Early in the Hospital Admission: Assess Patient Risk of Readmission

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

**Figure 1** is an outline of innovative practices and evidence-informed best practices that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices.

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**Figure 1: Practices to Improve Transitions Between Hospital and Home**

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.
**Description of this Evidence-Informed Best Practice**

Patients with multiple conditions and complex needs should be assessed for their risk of readmission using an evidence-based risk assessment tool as early as possible in the hospital admission period to address issues prior to transition and/or arrange post transition supports. The following section outlines existing screening tools that can be used for this assessment.

**Tools and Resources**

In an environmental scan and literature review, the following tools were found to be highly effective and commonly used assess patient risk for readmission. The decision to implement or administer one of these tools must be considered alongside other locally contextually relevant information.

<table>
<thead>
<tr>
<th><strong>Assess Patient Risk for Readmission</strong></th>
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<tbody>
<tr>
<td><strong>Name of Tool</strong></td>
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<tr>
<td>LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits)</td>
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<tr>
<td>PRA (Predictive Repetitive Admission)</td>
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<tr>
<td>DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale)</td>
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</tbody>
</table>

*The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.*
DIVERT is typically completed by the Care Coordinator, and can be derived from the InterRAI Home and Community Care Instruments at no additional cost. A screening Model is also available for those not running the interRAI platform.

Additional Resources

For additional information on Quality Improvement, please visit: http://qualitycompass.hqontario.ca/portal/getting-started.

References


4. van Walraven C, Dhalla IA, Bell C, Etchells E, Stiell IG, Zaruke K, Austin PC, Forster AJ. Derivation and Validation of an Index to Predict Early Death or Unplanned Readmissions after Discharge from Hospital to the Community. CMAJ. 2010;182(6):551-557.