

Letter to the Editor

Beyond Benchmarking: Learning From Hospital at Home Escalations

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To the Editors,

We read with interest the recent articles by Ko et al.¹ and Tierney et al.² examining escalation from Hospital at Home (HaH) back to the brick-and-mortar (BAM) hospital. Together, these papers highlight escalation as an important quality and safety metric within HaH and provide an opportunity for our specialty to standardise terminology before competing definitions become entrenched.

Although both articles examine “unplanned escalation”, they define it differently. Ko et al.¹ defined escalation as an unplanned return to hospital requiring at least an overnight BAM admission, whereas Tierney et al.² defined escalation as any unplanned transfer of care back to the BAM hospital. Similar terminology is also emerging within health service policy, with Queensland Health using the term “unplanned transfer” in its Hospital in the Home guideline.³ The emergence of related terminology across both research and policy highlights the need for consensus definitions.

The articles by Ko et al.¹ and Tierney et al.² represent complementary steps in the evolution of escalation reporting. Ko et al. provide benchmarking data, helping establish expected escalation rates across HaH services. Tierney et al. take the next step by identifying patient characteristics associated with escalation risk and developing a predictive tool.

Without a structured approach to reviewing escalation events, services may be able to quantify escalation rates but remain limited in their ability to identify modifiable system factors.

Benchmarking tells us how often escalations occur, while predictive models identify who may be at risk. Neither addresses the question most relevant to local quality improvement: what can we learn from escalations?

We propose a standardized escalation audit framework ([Table 1](#)). Built upon the data elements reported by Ko et al.,¹ it maintains alignment with emerging benchmarking standards while incorporating additional quality-improvement measures.

Importantly, the proposed framework is not intended solely for data collection. Escalation events could be reviewed through existing morbidity and mortality meetings,

quality committees, or multidisciplinary case review processes. Standardized capture of escalation characteristics, potential preventability, and lessons learned would allow services to move beyond measuring escalation rates and instead identify recurring system issues, monitor the impact of interventions, and share successful improvement strategies.

As HaH continues to mature internationally, the next step is not simply to measure escalation or predict it, but to learn from it through a shared language and standardized audit framework. If adopted across services, such a framework could support the development of regional or international escalation registries, allowing benchmarking data to be linked with quality improvement findings. Over time, this would enable HaH programs not only to understand how often escalations occur, but also why they occur and which interventions most effectively improve patient outcomes.

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CONFLICTS OF INTEREST

There are no conflicts of interests to declare.

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Table 1. Proposed Hospital at Home Escalation Audit Framework Based on the “So, What If Something Happens (SWISH)” Reporting Framework

Audit Domain	Data source	Quality Improvement Purpose
Date of escalation	New item	Records events for audit, trend analysis, and monitoring of improvement initiatives
Patient identifier (local service requirement)	New item	Enables local governance review and case-based learning
Planned versus unplanned transfer	SWISH domain	Distinguishes expected care transitions from genuine escalation events
Overnight versus non-overnight transfer	New item	Captures disruptions to the patient journey not reflected in overnight admission metrics
Timing of escalation (sociable vs non-sociable hours)	Modified SWISH domain	Identifies potential service gaps and informs workforce planning
Characteristics of deterioration	SWISH domain	Identifies broad causes of escalation and recurring patterns
Reason for deterioration	SWISH domain	Identifies specific clinical triggers that may inform pathway redesign
Previous escalation during same episode of care	SWISH domain	Identifies recurrent escalation patterns and patients requiring enhanced monitoring
ICU transfer within 24 hours	SWISH domain	Identifies severe deterioration and supports safety monitoring
Death following escalation	SWISH domain	Identifies severe adverse outcomes requiring governance review
Duration of HaH stay prior to escalation	SWISH domain	Provides context regarding timing and risk of deterioration
Return to HaH following escalation	SWISH domain	Distinguishes temporary from definitive transfers to BAM
Duration of BAM stay prior to return to HaH	SWISH domain	Provides context regarding the severity and duration of escalation
Subsequent HaH duration following return	SWISH domain	Demonstrates HaH as a continuum of care beyond the escalation event
Was the escalation potentially preventable?	New item	Facilitates structured review of modifiable contributors to escalation
Lessons learned and actions identified	New item	Supports organisational learning, service redesign, and monitoring of corrective actions

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