Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT®
Version 3.0 Tool

SECTION 1: Resident Characteristics and Risk Factors for Hospitalization

Resident ID _____ Date of birth _____

Date of ***most recent*** admission to nursing home _____ Age _____

a. Major diagnoses at admission _____

b. Conditions that put the resident at risk for hospital admission or readmission *(select all that apply)*:

- ☐ Cancer, on active chemo or radiation therapy
- ☐ CHF
- ☐ COPD
- ☐ Dementia
- ☐ End-Stage Renal Disease
- ☐ Fracture
- ☐ Multiple co-morbidities *(e.g. CHF, COPD and DM in the same patient; or multiple active diagnoses)*
- ☐ Polypharmacy *(e.g. 9 or more medications)*
- ☐ Surgical complications
- ☐ Other *(describe)*

_____

_____

c. Other Hospital Admission *(select one)*:

☐ Past 30 days ☐ Past year, but not in the past 30 days *(list dates and reasons below)* ☐ None in past year

_____

_____

_____

d. Emergency Department visit without hospital admission:

☐ Past 30 days ☑ Past year, but not in the past 30 days *(list dates and reasons below)* ☐ None in past year

_____

_____

_____

_____

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SECTION 2: Describe the Acute Change in Condition and Other Non-Clinical Factors that Contributed to the Transfer

a. Date the change in condition first noticed _____

b. Briefly describe the change, symptom, sign or other factor(s) that led to the transfer and then check each item below that applies

_____

_____

_____

c. Check ***all*** that apply

New or Worsening Symptoms or Signs

- ☐ Abdominal pain
- ☐ Abnormal vital signs *(low/high BP, high respiratory rate)*
- ☐ Altered mental status
- ☐ Behavior Symptoms *(agitation, psychosis)*
- ☐ Bleeding
- ☐ Cardiac arrest
- ☐ Chest pain
- ☐ Diarrhea
- ☐ Edema *(new or worsening)*
- ☐ Fall
- ☐ Fever
- ☐ Food and/or fluid intake *(decreased or unable to eat and/or drink adequate amounts)*
- ☐ Functional decline *(worsening function and/or mobility)*
- ☐ Gastronomy tube blockage or displacement
- ☐ Loss of consciousness *(syncope)*
- ☐ Nausea/vomiting
- ☐ Pain *(uncontrolled)*
- ☐ Respiratory arrest
- ☐ Respiratory infection
- ☐ Shortness of breath
- ☐ Seizure
- ☐ Skin wound or ulcer
- ☐ Unresponsiveness
- ☐ Urinary incontinence
- ☐ Weight loss
- ☐ Other *(describe)*

Abnormal Lab or Test Results

- ☐ Blood sugar *(high)*
- ☐ Blood sugar *(low)*
- ☐ EKG
- ☐ Hemoglobin or hematocrit *(low)*
- ☐ INR *(high or low)*
- ☐ Kidney function *(BUN and/or Creatinine)*
- ☐ Pulse oximetry *(low oxygen saturation)*
- ☐ Urinalysis or urine culture
- ☐ White blood cell count *(high)*
- ☐ X-ray
- ☐ Other *(describe)*

Diagnosis or Presumed Diagnosis

- ☐ Acute renal failure
- ☐ Anemia *(new or worsening)*
- ☐ CHF *(congestive heart failure)*
- ☐ Cellulitis
- ☐ COPD *(chronic obstructive lung disease)*
- ☐ DVT *(deep vein thrombosis)*
- ☐ Fracture (site: _____)
- ☐ Pneumonia
- ☐ UTI *(urinary tract infection)*
- ☐ Other *(describe)*

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SECTION 3: Describe Action(s) Taken to Evaluate and Manage the Change in Condition Prior to Transfer

a. Briefly describe how the changes in Section 2 were evaluated and managed and check each item that applies

_____

_____

_____

b. Check *all* that apply

Tools Used
- ☐ Stop and Watch
- ☐ SBAR
- ☐ Care Path(s)
- ☐ Change in Condition File Cards
- ☐ Transfer Checklist
- ☐ Acute Care Transfer Form *(or an equivalent paper or electronic version)*
- ☐ Advance Care Planning Tools
- ☐ Other Structured Tool or Form *(describe)*

Medical Evaluation
- ☐ Telephone only
- ☐ NP or PA visit
- ☐ MD visit
- ☐ Other *(describe)*

Testing
- ☐ Blood tests
- ☐ EKG
- ☐ Urinalysis and/or culture
- ☐ Venous doppler
- ☐ X-ray
- ☐ Other *(describe)*

Interventions
- ☐ New medication(s)
- ☐ IV or subcutaneous fluids
- ☐ Increase oral fluids
- ☐ Oxygen
- ☐ Other *(describe)*

c. Were ***advance directives*** considered in evaluating and managing the change in condition or deciding about this transfer? ☐ No ☐ Yes

If yes, were any new advance directives or related orders written as a result of this change in condition? ☐ No ☐ Yes

If yes, check all that apply

- ☐ Do Not Resuscitate Order (DNR)
- ☐ Do Not Hospitalize Order (DNH)
- ☐ Comfort or Pallative Care Orders
- ☐ Order for Hospice Care
- ☐ POLST, MOLST or POST

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SECTION 4: Describe the Hospital Transfer

a. Date of transfer _____ Day _____ Time (am/pm) _____

b. Clinician authorizing transfer: ☐ Primary MD ☐ Covering MD ☐ NP or PA ☐ Other

c. Outcome of transfer: ☐ Admitted, inpatient ☐ Admitted, observation ☐ Admitted, status uncertain
☐ ED visit only ☑ Other

d. Resident died in ED or hospital: ☐ No ☐ Yes ☑ Unknown

e. Hospital diagnosis(es) *(if available)* _____

f. Factors contributing to transfer *(check all that apply):*
- ☐ Advance directive not in place
- ☐ Resident preferred or insisted on transfer
- ☐ Resources to provider care in NH were not available
- ☐ Other *(describe)*
- ☐ Clinician insisted on transfer
- ☐ Family members preferred or insisted on transfer
- ☐ NH policies do not support providing care in NH

SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented? ☐ No ☐ Yes *(check all that apply and describe below)*
- ☐ The new sign, symptom, or other change might have been detected earlier
- ☐ Changes in the resident's condition might have been communicated better among NH staff, with MD/NP/PA, or with ER staff
- ☐ The condition might have been managed safely in the facility with available resources
- ☐ Resources were not available to manage the change in condition safely or effectively *(check all that apply)*
  - ☐ On-site primary care clinician ☐ Staffing ☐ Lab or other diagnostic tests
  - ☐ Pharmacy services ☐ Other *(describe)* _____
- ☐ Resident and family preferences for hospitalization might have been discussed earlier
- ☐ Advance directives and/or palliative or hospice care might have been put in place earlier
- ☐ Other *(describe)*

_____

_____

b. In retrospect, does your team think this resident might have been transfered sooner? ☐ No ☐ Yes *(if yes, describe)*

_____

c. After review of how this change in condition was evaluated and managed, has your team identified any opportunities for improvement?
☐ No ☐ Yes *(describe specific changes your team can make in your care processes and related education as a result of this review)*

_____

_____

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