Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT®
Version 4.0 Tool *

The INTERACT QI Tool is designed to help your team analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

Patient _____ Age _____

Date of most recent admission to the facility _____ /_____ /_____

Primary goal of admission ☐ Post-acute care ☐ Long-stay ☐ Other _____

SECTION 1: Risk Factors for Hospitalization and Readmission

a. Conditions that put the resident at risk for hospital admission or readmission:

☐ Cancer, on active chemo or radiation therapy
☐ CHF
☐ COPD
☐ Dementia
☐ Diabetes
☐ End-stage renal disease
☐ Fracture *(Hip)*
☐ Multiple active diagnoses and/or co-morbidities *(e.g. CHF, COPD and Diabetes in the same resident)*
☐ Polypharmacy *(e.g. 9 or more medications)*
☐ Surgical complications

b. Resident hospitalized in the ***past 30 days?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

_____

_____

c. Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

_____

_____

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 in condition and other factor(s) that led to the transfer and then check each item below that applies

_____

_____

_____

_____

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c. Vital Signs at time of transfer

Temp _____ Pulse _____ Pulse Ox *(if indicated)* _____% on ☐ Room Air ☐ O_2 (_____)

Respiratory rate _____ BP _____/_____ Glucose *(diabetics)* _____

d. Check ***all*** that apply

New or Worsening Symptoms or Signs

- ☐ Abdominal Pain
- ☐ Abnormal vital signs *(low/high BP, high respiratory rate)*
- ☐ Altered mental status
- ☐ Behavioral symptoms *(e.g. agitation, psychosis)*
- ☐ Bleeding *(other than GI)*
- ☐ Cardiac arrest
- ☐ Chest pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Edema *(new or worsening)*
- ☐ Fall
- ☐ Fever
- ☐ Food and/or fluid intake *(decreased or unable to eat and/or drink adequate amounts)*
- ☐ Function decline *(worsening function and/or mobility)*
- ☐ Gastrostomy Tube blockage or displacement
- ☐ GI bleeding
- ☐ Hypertension *(uncontrolled)*
- ☐ Loss of conciousness *(syncope)*
- ☐ Nausea / vomiting
- ☐ Pain *(uncontrolled)*
- ☐ Respiratory arrest
- ☐ Respiratory infection *(bronchitis, pneumonia)*
- ☐ Shortness of breath
- ☐ Seizure
- ☐ Skin wound or ulcer
- ☐ Stroke / TIA / CVA
- ☐ Trauma *(fall-related or other)*
- ☐ Unresponsive
- ☐ Urinary incontinence
- ☐ Weight loss
- ☐ Other *(describe)*

Abnormal Labs or Tests Results

- ☐ Blood sugar *(high)*
- ☐ Blood Sugar *(low)*
- ☐ EKG
- ☐ Hemoglobin or Hematocrit *(low)*
- ☐ INR *(high)*
- ☐ Kidney function *(BUN, 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)*
- ☐ Asthma
- ☐ CHF *(congestive heart failure)*
- ☐ Cellulitis
- ☐ COPD *(chronic obstructive lung disease)*
- ☐ DVT *(deep vein thrombosis)*
- ☐ Fracture (site:_____)
- ☐ Pneumonia
- ☐ UTI *(urinary tract infection)*
- ☐ Other *(describe)*

Other Factors

- ☐ Advance directive not in place
- ☐ Resident preference or concerns
- ☐ Family preference or concerns
- ☐ Clinician insisted on transfer despite staff willing to manage in facility
- ☐ Other *(describe)*

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
- ☐ Physician visit
- ☐ Other *(describe)*

Testing

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

Interventions

- ☐ New or change in medication(s)
- ☐ IV or subcutaneous fluids
- ☐ Oxygen
- ☐ Monitor vital signs
- ☐ Other *(describe)*

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c. Were ***advance care planning or advance directives*** considered in evaluating/managing the change? *(e.g. orders for Do Not Resuscitate (DNR), Do Not Intubate (DNI), palliative or hospice care, other such as POLST, MOLST or POST):* ☐ No ☐ Yes *(check all that apply)*

If yes, were the relevant advance directives: ☐ Modified as a result of this change in clinical condition/transfer?
☐ Already in place and documented?
☐ New as a result of this change in clinical condition/transfer?

Describe _____

SECTION 4: Describe the Hospital Transfer

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

b. Clinician authorizing transfer: ☐ Primary physician ☐ Covering physician ☐ NP or PA ☐ Other *(specify)* _____

c. Outcome of transfer: ☐ ED visit only ☐ Held for observation ☐ Admitted to hospital as inpatient

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

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

e. Factors contributing to transfer *(check all that apply and describe)*

☐ Advance directive not in place
☐ Resident preferred or insisted on transfer
☐ Family members preferred or insisted on transfer
☐ Discharged from the hospital too soon
☐ Clinician insisted on transfer despite staff willing to manage in the facility
☐ Facility policies do not support care in facility
☐ Resources to provide care in the facility were not available
☐ Other *(describe)*

_____

_____

SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented? ☐ No ☐ Yes *(describe)*

_____

_____

If yes, check one or more that apply:

☐ The new sign, symptom, or other change might have been detected earlier
☐ Changes in the resident's condition might have been communicated better among facility staff, with physician/NP/PA, or other health care providers
☐ 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 despite staff willing to manage in the facility *(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
☐ Discharged from the hospital too soon in unstable condition ☐ Other *(describe)*

_____

_____

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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)*

_____

_____

Name of person completing form_____ Date of completion _____/_____/_____