Implementing the INTERACT II Toolkit

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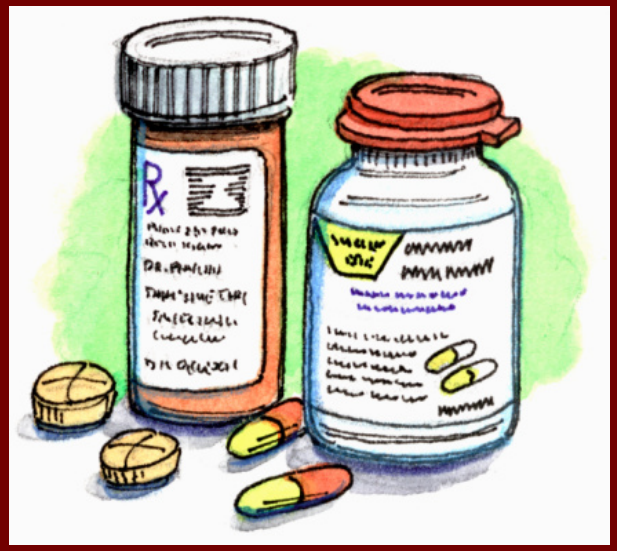
Goals for this session

- Describe the key components of the INTERACT II toolkit
- Share lessons learned and implementation strategies from work to date with INTERACT toolkit

Why It Matters



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

Purpose of the Toolkit

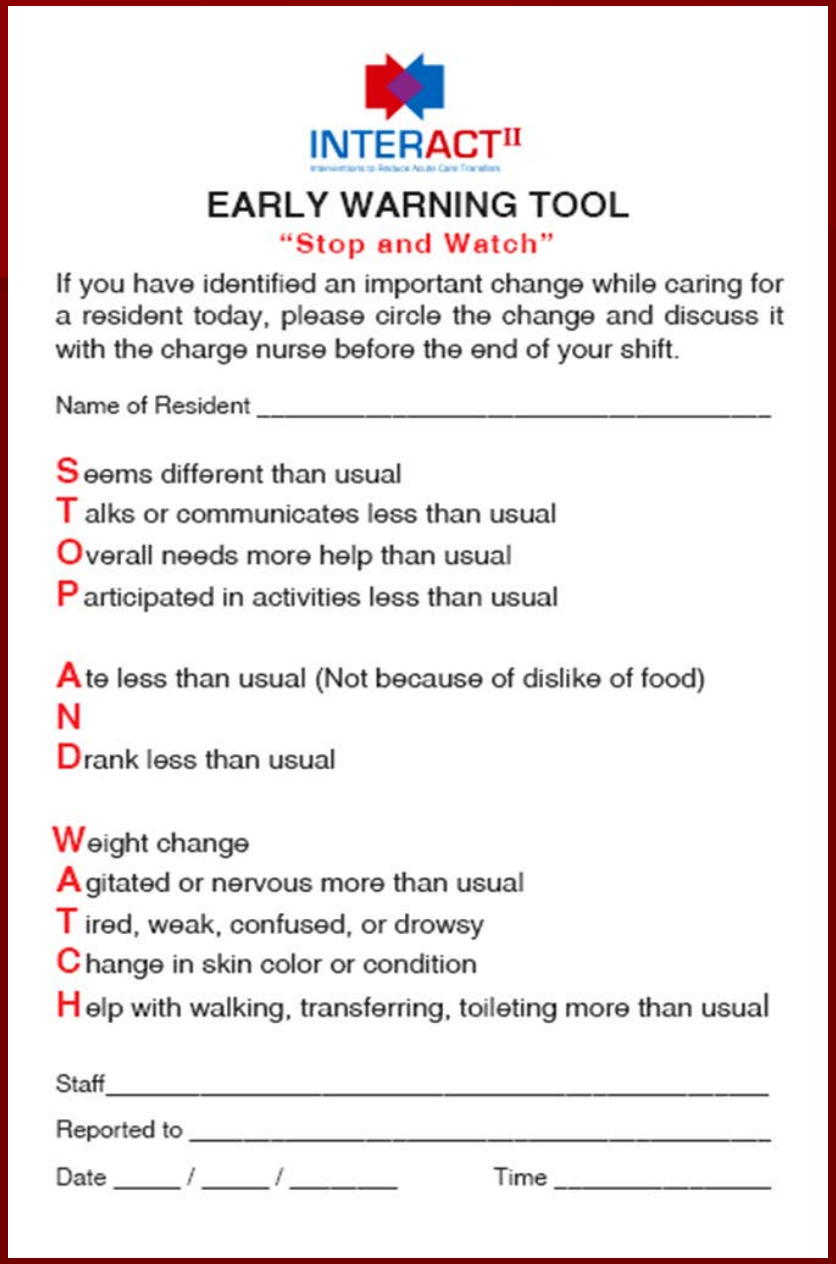
- Dr. Ouslander “Simple Test”
- Feasible and efficient
- Part of the “way we do business”

