Implementing the INTERACT II Toolkit

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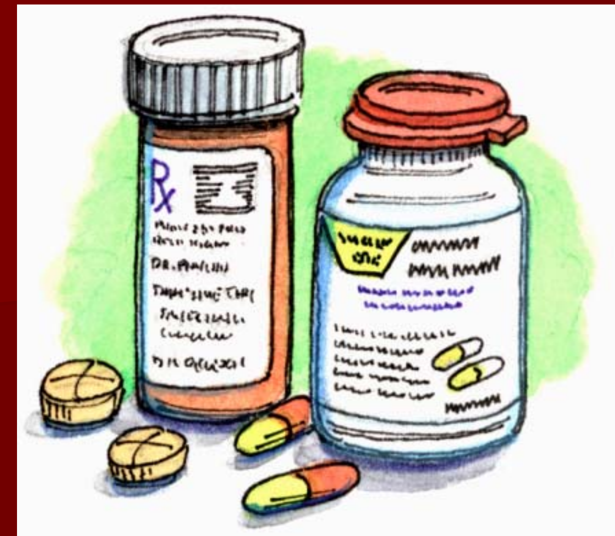
Now We Will

- Discuss the purpose of the INTERACT II toolkit
- Review the key tools in the INTERACT II toolkit
- Discuss Implementation Strategies
- Share Lessons Learned About Training

Why It Matters



A Toolkit to Improve Nursing Home Care by Reducing Avoidable Acute Care Transfers and Hospitalizations

The INTERACT II Tools, educational materials, and implementation strategies were developed by Drs. Joseph Ouslander, Gerri Lamb, Alice Bonner, and Ruth Tappen, and Laurie Herndon with input from a variety of direct care providers and national experts in a project supported by the Commonwealth Fund based at Florida Atlantic University.

Initial versions of the INTERACT Tools were developed by Dr. Ouslander and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a special study contract from CMS.

Purpose Of Toolkit

- Aid in the early identification of a resident change of status
- Guide staff through a comprehensive resident assessment when a change has been identified
- Improve documentation around resident change in condition
- Enhance communication with other health care providers about a resident change of status

Overall Approach

- Dr. Ouslander “Simple Test”
- Feasible and efficient
- Part of the “way we do business”
- Acceptable to staff

“I love this project!

(I love that it's short on rhetoric and theory and focuses on tools and I especially love the flexibility you've given facilities to tailor it to their needs)”

Organization of Tools in Toolkit Champion Resource Binder

Communication Tools

Clinical Care Paths

Advance Care Planning Tools

Communication Tools

- Early Warning Tool
- SBAR and Progress Note
- Resident Transfer Form
- Transfer Checklist

EARLY WARNING TOOL

"Stop and Watch"

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident ___________________________________

Seems different than usual
Talks or communicates less than usual
Overall needs more help than usual
Participated in activities less than usual

Ate less than usual (Not because of dislike of food)
N
Drank less than usual

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Staff____

Reported to ______________________________________

Date _____ / _____ / _______ Time _______________

- Where to keep it
- Who should use it
- Different languages
- Limited response
- Formatting
- Tracking utilization
- Staff Literacy
- Nonpunitive approach

Adapted from Boockvar et al., J Am Geriatr Soc 48:1086 (2000)

- “We use it for EVERYTHING”
- “Organize Your Thoughts Form”
- Easy to recognize change in condition
- Can identify “near misses”
- “Warm hand off”
- Behavioral program
- Standard work= Reliable outcomes

SBAR

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

Before Calling MD/NP/PA:

- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Review chart:** recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is ______________________________

____

This started______________________________

This has gotten (circle one) worse/better/stayed the same since it started

Things that make the condition worse are ______________________________

Things that make the condition better are ______________________________

Other things that have occurred with this change are ______________________________

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home ______________________________

Pertinent history (e.g. recent falls,fever, decreased intake, pain, SOB, other) ______________________________

