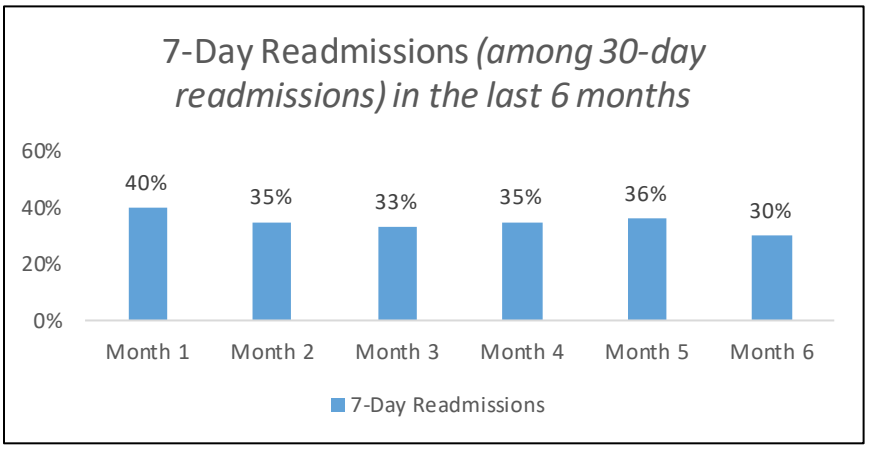
7-Day Readmission Chart Audit Tool Instructions

Background/Purpose: Readmission data show that for the last six months, of those who readmitted in 30 days, 30 percent or more have returned to the hospital within 7 days of discharge. The purpose of this tool is to obtain insight into why a readmission within 7 days of a hospital discharge has occurred and how it could have been avoided. It will help identify patterns and trends among readmitted patients, existing gaps in the organization's current discharge processes, and opportunities for performance improvement.

7-day readmissions (among 30-day readmissions) in the last 6 months



Description: This one-page audit tool prompts clinical or quality staff members to review a list of factors commonly attributed to preventable hospital readmissions. The review can help you understand the kinds of barriers patients, families, and providers face during preparation of discharge to the post-hospital transitional care period and the circumstances leading patients to return to the hospital.

Data Collection: The audit can be completed by performing a brief chart review of the first admission and the readmission, and/or through an interview of the patient, family member, or clinicians involved in the patient's care. Additional assessment can be obtained by contacting the patient's primary care provider, home health agency, or mental health provider, for example, to gain their perspective. Another approach that you may want to consider is to use the audit questions as a start-point in conversation when conducting the 7-day huddle.

Implementation: Each day, identify the patients in your care who were readmitted within 7 days of their last hospital discharge. Patients with a planned readmission are excluded from the audit. Complete the audit tool on each patient or use the questions as a start-point in conversation when conducting the 7-day huddle. Share these results with the interdisciplinary team, a readmission workgroup, or a daily 7-day readmission huddle.

Performance Improvement: Aggregate the results of your audits each month to identify the common trends, patterns, and themes. Review current processes surrounding the pre-hospital preparation and post-hospital transitions of patients, and focus process improvement efforts that close the gaps found.

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Patient Label

7-Day Readmission Chart Audit Tool

Index admission dates_____through_____/Readmission dates_____through_____

1. Is this readmission related to the previous admission? Y or N
2. Is this a hospital penalty related condition?
a. If yes, circle one: Acute MI / HF / PN / COPD / CABG / Elective TKA/THA*
b. If no, is readmission reason listed as a comorbid condition on the index admission? Y or N
3. What is the admission source (circle one)? Home / home health agency (HHA) / skilled nursing facility (SNF) / hospice / long-term acute care / inpatient psychiatric / inpatient rehabilitation
4. How many days between discharge and readmission (circle one)? 0–1, 2–4, or 5–7
5. How many times was the patient in the hospital in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
6. How many times was the patient in the ED in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
7. Is the patient on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
8. Discharged on seven or more medications? Y or N
9. What is the reason for readmission? Check all that apply:
   - ☐ Chronic condition/exacerbation of disease process
   - ☐ Post-operative complication (wound healing, infection, sepsis)
   - ☐ Post-discharge challenges identified (lack of transport, finances, housing, medical care) but not evaluated for or linked to available resources
   - ☐ Patient/family/caregiver did not understand discharge instructions
   - ☐ Patient/family/caregiver did not obtain medications/supplies
   - ☐ Patient/family/caregiver did not agree with higher level of care recommended at previous discharge (refused HHA or SNF)
   - ☐ Discharge services arranged/made were not followed through by service provider. If checked, add service(s) arranged here: _____
   - ☐ Patient left against medical advice (AMA) from previous admission
10. Did patient have a validated primary care physician (PCP) assignment at previous discharge? Y or N
    - ☐ If yes, was a follow-up appointment made with patient's PCP or specialist at previous discharge and documented in discharge instructions? Y or N
    - ☐ Did patient keep scheduled follow up appointment? Y or N
    - ☐ If no, why (circle one)? Felt better, did not show/cancelled, no transportation, financial barrier, readmitted prior to the appointment, date, or other ____
11. Did patient comply with medication orders after discharge? Y or N
    - ☐ If no, why (circle one)? No transportation, financial barriers/lack of resources, did not want to fill, filled but not taking, had something similar at home, or other_____
12. To identify if other patterns or trends exist, indicate:
    a. Discharge unit _____
    b. Hospitalist group_____Discharging physician _____
    c. What day of the week was the patient discharged (circle one)?
    Sun Mon Tues Wed Thurs Fri Sat
13. Was an evaluation of discharge needs documented by case management on the index admission? Y or N
14. Were there emergency room or observation visits between the index admission and readmission? Y or N