“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)

Communication Tools

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



INTERACT II

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

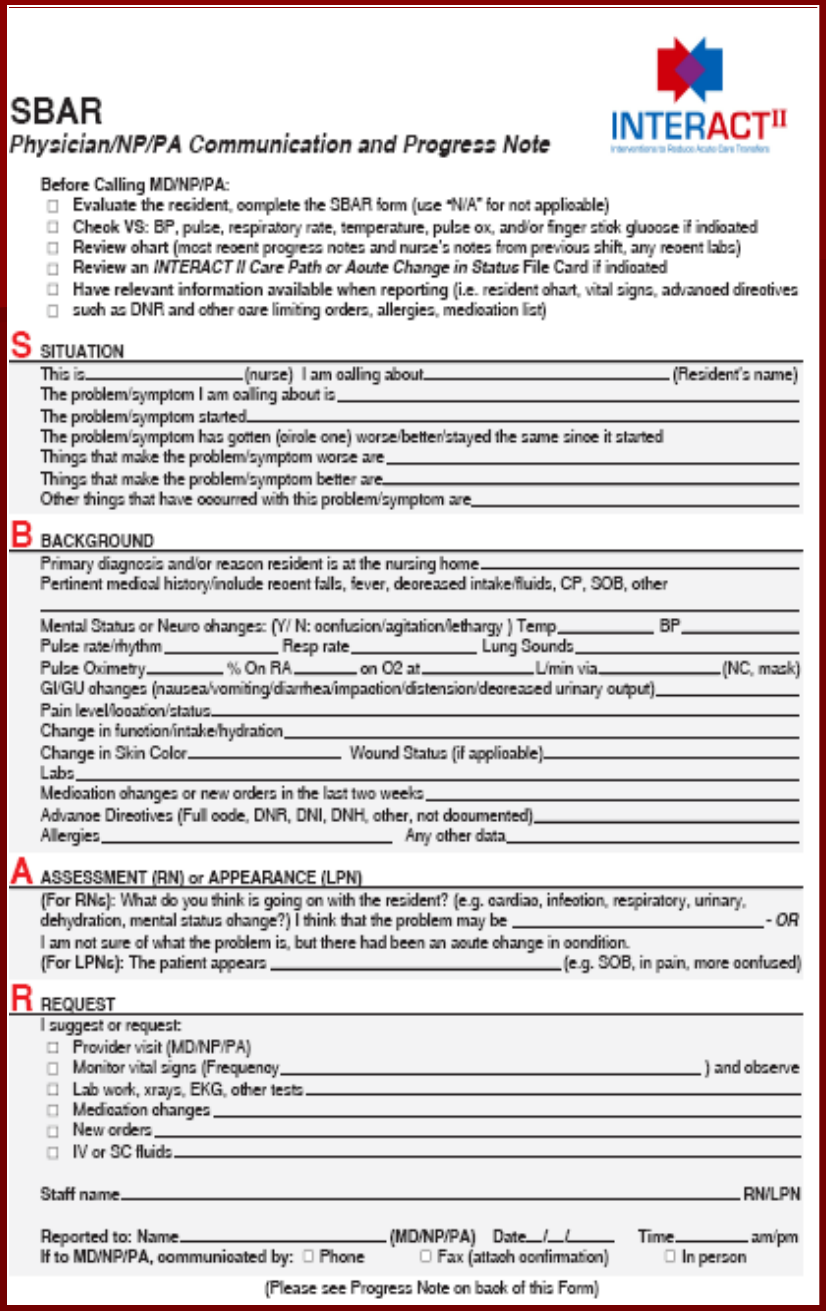
Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Staff_____

Reported to _____

Date _____ / _____ / _____ Time _____

- Who should use it/where to keep it
- Different languages
- Limited response
- Formatting ideas
- Implementation ideas



SBAR

Physician/NP/PA Communication and Progress Note

INTERACT II

Before Calling MD/NP/PA:

- ☐ Evaluate the resident, 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 (most recent progress notes and nurse's notes from previous shift, any recent labs)
- ☐ Review an *INTERACT II Care Path or Acute Change in Status* File Card if indicated
- ☐ 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

This is _____ (nurse) I am calling about _____ (Resident's name)
The problem/symptom I am calling about is _____
The problem/symptom started _____
The problem/symptom has gotten (circle one) worse/better/stayed the same since it started
Things that make the problem/symptom worse are _____
Things that make the problem/symptom better are _____
Other things that have occurred with this problem/symptom are _____