____

Vital signs BP________/__________ HR ______________ RR ______________ Temp ______________

Pulse Oximetry ____________% On RA__________on O2 at ____________L/min via__________(NC, mask)

Change in function or mobility ______________________________

Medication changes or new orders in the last two weeks ______________________________

Mental status changes (e.g. confusion/agitation/lethargy) ______________________________

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)

Pain level/location______________________________

Change in intake/hydration______________________________

Change in skin or wound status ______________________________

Labs ______________________________

Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)

Allergies ______________________ Any other data ______________________

A ASSESSMENT (RN) OR APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be ______________________________*-OR*
I am not sure of what the problem is, but there had been an acute change in condition.

(For LPNs): The resident appears (e.g. SOB, in pain, more confused) ______________________________

R REQUEST

I suggest or request **(check all that apply):**

- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ IV or SC fluids
- ☐ Other (specify) ____________________
- ☐ Monitor vital signs and observe
- ☐ Change in current orders ____________________
- ☐ New orders ____________________
- ☐ Transfer to the hospital

Staff name ______________________________**RN/LPN**

Reported to: Name ______________________**(MD/NP/PA) Date**___/___/___ **Time**________**a.m./p.m.**

If to MD/NP/PA, communicated by: ☐ Phone ☐ In person

Resident name ______________________________

(Complete a progress note on the back of this form)

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Updated January 2011

RESIDENT TRANSFER FORM

SENT TO: *(Name of Hospital)*

SENT FROM: *(Name of Nursing Home)*

Date:___/___/________ Unit: ________

RESIDENT:
Last Name *First Name* *MI*

DOB:_____/____/________
Language: English Other:______________
Resident is: SNF/rehab Long-term

CONTACT PERSON:
(Relative, guardian or DPOA/Relationship)
name
Is this the health care proxy? Yes No
Telephone:( )_______ - ___________
Notified of transfer: Yes No
Aware of diagnosis: Yes No

CODE STATUS:
DNR DNH DNI Full Code

MD/NP/PA IN NURSING HOME:
MD NP PA
name
Telephone:( )___-______ Pager:( )___-______

WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?
name *title* Telephone:( )____-__________

REASON FOR TRANSFER *(i.e., What Happened?)*

List of Diagnoses:________________________________

VS: BP____ HR____ RR____ T_____ pOx_____ FS glucose ____ Time Taken: ____:_____ AM/PM
Allergies:________________________ Tetanus Booster *(date)*:_____/_____/________

Usual Mental Status:
- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, but cannot follow simple instructions
- Not alert

Usual Functional Status:
- Ambulates independently
- Ambulates with assistance
- Ambulates with assistive device
- Not ambulatory

Please see SBAR form for additional information

DEVICES / SPECIAL TREATMENTS:
IV/PICC line
Pacemaker
Foley Catheter
Internal Defibrillator
TPN
Other: ______________

AT RISK ALERTS:
None
Falls
Pressure Ulcer
Aspiration
Wanderer
Elopement
Seizure
Harm to: Self Others
Restraints
Limited/non-weight bearing: Left Right
Other:__________

ISOLATION / PRECAUTION:
MRSA VRE
C-Diff
Other:__________
Site:__________
Comment:__________

CAPABILITIES OF THE NURSING HOME TO CARE FOR THIS RESIDENT:
IVF therapy IV antibiotics MD/NP/PA follow up visit within 24 hours
Q shift monitoring by an RN Other:______________________

NURSING HOME WOULD BE ABLE TO ACCEPT RESIDENT BACK UNDER THE FOLLOWING CONDITIONS:
ED determines diagnosis, and treatment can be done in NH
VS stabilized and follow up plan can be done in NH
Other: ______________________________

Form Completed By:
name *title* *signature*

Report Called In By:
name *title*

Report Called To:
name *title*

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- “It took two nurses working together 30 minutes to fill this out”
- “This isn’t so different from what we usually do”
- “Gets easier with practice”
- Take old forms off units

