PREVENTING READMISSION

The power of just one phone call or home visit

A study has shown that timely post-discharge follow-up by a nurse cuts patients’ readmission risk

By Jennifer Trueland

Too often, older people find themselves back in hospital just a few days after being discharged – but it doesn’t have to be that way.

A study has shown that simply offering nurse-led support, either a phone call or a home visit, within 48 hours of someone getting home cuts the risk of readmission by an astonishing 41%.

Simple interventions

Now the researchers at Aston University and Solihull Hospital in the West Midlands are hoping these simple interventions might be adopted more widely, which would not only benefit individuals and their families, but also deliver significant savings for the health service as a whole.

‘Being in hospital can be hard for people,’ says consultant geriatrician Martha Pinkney, one of the researchers. ‘They are faced with huge amounts of information, they might have new medication to take and they’re not quite sure what to do, and when you’re talking about people in their eighties, they might have multiple conditions. It’s a real challenge,’ she says.

Little wonder then, that around 15% of people over-65 are readmitted within a month of being discharged from hospital, at huge cost to them and to the NHS.

Co-author James Brown, a senior lecturer in Aston University’s School of Life and Health Sciences, says they wanted to address the ‘gap’ between the moment people are discharged from hospital and their first contact with health services once they are back at home.

‘We found that the time it took for GPs to receive letters saying their patient had been admitted was more than four days, but that a lot of hospital readmissions were happening in the first three days of discharge,’ he says. ‘That meant people were being discharged, then readmitted before their GP even knew they’d been admitted in the first place. It’s a gap, and people are falling through it.’

The study findings

The researchers, who published their findings in Future Healthcare Journal, looked at two groups of older patients in Solihull in the West Midlands. Community nurses tried to contact the intervention group (303) patients within 48 hours of discharge from hospital; a comparison group (453) did not receive a follow-up call as part of the research. Of the 303 patients in the intervention group, 288 were contacted by telephone and 202 received a home visit.

While almost 16% of the comparison group were readmitted to hospital as emergency cases within 30 days of leaving, the

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James Brown (pictured), senior lecturer, Aston University’s School of Life and Health Sciences
figure for the intervention group was 9% – meaning that patients who weren’t actively contacted were almost twice as likely to be readmitted.

Medications advice and referral to a GP were the most common interventions, but others included referral for mental health nursing, for equipment, and continence advice.

The experience of the comparison group (16% readmission) tallies with national figures. According to NHS England, around 15% of people aged over-65 discharged from hospital are readmitted within 28 days, while the campaign group Healthwatch estimates the total cost of readmissions at around £2.4 billion per year. The researchers posit that if the intervention were applied at a national level, thousands of readmissions could be averted – and at hundreds of millions of pounds saved.

Pressure to discharge
‘NICE guidance recommends that a discharge co-ordinator follows up with people within 24 hours of their leaving hospital, but the high rate of readmissions suggests this isn’t happening in all cases,’ says Dr Brown. ‘This new evidence suggests NHS trusts and community teams could substantially reduce pressure on their services if they implemented these very simple interventions.’

Dr Brown believes there are several reasons people are discharged only to need imminent readmission, including the pressure to free up hospital beds – and the natural desire of people to get home. ‘Most people aged over 65 want to be at home, and I know my own mum and dad would be keen to leave hospital even if they weren’t quite ready to go home.

‘There are so many services available to support people at home, but the problem is that there is so often a critical two to three-day period when services don’t know that people are back home.’

Although the results were so impressive, there was no funding...
to continue the service at the end of the study period. Drs Brown and Pinkney, however, hope they can conduct a further, larger randomised controlled trial that, if it achieves similar results, would add weight to the evidence. They have attracted interest from the Department of Health in England and from some other units that have asked for more information on the approach.

‘I hope we can see this sort of service implemented nationally,’ says Dr Pinkney. ‘It would make a huge difference, not just to the patients at risk of readmission and their families, but to health services as well. We hear about the pressure on the front door, and readmissions have a big impact on front door-services. If we could reduce the pressure there, it benefits the whole system as well as individual patients.’

A life-saving visit
She is sure there were many patients who took part in the pilot project who would have ended up in hospital had they not had the timely and proactive intervention. She points to one woman who had been discharged with medication for seizures, but who continued to have them when she returned home. The community nurse contacted Dr Pinkney, who confirmed that the dose of the medicine could be safely increased; this was done, and the seizures stopped, without the need for admission.

Another patient had been started on anticoagulation after a pulmonary embolism, but had thought it was an antibiotic so had stopped taking it. This was picked up by the community nurse on the home visit, who was able to ensure the patient took the medication correctly, potentially saving her life.

‘These are real-life examples of the impact that this initiative had,’ says Dr Pinkney. ‘There’s a real need for it, and I’m hopeful our work will help persuade people it should be implemented.’

Jennifer Trueland is a health journalist

Read the study findings in full at tinyurl.com/readmissions-FHJ

The nurses’ perspective
Jenny Love has no doubt about the value of a simple phone call or home visit shortly after an older person has been discharged from hospital – in fact, she calls it eye-opening.

She was one of the two community nurses who took part in the Solihull project; it was down to her and her colleague to make contact with patients who met the criteria.

Ms Love was seconded from her post as a sister in the local rapid response team, which provides community-based support to people who would otherwise have to go to hospital.

Not everyone knows about the vast array of services
‘I think there’s a definite need for this kind of service,’ she says. ‘This is not a criticism of hospitals, but we were best placed to know what services were available – there is a vast array of services out there, but not everyone knows they are there. I definitely believe some of the people we saw would have been back in hospital if we hadn’t seen them. It was actually quite an eye-opener.’

She believes her professional background in nursing was valuable to the project, but that support from the wider team was crucial too. ‘Being a nurse, you have quite a broad experience. Sometimes all that someone needs is a little bit of reassurance – they get home from hospital and they’re not quite sure what they’re supposed to do.

‘But we also had other people to call on – we could ring and get advice from a community pharmacist at the drop of a hat, and we could also contact a geriatrician who worked in the community.

‘We got a very positive response from patients and their families and the feedback was very good. The main thing that people said was they felt reassured.’

One of the problems is generational. ‘The older population often don’t want to call doctors out because they don’t want to waste the doctor’s time,’ she says. ‘So they suffer in silence.’

A phone call is useful, but a home visit is better
Although a phone call (to patients) could be helpful, home visits were the way to gauge what was really going on, she adds. ‘When you phone, people would say everything is fine, but it’s only when you get there that you can see they’re struggling,’ she says. ‘They’d say that yes, they were taking their medication, but when you go out, you see little baskets of pills that they were taking before they went into hospital.’

Sometimes, she adds, they were continuing to take medicines that had contributed to their admission in the first place, such as water tablets that had led to low blood pressure. As well as reassurance, the nurses were able to offer education to help people to self-manage at home. For example, if someone had been in hospital with a COPD exacerbation, they could be taught the signs and symptoms so that they could take action at an earlier stage and ideally prevent a further hospital admission.

The nurses could also refer on to specialist services, such as the continence team, and to the rapid response service if a patient required more intensive home-based care.

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