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____
Pertinent medical history/include recent falls, fever, decreased intake/fluids, CP, SOB, other
_____
Mental Status or Neuro changes: (Y/ N: confusion/agitation/lethargy) Temp _____ BP _____
Pulse rate/rhythm _____ Resp rate _____ Lung Sounds _____
Pulse Oximetry _____ % On RA _____ on O2 at _____ L/min via _____ (NC, mask)
GI/GU changes (nausea/vomiting/diarrhea/impaction/distension/decreased urinary output) _____
Pain level/location/status _____
Change in function/intake/hydration _____
Change in Skin Color _____ Wound Status (if applicable) _____
Labs _____
Medication changes or new orders in the last two weeks _____
Advance Directives (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 patient appears _____ (e.g. SOB, in pain, more confused)

R REQUEST

I suggest or request:

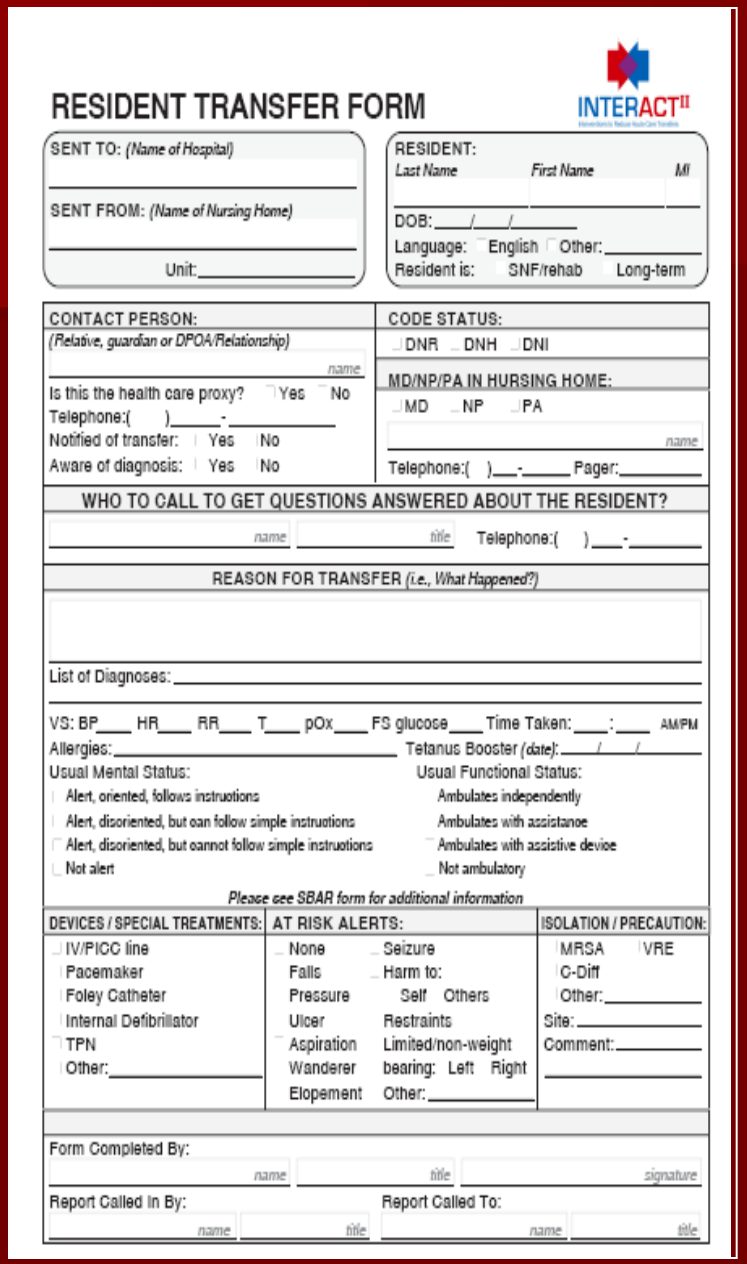
- ☐ Provider visit (MD/NP/PA)
- ☐ Monitor vital signs (Frequency _____) and observe
- ☐ Lab work, xrays, EKG, other tests _____
- ☐ Medication changes _____
- ☐ New orders _____
- ☐ IV or SC fluids _____

Staff name _____ RN/LPN

Reported to: Name _____ (MD/NP/PA) Date __/__/____ Time _____ am/pm
If to MD/NP/PA, communicated by: ☐ Phone ☐ Fax (attach confirmation) ☐ In person

(Please see Progress Note on back of this Form)

- "We use it for EVERYTHING"
- "Staff are really learning, gathering tools necessary to communicate with the physician"
- "Organize Your Thoughts Form"
- Easy to recognize change in condition
- Can identify "near misses"