ACUTE CARE TRANSFER DOCUMENT CHECKLIST

RESIDENT NAME ____

COPIES SENT WITH RESIDENT (Check all that apply):

These documents should ALWAYS accompany patient:

____ Resident Transfer Form

____ Face Sheet

____ Current Medication List or Current MAR

____ Advance Directives

____ Care limiting Orders

____ Out of hospital DNR

____ Bed hold policy

Send these documents IF INDICATED:

____ SBAR/Nurse's Progress Note

____ Most Recent History & Physical and any recent hospital discharge summary

____ Recent MD/NP/PA Orders related to Acute Condition

____ Relevant Lab Results

____ Relevant X-Rays

____ PERSONAL BELONGINGS SENT WITH RESIDENT:

____ Eyeglasses ____Hearing Aid ___ Dental Appliance

____ Other (specify)

Signature of ambulance staff accepting envelope:________________________

(Please make a copy and keep this for your records in the nursing home)

QUALITY IMPROVEMENT TOOL

The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

Section 1: BACKGROUND INFORMATION

_______________ _______________ _______________ _______________

Resident's Last Name	First Name	Age	Unit/Room #

a. Date of ***most recent*** admission to nursing home: ______/______/______

b. Resident hospitalized in the past 12 months? ☐ No ☐ Yes **If yes, list dates and reasons below:**

____

____

____

____

Section 2: DESCRIBE THE ACUTE CHANGE IN CONDITION THAT LED TO TRANSFER

Date the change in condition first noticed: ______/______/______

a. **Check *all* that apply:**

CHANGE IN:
- ☐ Appetite/intake
- ☐ Behavior
- ☐ Function
- ☐ Skin or a wound

NEW CONDITION:
- ☐ Bleeding
- ☐ Breathing difficulty or SOB
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fall
- ☐ Pain (new or worsened)
- ☐ Other (specify) ______________

NEW SYMPTOM(S)/SIGNS OF:
- ☐ Altered mental status
- ☐ Congestive heart failure
- ☐ Dehydration
- ☐ Fever
- ☐ Lower respiratory infection
- ☐ Urinary tract infection

OTHER CHANGE:
- ☐ Abnormal lab value(s)
- ☐ Abnormal vital signs
- ☐ Family concern
- ☐ Other (specify) ______________

b. Briefly describe the symptom, sign or change in condition that led to the transfer:

____

____

____

____

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Section 3: EVALUATION AND MANAGEMENT

a. **Check *all* that apply:**

TOOLS USED:
- ☐ Stop and Watch
- ☐ SBAR Progress Note
- ☐ Care Path
- ☐ Change in Condition Cards

MEDICAL EVALUATION:
- ☐ Telephone only
- ☐ On-site visit - MD
- ☐ On-site visit - NP or PA

TESTING:
- ☐ Blood tests
- ☐ Urinalysis or culture
- ☐ Xray
- ☐ Other (specify)

INTERVENTIONS:
- ☐ New medication
- ☐ IV or SC fluids
- ☐ Other (specify)

b. Briefly describe how the symptoms, signs, or change was evaluated and managed before hospital transfer:

____

____

c. Was advanced care planning (e.g. DNR, DNH, palliative or hospice care) discussed? ☐ No ☐ Yes

d. Was the resident transferred to the hospital? ☐ No **(skip to Section 5)** ☐ Yes **(complete Sections 4 and 5)**

Section 4: TRANSFER INFORMATION

Date of transfer: ______/______/______ Day (circle): M T W Th F Sa Sn Time of transfer: _____:_____ a.m./p.m.

