of the Quality Agenda is that of patient safety, with reduction of infection rates being of paramount importance (Ousey and White, 2010).

This being the case, the role of nurses in identifying wound infections becomes

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central to addressing the problem. Thus, link, community, infection control and tissue viability nurses will all have a major role to play in achieving this target. In elective surgery, pre-admission screening can identify factors which will facilitate discharge into appropriate community care. This will ensure that any HCAIs will be identified early and treated appropriately. Central to this will be the best use, and availability of, antimicrobial wound dressings. The latter is currently a topic of considerable interest and of some controversy. While argument rages over the value of evidence for negative pressure wound therapy (NPWT) and silver-containing dressings, in the right hands these can be of immense value in managing postoperative wounds.

Some of the key programme points related to avoiding postoperative infections (and consequent readmissions) are summarised below. A copy of the full document is available online at: www.cabinetoffice.gov.uk/media/409088/pfg_coalition.pdf:

- ▶▶ Extension of best practice on improving discharge from hospitals, maximising day care operations and reducing delays
- ▶▶ The Care Quality Commission will be strengthened to become an effective inspectorate
- ▶▶ Patients will be able to rate hospitals and doctors on quality of care, and must now be told if something goes wrong with their care
- ▶▶ Hospitals will be measured on clinical outcomes, e.g. cancer/stroke survival rates and reducing hospital infections.

To illustrate these points, in a recent study a cohort of over 600,000 patients,

of whom 84 081 (13.5%) were diagnosed with SSIs, and more than half (48,725) were diagnosed post-discharge (Daneman et al, 2010). Post-discharge infections were associated with an increased risk of reoperation return emergency room visit, and readmission. The most common risk index predicted incremental increases in the risk of in-hospital SSIs, but did not predict increases in the risk of post-discharge infection. Patients with post-discharge infections had baseline characteristics more akin to uninfected patients than patients with in-hospital infections. Predictors of post-discharge infection included shorter procedure duration, shorter length of stay, rural residence, alcoholism, diabetes and obesity. It is clear that nurses, tissue viability in particular, will have a major role to play in achieving this initiative.

As this is a national priority and strategy it will be imperative for tissue viability leads to identify the implications at a local level. In addition, it would be worth an investigation, nationally and at a local level to identify the number of readmissions that are due to SSIs. **WUK**

References

- Daneman N, Lu H, Redelmeier DA (2010) Discharge after discharge: predicting surgical site infections after patients leave hospital. *J Hosp Infect* 75(3): 188–94
- Ousey K, White RJ (2010) Embedding the quality agenda into tissue viability and wound care. *Br J Nurs* 19(11): S18–22
- Peñaloza MC (2010) *UK Centre for the Measurement of Government Activity Public Service Output, Inputs and Productivity: Healthcare Triangulation*. Office of Public Sector Information, Richmond: 16