Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT®
Version 4.5 Tool

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:

☐ Cancer, on active chemo or radiation therapy
☐ Heart Failure *(HF)*
☐ Congestive Obstructive Pulmonary Disease *(COPD)*
☐ Dementia
☐ Diabetes
☐ End-Stage Renal Disease
☐ Fracture *(Hip)*
☐ Infection with ongoing Treatment
☐ High Risk Medications
☐ Anticoagulant ☐ Diabetic Agent ☐ Opioids
☐ Multiple active diagnoses and/or co-morbidities
(e.g. HF, COPD and Diabetes in the same patient/resident)
☐ Polypharmacy *(e.g. 9 or more medications)*
☐ Surgical complications

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_2 (_____)

Respiratory rate_____ BP_____/ _____ Glucose *(diabetics)*_____

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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 O2<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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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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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 ☐ 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 _____/_____/_____