



Review of Heart Failure Patients Who Were Readmitted

IDENTIFY AND DOCUMENT FACTORS CONTRIBUTING TO READMISSION:

Identifying potential gaps in transitional care for patients with heart failure that contribute to potentially preventable readmissions can improve patient care and enhance quality improvement efforts.

LIST OF TYPICAL BREAKDOWNS:

Typical breakdowns associated with patient assessment:

- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for the discharge
- Unrealistic optimism of patient and family to manage heart failure regimen at home
- Failure to recognize worsening clinical status prior to discharge from the hospital
- Lack of understanding of the patient's physical and cognitive functional health status resulting in discharge/transfer to a care venue that does not meet the patient's needs
- Not identifying or addressing co morbid conditions (underlying depression, anemia, hypothyroidism etc.)
- No advance directive or planning
- Incomplete medication reconciliation due to inaccurate records
- Medication errors and adverse drug events caused by patient and family-caregiver confusion
- Multiple drugs and/or doses exceed patient's or caregivers ability to manage
- Failure to optimize doses prospectively

Typical breakdowns found in and family caregiver education:

- Written discharge instructions can be confusing, contradictory to other instructions, difficult for the patient to understand or specifically relevant to the individuals current health status.
- Failure to clarify if patient and caregiver understood instructions and plan of care
- Failure to address prior non-adherence about self-care, diet, medications, therapies, daily weights, follow-up and testing
- Providing information on broad themes without details on how to make it work for the individual patient based on lifestyle, economic constraints, social support, and other factors impeding compliance.

Typical breakdowns in handoff communication:

- Lack of communication resulting in primary care provider not knowing patient admitted
- Inadequate evidence-based heart failure care (i.e., missing/incomplete)
- Medication discrepancies and lack of reconciliation & optimization
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps to patient, caregiver, nursing home team, primary care physician or home health care team.
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis
- Lack of understanding by the healthcare receiver of information regarding heart failure medical and self-care management

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TAKING THE FAILURE OUT OF HEART FAILURE

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- Discharge instructions missing, inadequate, incomplete, or illegible
- Discharge instructions provided at inopportune moments (e.g., patient cannot focus on logistic concerns about leaving hospital/arriving home).
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen)
- Having the care provided by the facility unravel as the patient leaves the hospital (e.g., poorly understood cognition issues emerge)
- Poor assessment of social support and lack of understanding on what constitutes proper social support
- Lack of understanding by the healthcare receiver of information regarding heart failure medical and self-care management

Typical breakdowns following discharge from the hospital:

- Medication errors
- Patient lack of adherence to self-care, e.g., medications, therapies, diet (sodium restriction), and/or daily weights because of poor understanding or confusion about needed care, how to get appointments, or how to access or pay for medications
- Discharge instructions that are confusing, contradictory to other instructions, or are not tailored to a patient's level of understanding
- No follow-up appointment or follow-up needed with additional physician expertise
- Follow-up appointments are not within the recommended 7 days following discharge, Follow-up appointment scheduling was left to the patient
- Inability to keep follow-up appointments because of illness or transportation issues
- Inability to keep follow-up appointments because of financial issues
- Patient not knowing who to contact first should their condition worsen
- Lack of adequate group of caregivers or caregivers are not knowledgeable about how to appropriately care and monitor the patient.

Readmission Work Sheet

This work sheet may be used to assist in identifying potential gaps in care and may aid in care transition quality improvement efforts. This provides a way to identify process change opportunities outlining barriers and potential causes.

PATIENT INTERVIEW:

What made you come back to the hospital? Why did you come back to the hospital? [What did the patient or family think contributed to this readmission?] _____

How were you able to use the discharge instructions/transition care plan? How was the plan helpful? What could have been better? [Are there any self-care instructions that may have been misunderstood?] _____

Please tell me what you remember from your instructions that were given before you left the hospital. [Can the patient teach back 3 critical self-care instructions?] _____

When did you last see your doctor? The last doctor's appointment? _____

Were you able to see/call your doctor before you came back into the hospital? _____

Often times there are options to care based on your needs. Were you able to talk about other options for care or talk about advance directives? Were you able to discuss options such as palliative, end-of-life care, or hospice as an option? _____ If yes, what did you decide upon? _____

What telephone numbers were you given to call? _____

What information was not given to you during your last admission that may have prevented this hospital visit?



