

# 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"/> High Risk Medications  |
| <input type="checkbox"/> Congestive Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Anticoagulant <input type="checkbox"/> Diabetic Agent <input type="checkbox"/> Opioids                       |
| <input type="checkbox"/> Dementia  | <input type="checkbox"/> Infection with ongoing Treatment   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Multiple active diagnoses and/or co-morbidities<br>(e.g. HF, COPD and Diabetes in the same patient/resident) |
| <input type="checkbox"/> End-Stage Renal Disease                         | <input type="checkbox"/> Polypharmacy (e.g. 9 or more medications)  |
| <input type="checkbox"/> Fracture (Hip)                                  | <input type="checkbox"/> Surgical complications   |
| <input type="checkbox"/> Heart Failure (HF)                              |   |

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

- 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 adequate amounts*)
- Function decline (*worsening function and/or mobility*)
- GI bleeding, blood in stool
- Hematoma
- Hypertension (*uncontrolled*)
- Hypoxia – (*low p O<sub>2</sub><90*)
- Loss of consciousness (*syncope, other*)
- Nausea/vomiting
- Pain (uncontrolled)
- Respiratory arrest
- Respiratory infection (*bronchitis, 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*)
- COVID (*Positive*)
- 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*)
- COVID
- 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 (*describe*) \_\_\_\_\_

#### 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*) \_\_\_\_\_

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



### 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
- Infection or Sepsis Guidance
- 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 on 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

If **yes**, were the relevant advance directives (**check only one**):

- 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 \_\_\_\_\_

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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
- Clinician insisted on transfer despite staff willing to manage in the 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

### 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 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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_