MD authorizing transfer: ☐ Primary MD ☐ Covering MD ☐ Other (______________________)

a. What contributed to the transfer? **(Check *all* that apply):**

- ☐ Abnormal vital signs
- ☐ Abnormal lab(s)
- ☐ Injury
- ☐ Worsening condition despite intervention
- ☐ MD insisted on transfer
- ☐ Resident preference or insistence
- ☐ Family preference or insistence
- ☐ Other (specify)

b. Briefly describe the main reason(s) for transfer:

____

____

Section 5: OPPORTUNITIES FOR IMPROVEMENT

a. After review of how the new symptoms, signs, or other change were evaluated and managed, has your team identified any opportunities for improvement? ☐ No ☐ Yes **If yes, describe briefly**

____

____

____

b. In retrospect, does your team think this transfer might have been prevented?

☐ No ☐ Yes **If yes, check all that apply and describe briefly**

- ☐ The new sign, symptom, or other change might have been detected earlier
- ☐ The condition might have been managed safely in the facility without transfer
- ☐ Advance directives and/or palliative or hospice care could have been discussed
- ☐ Other (specify)

____

____

____

____ ______/______/______

Name of person completing form **Date of completion**

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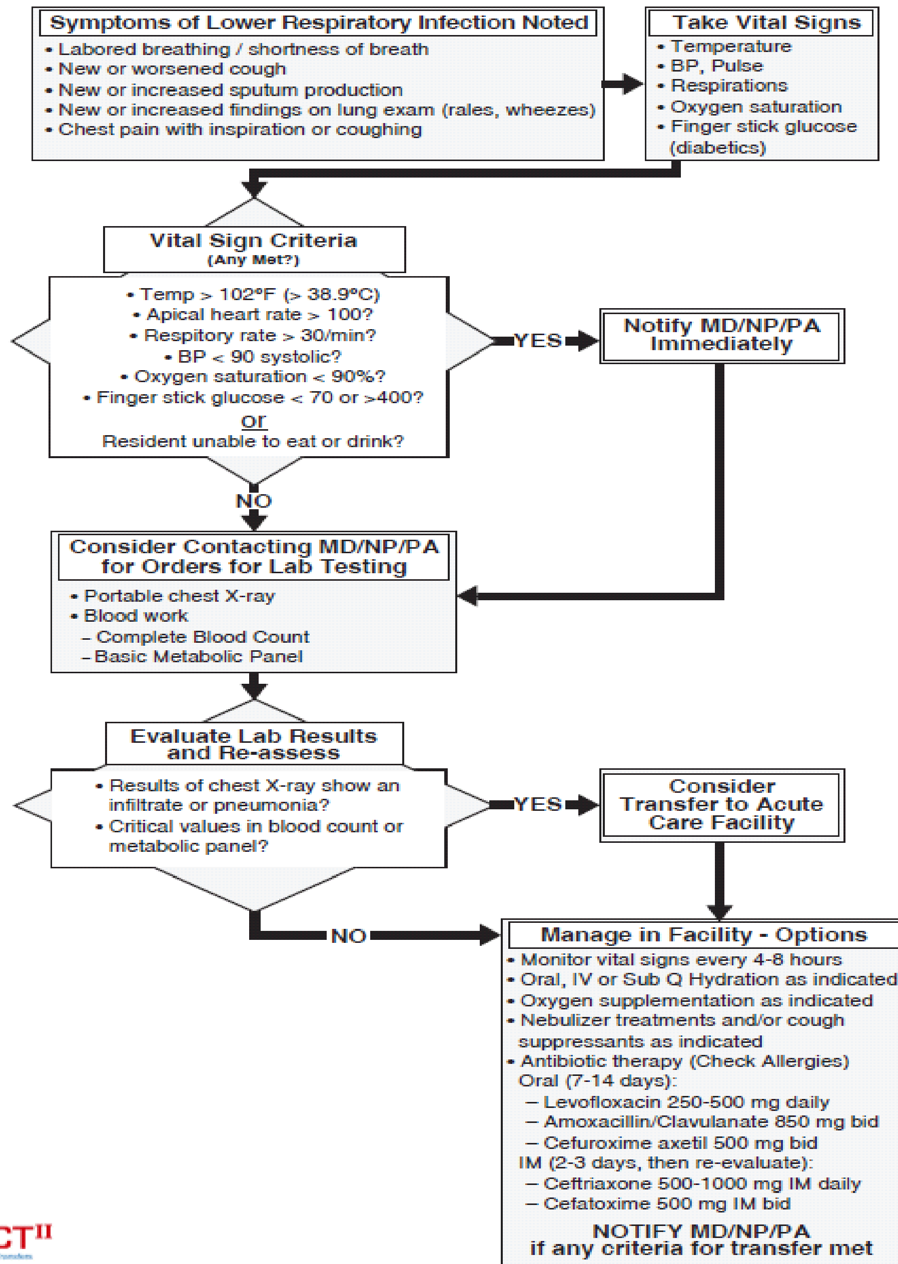
"My initial determination was based on the fact that ….if the patient was admitted….I automatically felt is was unavoidable…..but I've had a culture change with my thought process"…



