

# Quality Improvement Tool

## For Review of Acute Care Transfers



The INTERACT QI Tool is designed to help your team analyze hospital transfers (*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:  Post-acute care  Long-stay  Others: \_\_\_\_\_

### SECTION 1: Risk Factors for Hospitalization and Readmission

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

- |   |   |
|---|---|
| <input type="checkbox"/> Cancer, on active chemo or radiation therapy | <input type="checkbox"/> Fracture ( <i>Hip</i> )  |
| <input type="checkbox"/> CHF  | <input type="checkbox"/> Multiple active diagnoses and/or co-morbidities<br>( <i>e.g. CHF, COPD and Diabetes in the same patient/resident</i> ) |
| <input type="checkbox"/> COPD   | <input type="checkbox"/> Polypharmacy ( <i>e.g. 9 or more medications</i> )   |
| <input type="checkbox"/> Dementia                                     | <input type="checkbox"/> Surgical complications   |
| <input type="checkbox"/> Diabetes                                     |   |
| <input type="checkbox"/> End-stage renal disease                      |   |

b. Was Patient/Resident hospitalized in the **30 days before their most recent admission to the facility**?  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

#### c. Vital signs at time of transfer

Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Pulse Ox (*if indicated*) \_\_\_\_\_ % on  Room Air  O<sub>2</sub> (\_\_\_\_\_) \_\_\_\_\_

Respiratory rate \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Glucose (*diabetics*) \_\_\_\_\_

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## For Review of Acute Care Transfers (cont'd)

### d. Check all that apply

#### New or Worsening Symptoms or Signs

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

#### 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
- Family and/or resident 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 (*e.g. in a specialist office or while at dialysis*) \_\_\_\_\_

#### 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
- Increase oral fluids
- Oxygen (*if available*)
- Other (*describe*) \_\_\_\_\_

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 \_\_\_\_\_

(continued)

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## For Review of Acute Care Transfers (cont'd)



### 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
- 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
  - Pharmacy services
  - Staffing
  - Other (describe) \_\_\_\_\_
  - Lab or other diagnostic tests
- 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
- 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_