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What other hospitals, emergency rooms or other care facilities have you visited in the last 30 days? _____

Were you able to obtain your medicines that were prescribed for you during your last hospital visits? _____

If not, why not? _____

INTERVIEW THE CARE TRANSITION TEAM (PHYSICIAN, CLINIC, HOME CARE, NURSING HOME, AND HOME HEALTH):

What contributing causes are known for the patient's readmission? Would you have predicted a readmission on this patient?

Check all that apply:

<input type="checkbox"/> Abnormal lab results	<input type="checkbox"/> Function/Mobility	<input type="checkbox"/> Home Health
<input type="checkbox"/> Vital Signs	<input type="checkbox"/> Discharge/Handover/Care Transition Plan	<input type="checkbox"/> Post Procedure Complications
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Family support	
<input type="checkbox"/> Cognition/Depression	<input type="checkbox"/> Medications	

Insert Patient Sticker Here

REVIEW THE PATIENT CHARTS FROM CURRENT AND PREVIOUS ADMISSION-30 DAYS OR LESS BETWEEN ADMISSIONS)

Note the number of days between the previous discharge and this readmission date. _____

Did patient have a follow-up physician visit scheduled? No Yes

If yes, did the patient follow-up with his/her visit? No Yes

Number of days after previous discharge for urgent care/ed/outpatient visits _____

Were there any urgent clinic/ED/ outpatient visits? No Yes

Number of days after previous discharge _____

THE PREVIOUS ADMISSION:

Discharge Date: _____ Time: _____ Day: _____

When discharged from previous admission, the patient went:

- Home
- Nursing Home _____
- Home with Home Health Care _____
- Home with Home Care _____
- Hospice _____
- Other: (List) _____

Functional Status of the patient on discharge: Fully dependent Somewhat dependent Independent

Was a clear discharge/transition plan documented? Yes No

Does documentation exist for appropriate patient education? Yes No

Was there evidence of Teach Back? (Checking patients understanding or recall) Yes No

Referrals were made to the following:

_____	_____
_____	_____
_____	_____

Medications were provided to patient at time of discharge Yes No



THIS READMISSION:

Readmission Date: _____ Time: _____ Day: _____

Admission was related to previous admission above. Yes No

Note Reason(s) for readmission

Category of Readmission

- Foreseen or planned – device replacement, cardiac catheterization, cardiac surgery, chemo-radiation therapy, treatment follow-up, planned surgery, etc.; Unforeseen, caused by new problem Unforeseen, related to problems with the previous admission

Potential Hospital Problem:

Care given in the hospital was either directly or indirectly responsible for the readmission. Yes No

(Example: Post-operative infection, lack of lab or x-ray/diagnostic results follows up)

Potential Outpatient Problems:

Caused or contributed to the environment into which the patient was discharged Yes No

(Example: Patient went home and had much poorer social support than indicated by patient during discharge planning.)

Notes on any opportunities or circumstances of the patient that may help determine reasons for this readmission:

Identified Opportunities & Area Involved	Corrective Action	Responsibility to Address	Interventions for this Patient Encounter (if currently admitted)	Responsibility to Address

Insert Patient Sticker Here

IDENTIFIED CAUSES

MEDICATION MANAGEMENT

- No prescription given
- Medication prescription not filled
- Medication not on insurance formulary causing delay in prescription fill/refill
- Medications not listed for patient
- Adverse reaction to medications
- Medication list incomplete [patient did not inform caregivers of all medications being taken at home]
- Chose not to adhere to medications

SELF-MANAGEMENT

- Lack of transportation access
- Financial barriers
- Language barriers
- Unable to perform care
- Self neglect/abuse
- Chose not to adhere to:
 - Medication regimen
 - Low sodium diet
 - Weight management
 - Daily exercise / activity plan and/or recommendation for cardiac rehabilitation
 - Monitoring for new or worsening signs or symptoms of heart failure

LACK OF COMMUNICATION – (Pending diagnostic results not communicated with PCP)

- No transition/discharge summary sent to PCP
- NO PCP noted at time of admission with no follow up to find provider prior to discharge

INFECTIOUS PROCESS

- Colonized (Requires Isolation)
- Infection (Active Process)

REFERRAL/OUTPATIENT NEEDS PROCESS

- No referral noted
- Lack of referral follow up with: _____
- Referral to agency unable to meet individuals needs _____
- Unaddressed co-morbidity
- Mobility/Home Safety

Insert Patient Sticker Here