- Fever
- Mental Status Change
- Dehydration
- UTI
- CHF

Advance Care Planning Tools

Identifying Residents to Consider for Palliative Care and Hospice	Pocket Card
Advance Care Planning Communication Guide	File Cards
Comfort Care Order Set	File Cards
Educational Information for Families	Reprints

ADVANCE CARE PLANNING TRACKING FORM

RESIDENT NAME: ____

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans.

The purpose of this form is to provide a tool to document that these discussions are taking place. Improving advance care planning is a now a goal of the ***Advancing Excellence in America's Nursing Homes Campaign.*** This form has been adapted from the campaign's website: http://www.nhqualitycampaign.org/files/impguides/6_AdvanceCarePlanning_TAW_Guide.pdf

AT ADMISSION (within about a week of admission or readmission)

Check one of the following:

☐ Resident and/or responsible party do NOT want to have this discussion

☐ Discussion about advance care planning held with (check one or both of the following):

____ Resident

____ Resident's surrogate; name: ________________________

Staff or healthcare provider completing this form:

______________________________ ______________________

Name Title

Signature: ____

Date of Discussion: ______/_____/_____

Location of Advance Care Plan documentation (i.e., medical record, plan of care, progress notes):

____

Use Continuation Pages to document additional Advance Care Planning Reviews and Discussions

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Lessons Learned About Implementation

Lessons Learned: Getting Started

- Leadership “buy in” is important
- “This is great…we would love to do this at our facility”

Remember…

The frontlines are where it happens

The Champion

- "I still think there is incredible value to this project and am going to keep working very hard on it"
- "I tell the staff to go out onto the units and look for transfers waiting to happen"
- "I'm seeing it happen…walking on the units and seeing the nurses using the SBAR…it's great."

"I am going to elicit an alliance'

Champion Responsibilities

- Work on buy-in from key people
- Think about finding a partner/team of your own
- Think about the off shift
- Develop plan for training staff

Getting Started: Training Sessions

- 1/2 to ¾ day at each site
- Met with key staff for 30-45 min each
  - Administrator/DON/Medical Director/Dept heads
  - Nursing staff
  - CNA staff
  - Social Workers
  - Rehab staff
  - NPs when available

Feedback on the training

- Team approach from the beginning
- Consider involving the medical director
- Frequent repeats
- Small groups
- 1:1
- "It's about more than just the tools"

Getting Started: The Acute Care Connection

- More receptive with discussions about Accountable Care Organizations and Payment Reform
- Compliments Disease Management initiatives
- Who is the right person to contact?
- STAAR Initiative www.ihi.org

Relationships Matter

- “Our NP told me she couldn’t believe how much the nursing assessments have improved since we started this”
- Ambulance Drivers
- Vendors
- Home Care
- Resident Family Councils
- “It’s all about teamwork”

Lessons Learned

- It can be done
- Allow 3 months to get started
- Anticipate questions
- Promote as integrated set of tools
- Anticipate enthusiasm
- Be ready for refining and critical thinking at 12-18 months
  - Ex. Cross Continuum Team →
  - Transfer Form →
  - Post Acute Checklist

