Readmission Root Cause Analysis Tool - Inpatient Facility

Facility: _____ Reviewer: _____

Time Period Reviewed: _____ Date of Review: _____

Key: Y (Yes) for compliance with best practices identified.
N (No) for non-compliance with best practices identified. If documentation is partial, the reviewer writes "N."
NA (Not Applicable)

Drivers			Best Practices for Care Transitions	1	2	3	4	5	6	7	8	9	10	Total Charts	Total Possible	% Yes
Patient Activation	Lack of Known, Standard Process	Transfer of Information														
X	X		**1.** Patient/family educated about the diagnosis throughout the inpatient stay.													
	X		**2.** Post-discharge appointments for physician office or lab are coordinated with the patient/ family *and* set prior to discharge.													
X	X		**3.** Patient/family is educated on importance of follow-up care and keeping appointments.													
X			**4.** Patient/family verbalizes ability to obtain transportation to appointments.													
X			**5.** Patient/family educated on complete tests or studies and importance of follow-up for future tests.													
	X		**6.** Medication reconciliation occurs at admission and discharge.													
X	X		**7.** Patient/family educated on medication regimen, medication purpose, dosage, side effects and untoward effects and which to communicate to the healthcare providers.													
X			**8.** Patient/family has a local pharmacy with ability to obtain medications in a timely manner.													

Key: Y (Yes) for compliance with best practices identified.
N (No) for non-compliance with best practices identified. If documentation is partial, the reviewer writes "N."
NA (Not Applicable)

Drivers			Best Practices for Care Transitions	1	2	3	4	5	6	7	8	9	10	Total Charts	Total Possible	% Yes
Patient Activation	Lack of Known, Standard Process	Transfer of Information														
	X		**9.** Reconcile the discharge plan with the national guidelines for AMI, CHF and PNE and associated pathways.													
X			**10.** Educate pateint on symptoms (Red Flags) of disease/condition to report to the physician.													
X	X		**11.** Instruct patient on a special plan of how to contact the PCP or back-up by providing contact numbers for office hours and after hours communication.													
X	X		**12.** Educate patient/family on which symptoms constitute an emergency and what to do in case of an emergency.													
	X		**13.** Identify end-of-life issues; address advance care planning.													
	X		**14.** Identify need for community resources (HHA, AAA, Meals on Wheels, etc.).													
	X	X	**15.** Comprehensive discharge plan is sent to the physician and other follow-up providers prior to discharge. Information includes:													
	X	X	• reason for hospitalization with specific principal diagnosis and other pertinent diagnoses													
	X	X	• history and physical assesment													
	X	X	• procedures, treatments and care services provided													
	X	X	• patient physical and mental status at discharge													
	X	X	• medication list that is comprehensive, reconciled *and* details current allergies or prior reactions													

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Drivers			Best Practices for Care Transitions	1	2	3	4	5	6	7	8	9	10	Total Charts	Total Possible	% Yes
Patient Activation	Lack of Known, Standard Process	Transfer of Information														
	X	X	• list of acute medical issues, tests and studies for which confirmed results are pending at the time of discharge and require follow up													
	X	X	• consulting service information and evaluation including rehabilitation													
X	X	X	**16.** Assess degree of understanding of discharge plan by the patient/family by asking patient/ family to explain (in their own words) the details of the plan; Teach Back on Plan of Care.													
	X		**17.** Interpreter used for patients/families with language and literacy barriers.													
X	X		**18.** Family and/or caregivers were included in patient education (e.g., cognitively impared, nonadherant).													
	X	X	**19.** Written discharge plan given to patient and family/caregiver at time of discharge.													
X		X	**20.** Patient is assigned to a care transitions coach.													
	X		**21.** Telephone call from professional staff or coach 2-3 days post-discharge to provide reinforcement of the discharge plan and to identify *and* resolve issues arrising since discharge.													

Comments: _____

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