In the Autumn 2018 issue of *The Australian Hospital and Healthcare Bulletin*, Shaban¹ provided an overview of the recent rise of financial penalties for preventable hospital-acquired complications (HACS) within the Australian health system. The Australian Commission on Safety and Quality in Healthcare (ACSQHC) has established 16 hospital-associated complications — a “complication for which clinical risk mitigation strategies may reduce, but not necessarily eliminate, the risk of that complication occurring”¹² — for which price prevention will shortly apply. The underlying philosophy of this approach is that all hospital-acquired complications can be reduced, but not necessarily eliminated, by providing patient care that mitigates avoidable risks to patients.

Infections of the urinary tract are one of the most common healthcare-associated infections, with the main risk factor being the use of an indwelling urinary catheter.³ In broad terms, a urinary tract infection (UTI) is a general term referring to infections in the lower urinary tract (urethra to the bladder) or the upper urinary tract (ureters to the kidneys). Catheter-associated UTI (CAUTI) refers to infections that are associated with indwelling urinary catheter use.³ Patients with UTIs are at risk of progression to sepsis, a condition with increased mortality.⁴ Patients with symptomatic UTIs will require treatment, such as removing a catheter and antimicrobials.⁵ Asymptomatic bacteriuria can often occur without urinary tract symptoms and may not require treatment with antibiotics, even in the presence of a urinary catheter.⁷

The ACSQHC reports that CAUTIs are the most prevalent of all hospital-acquired UTIs in Australia, and make up at least 80% of all hospital-acquired UTIs.⁷ In response to this, the ACSQHC has recently published >
HAC Tool Kits to assist health services with the implementation of this new price-prevention framework. In this publication, the ACSQHC reports that:

In 2015-16, hospital-acquired UTIs accounted for 26.6% of all hospital-acquired infections. On average, a patient with a hospital-acquired UTI will remain in hospital for 20.6 days longer than a patient without this complication and a hospitalisation involving a hospital-acquired UTI may therefore be associated with $42,724 in extra costs, with the national average cost per admitted acute overnight stay being $2,074.

The validity of certain elements of data used by the ACSQHC to underpin UTI prevention measures and costs is uncertain. The suggested incidence of UTIs would appear to be consistent with previous studies. However, there are no reliable Australian data, particularly in the absence of national surveillance and national HAI point prevalence studies. Numerous studies have shown that appropriate statistical methods are required to estimate the contribution of infection to length of stay. Failing to account for these will result in a large overestimation of length of stay. A recent Australian study has shown that healthcare-associated UTIs may be associated with approximately four additional days in hospital. A further issue is that numerous studies have shown that coding data is a poor predictor of HAI incidence, providing further evidence for robust HAI surveillance systems. If coding data is used for financial gain or penalty, the process is vulnerable to gaming.

There is no question that HACs are here to stay. What we argue is that the source of HACs data needs be derived from valid and reliable systems, especially if they are associated with financial penalties.

References

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