Completed by:_____Date:_____Follow-up action: _____

* Myocardial infarction (MI), heart failure (HF), pneumonia (ON), chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), total hip/total knee arthroplasty (THA/TKA)

7-Day Readmission Analysis Worksheet

Instructions

Review 10 patient readmissions that occurred within 7 days of discharge. Consider the following:

- What patterns are you seeing?
- Were there trends in the patients' diagnoses?
- Is patient education documented throughout the hospitalization?
- Were the patients on high-risk medications?
- Did these patients come from the same discharge unit?

Things to Consider

- What additional data are needed to be more specific to the population the intervention will target?
- What tools/or departments are collecting data (e.g., checklist to audit medication administration record (MAR), data from pharmacy department for high-risk med use, staff feedback, patient interviews, etc.)?
- By when do you need the additional data?

Create Data Visuals to Report the Data

Data can be displayed using various methods.

- Visual information can help a team focus on the causes that will have the greatest impact if solved.
- Information should be displayed in an easy-to-interpret visual format.
- Status of information can quickly be determined as moving in a positive or negative direction.
- Trends and patterns can be identified easily.

On the following page are three examples of easy-to-use charts. These charts can provide the team with information to use in the improvement planning process.

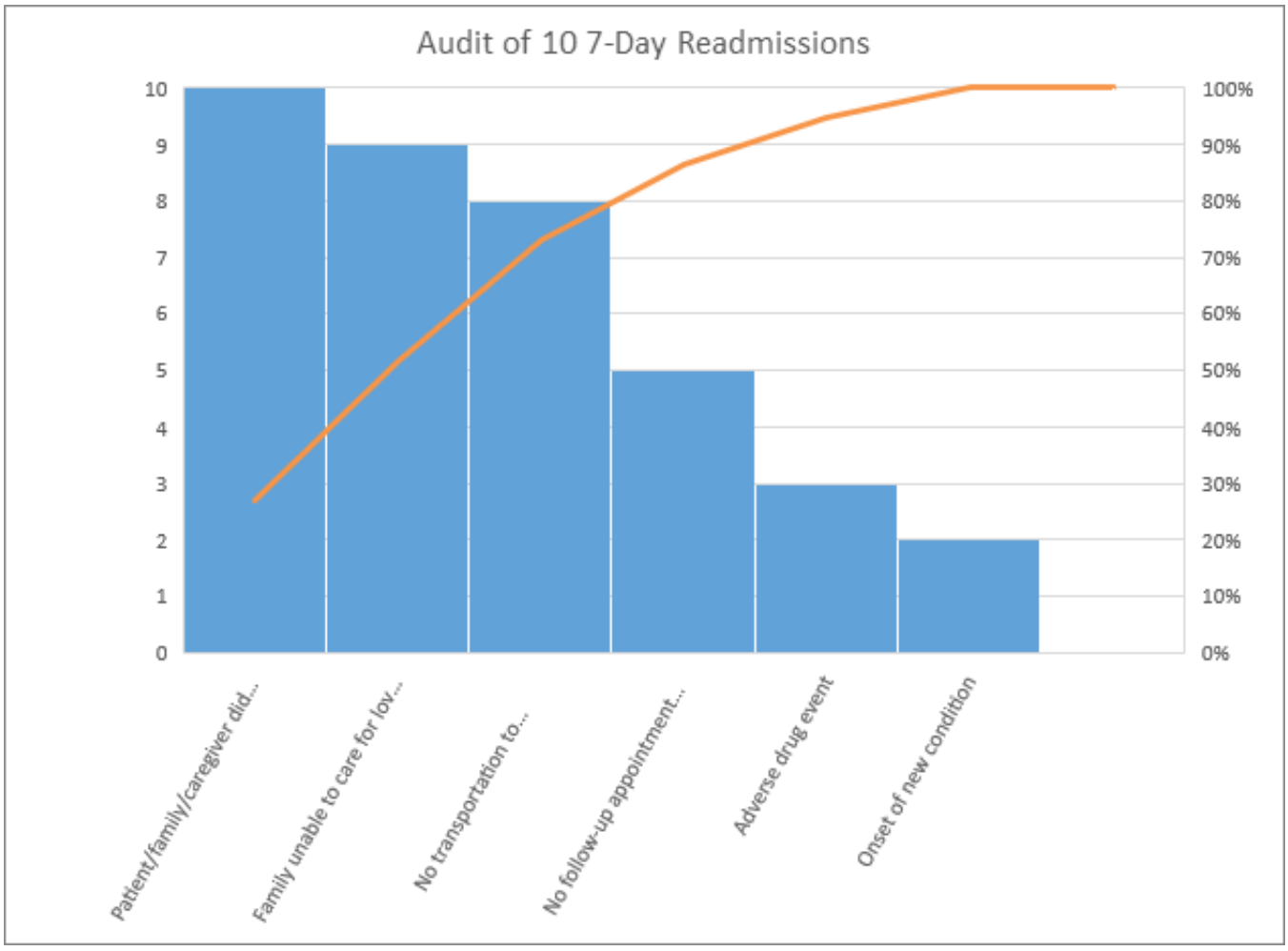
Pareto Chart

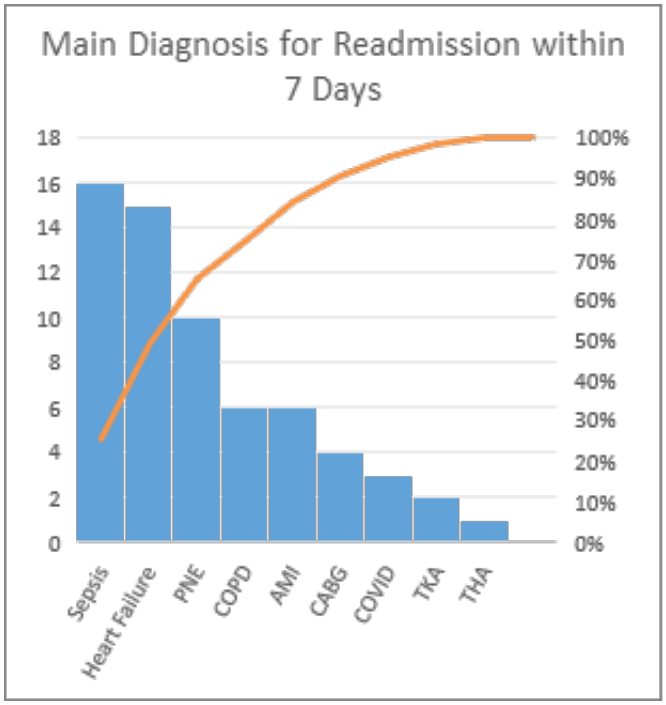
List problem categories on the horizontal axis and frequencies on the vertical axis.

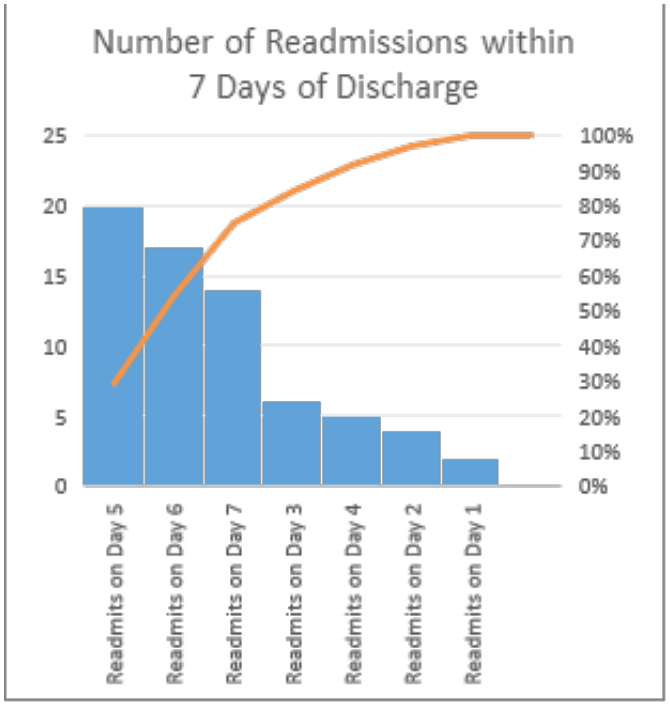
3 Easy Steps to Create a Pareto Chart

1. Gather data and insert into Excel.
2. Use the "sort" feature to order your values from largest to smallest (not essential if you have Excel 2016).
3. Highlight category and counts> Insert Chart > Histogram> Pareto.

A Pareto chart template is available upon request.


Audit of 10 7-Day Readmissions
10
9
8
7
6
5
4
3
2
1
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Patient/family/caregiver did...
Family unable to care for lov...
No transportation to...
No follow-up appointment...
Adverse drug event
Onset of new condition


Main Diagnosis for Readmission within 7 Days
18
16
14
12
10
8
6
4
2
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Sepsis
Heart Failure
PNE
COPD
AMI
CABG
COVID
TKA
THA


Number of Readmissions within 7 Days of Discharge
25
20
15
10
5
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Readmits on Day 5
Readmits on Day 6
Readmits on Day 7
Readmits on Day 3
Readmits on Day 4
Readmits on Day 2
Readmits on Day 1