7-Day Readmission Checklist and Audit Tool Instructions

Purpose: To obtain insight into why a readmission within 7 days of a hospital discharge has occurred and how it could have been avoided. To identify patterns and trends among readmitted patients, existing gaps in the organization's current discharge processes, and opportunities for performance improvement.

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.

Potential Gaps:

1. Evaluation of patient self-management knowledge, skills, and confidence
2. Evaluation of health literacy and use of teach-back to validate comprehension
3. Focusing on patient's reason for admission while ignoring chronic comorbid condition management
4. Failure to obtain an accurate and comprehensive medication history and incomplete medication reconciliation
5. Evaluation of social determinants of health, including food insecurity, lack of quality housing, medical care, transportation, and financial and social resources
6. Failure to secure and communicate a timely follow-up appointment within the 7-day period after discharge
7. Failure to provide a timely follow-up phone call to reinforce disease and medication discharge orders and follow up care
8. Failure to identify and secure skilled services for patient needing higher level of care support after discharge

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Patient Label

7-Day Readmission Checklist and 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. Is the patient on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
6. Discharged on seven or more medications? Y or N
7. Medication reconciliation completed in full on previous discharge? Y or N
8. 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
9. 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 _____
10. 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_____
11. 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
12. Was an evaluation of discharge needs documented by case management on the index admission? Y or N
13. 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)

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