Implementation Strategies Think About

- "Starting with SBAR on the subacute unit"
- "I think the majority of staff are missing early warning signs. It is not a matter of not using Stop and Watch but overall warning signs that are small are missed. What we recognize is the huge LEAP from warning to…
  probably gone too far… and now can not do appropriate interventions and work up in facility…. thus off they go"

Implementation Strategies Think About

- SBAR serves as progress note
- Resident Transfer Form: Take the old ones off the unit
- "Our transfer form was almost exactly like this one so we kept it"

Implementation Strategies
Think About

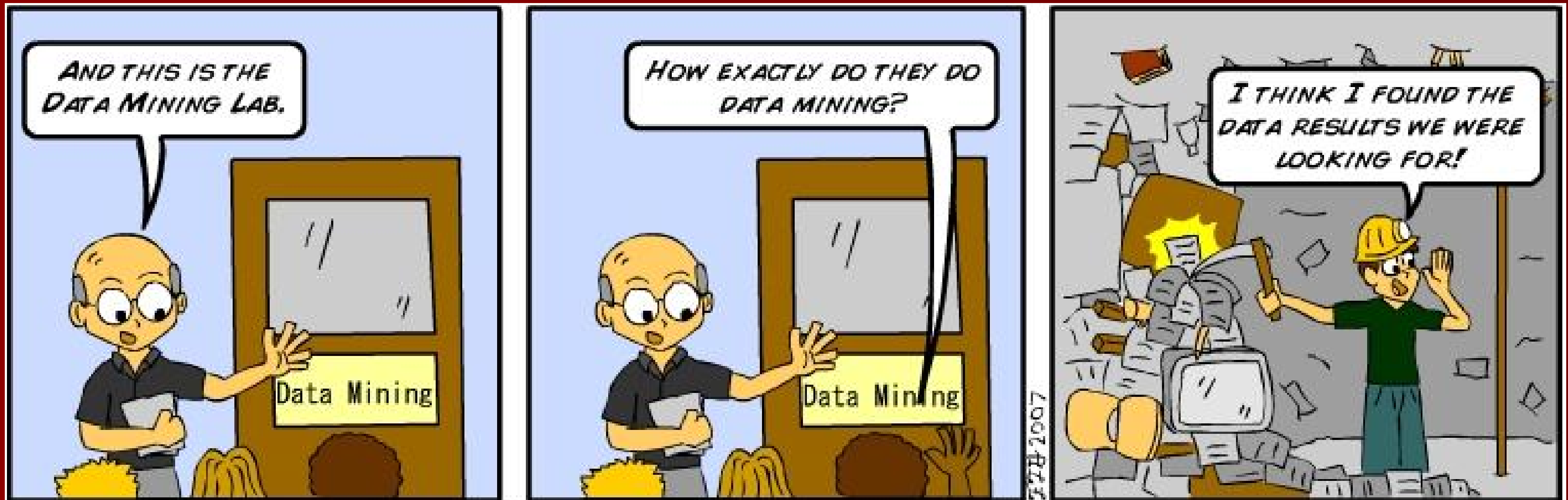
Physician Orders
for Life-Sustaining Treatment (POLST)

THE AMERICAN JOURNAL of MEDICINE®

Randomized Trial of a Warfarin Communication Protocol for Nursing Homes: an SBAR-based Approach

Field, T., et al
Volume 124, Issue 2, February 2011

Implementation Strategies
Think About



ACUTE CARE TRANSFER LOG

Facility Name ______________________________ Month/Year ________/________

Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

*Hosp = Hospital
H = Home
O = Other

* S = Skilled (Medicare Part A)
LT = Long-term (Medicaid, private pay)
O = Other (e.g. managed care)

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Customizing the program

- Newsletter
- Grand Rounds
- Morbidity and Mortality Rounds
- NCR paper for Transfer Forms
- Tools part of new hire orientation
- Scratch cards, free lunch
- "Its about more than just the tools. It's about culture and how you do business"

Thank You!