Quality Improvement Tool
For Review of Acute Care Transfers

The INTERACT QI Tool is designed to help your team analyze hospital transfers \textit{(including ER visits, observation stay and admissions)} 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/Resident ___________________________ Age ________________

Date of most recent admission to the facility _________/_______/_______

Primary goal of admission: \(\square\) Post-acute care \(\square\) Long-stay \(\square\) Others: ______________________________

\textbf{SECTION 1: Risk Factors for Hospitalization and Readmission}

\textbf{a. Conditions that put the resident at risk for hospital admission or readmission:}

\(\square\) Cancer, on active chemo or radiation therapy
\(\square\) Heart Failure (HF)
\(\square\) Congestive Obstructive Pulmonary Disease (COPD)
\(\square\) Dementia
\(\square\) Diabetes
\(\square\) End-stage renal disease

\(\square\) Fracture (Hip)
\(\square\) High Risk Medications
\(\square\) Anticoagulant
\(\square\) Diabetic Agent
\(\square\) Opioids
\(\square\) Multiple active diagnoses and/or co-morbidities
\(\text{\textit{e.g.}}\) HF, COPD and Diabetes in the same patient/resident
\(\square\) Polypharmacy (\textit{e.g.} 9 or more medications)
\(\square\) Surgical complications

\textbf{b. Was Patient/Resident hospitalized in the 30 days before their most recent admission to the facility?} \(\square\) No \(\square\) Yes (\textit{list dates and reasons})
\(\text{(Other than the one being reviewed in this tool)}\)

\textbf{c. Other hospitalizations or emergency department visits in the past 12 months?} \(\square\) No \(\square\) Yes (\textit{list dates and reasons})
\(\text{(Other than the one being reviewed in this tool)}\)

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

\textbf{a. Date the change in condition first noticed} _________/_______/_______

\textbf{b. Briefly describe the change in condition and other factor(s) that led to the transfer and then check each item below that applies}

\textbf{c. Vital signs at time of transfer}

\begin{itemize}
  \item Temp __________
  \item Pulse _________
  \item Pulse Ox (if indicated) ________ \%
  \item O2 (if indicated) ________
  \item Room Air \(\square\)
  \item BP _________/_______
  \item Glucose (diabetics) __________
\end{itemize}
Quality Improvement Tool
For Review of Acute Care Transfers (cont’d)

d. Check all that apply

New or Worsening Symptoms or Signs

- Abdominal distention/suspected bowel obstruction
- Abdominal Pain
- Abnormal vital signs (low/high BP, high/low respiratory rate)
- Altered mental status
- Behavioral symptoms (e.g. agitation, psychosis)
- Bleeding (other than GI)
- Cardiac arrest
- Chest pain
- Constipation
- Cough
- Dehydration/volume depletion
- Diarrhea
- Dizziness/vertigo
- Edema (new or worsening)
- Fall
- Fever
- Food and/or fluid intake (decreased or unable to eat and/or drink inadequate amounts)
- Function decline (worsening function and/or mobility)
- Gl bleeding, blood in stool
- Hematoma
- Hypertension (uncontrolled)
- Hypoxia – (low P O2<90)
- Loss of consciousness (syncope, other)
- Nausea/vomiting
- Pain (uncontrolled)
- Respiratory arrest
- Respiratory infection (bronnchitis, pneumonia)
- Shortness of breath
- Seizure
- Skin wound or pressure ulcer/injury
- 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
- Cellulitis
- COPD (Chronic Obstructive Pulmonary Disease)
- DVT (Deep Vein Thrombosis)
- Fracture (site: ____________)
- HF (Heart Failure)
- Pneumonia
- Sepsis
- UTI (Urinary Tract Infection)
- Other (describe)
- Need for diagnostic and other procedures including transfusions
  - Gastrostomy tube blockage or displacement
  - Transfusion (planned)
- Other

Other Factors Contributing to the Transfer

- Advance directive not in place
- Clinician insisted on transfer despite staff willing to manage in facility
- Direct admission (from dialysis or other specialty office)
- Discharged from the hospital too soon
- Family members/representative preferred or insisted on transfer
- Planned admission (for surgery or other procedure)
- Resident preferred or insisted on transfer
- Resources to provide care in the facility were not available
- 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

<table>
<thead>
<tr>
<th>b. Check all that apply</th>
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<tbody>
<tr>
<td><strong>Tools Used</strong></td>
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<tr>
<td>□ Stop and Watch</td>
</tr>
<tr>
<td>□ SBAR</td>
</tr>
<tr>
<td>□ Care Path(s)</td>
</tr>
<tr>
<td>□ Change in Condition File Cards</td>
</tr>
<tr>
<td>□ Transfer Checklist</td>
</tr>
<tr>
<td>□ Acute Care Transfer Form (or an equivalent paper or electronic version)</td>
</tr>
<tr>
<td>□ Advance Care Planning Tools</td>
</tr>
<tr>
<td>□ Infection or Sepsis Guidance</td>
</tr>
<tr>
<td>□ Other Structured Tool or Form (describe)</td>
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<table>
<thead>
<tr>
<th><strong>Medical Evaluation</strong></th>
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<tbody>
<tr>
<td>□ Telephone only</td>
</tr>
<tr>
<td>□ NP or PA visit</td>
</tr>
<tr>
<td>□ Physician visit</td>
</tr>
<tr>
<td>□ Other (e.g. in a specialist office or while on dialysis)</td>
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<table>
<thead>
<tr>
<th><strong>Testing</strong></th>
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<tbody>
<tr>
<td>□ Blood tests</td>
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<tr>
<td>□ EKG</td>
</tr>
<tr>
<td>□ Urinalysis and/or culture</td>
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<tr>
<td>□ Venous doppler</td>
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<tr>
<td>□ X-ray</td>
</tr>
<tr>
<td>□ Other (describe)</td>
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<tr>
<th><strong>Interventions</strong></th>
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<tbody>
<tr>
<td>□ New or change in medication(s)</td>
</tr>
<tr>
<td>□ IV or subcutaneous fluids</td>
</tr>
<tr>
<td>□ Increase oral fluids</td>
</tr>
<tr>
<td>□ Oxygen (if available)</td>
</tr>
<tr>
<td>□ Other (describe)</td>
</tr>
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<tr>
<th>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, others such as POLST, MOLST or POST):</th>
</tr>
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<tbody>
<tr>
<td>□ No</td>
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<tr>
<td>□ Yes</td>
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If yes, were the relevant advance directives (check only one):

<table>
<thead>
<tr>
<th>□ Modified as a result of this change in clinical condition/transfer?</th>
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<tbody>
<tr>
<td>□ Already in place and documented?</td>
</tr>
<tr>
<td>□ New as a result of this change in clinical condition/transfer?</td>
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</table>

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
□ Family members/representative preferred or insisted on transfer
□ Clinician insisted on transfer despite staff willing to manage in the facility
□ Planned admission (for surgery or other procedure)
□ Direct admission (from dialysis or other specialty office)
□ Resident preferred or insisted on transfer
□ Resources to provide care in the facility were not available
□ Discharged from the hospital too soon
□ 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) ________________________________

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 or resident representative 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
□ Other (describe) ________________________________

b. In retrospect, does your team think this resident might have been transferred 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 __________/________/________