RESIDENT TRANSFER FORM

INTERACT II

SENT TO: *(Name of Hospital)*

SENT FROM: *(Name of Nursing Home)*

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

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:

Form Completed By:

name *title* *signature*

Report Called In By:

name *title*

Report Called To:

name *title*

- "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
- By the end, heard very little on the calls

INTERACT II

Interventions to Reduce Acute Care Transfers

ACUTE CARE TRANSFER DOCUMENT CHECKLIST

RESIDENT NAME _____

COPIES SENT WITH RESIDENT (Check all that apply):

These documents should ALWAYS accompany patient:

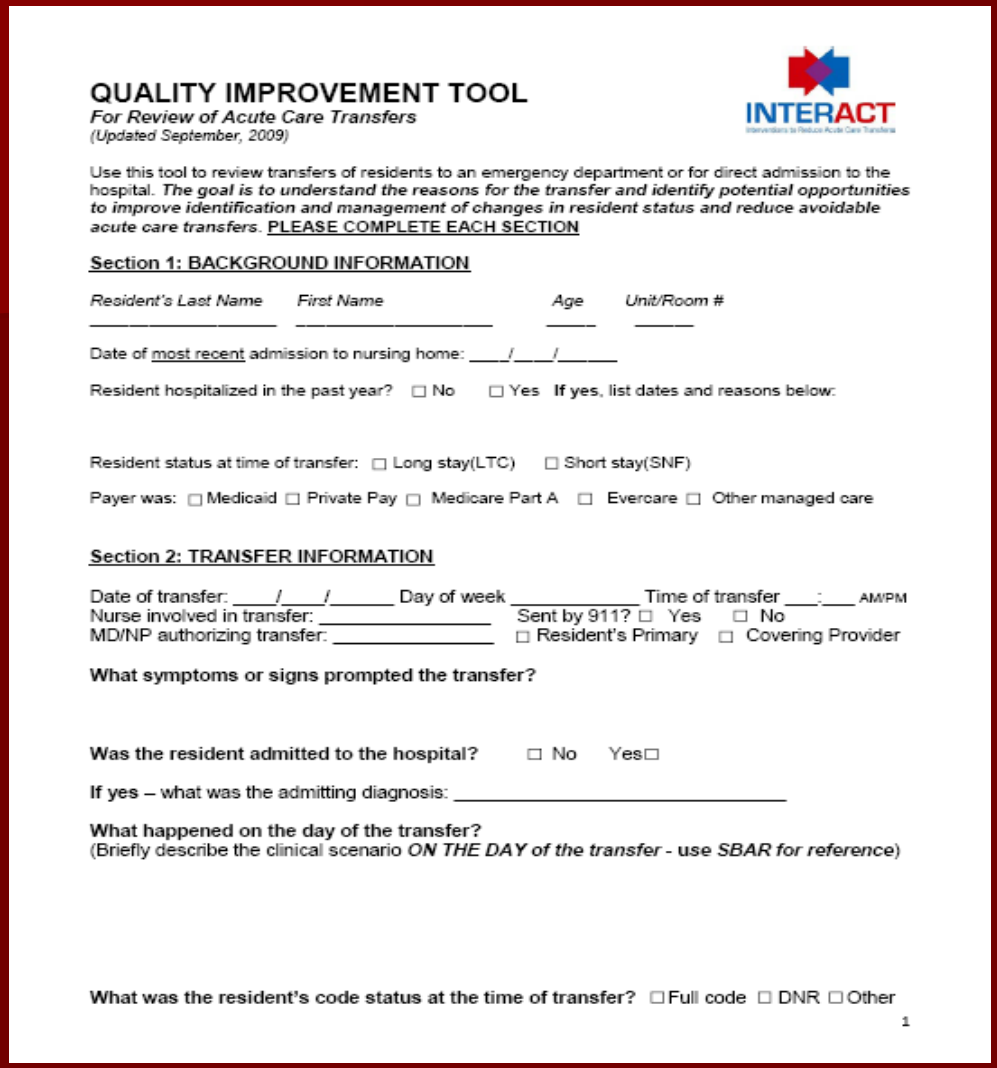
____ Resident Transfer Form
____ Face Sheet
____ Current Medication List or Current MAR
____ Advance Directives
____ Care limiting Orders
____ Out of hospital DNR
____ Bed hold policy

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

For Review of Acute Care Transfers
(Updated September, 2009)

INTERACT

Use this tool to review transfers of residents to an emergency department or for direct admission to the hospital. ***The goal is to understand the reasons for the transfer and identify potential opportunities to improve identification and management of changes in resident status and reduce avoidable acute care transfers.*** **PLEASE COMPLETE EACH SECTION**

Section 1: BACKGROUND INFORMATION

Resident's Last Name _____ *First Name* _____ *Age* ____ *Unit/Room #* ____

Date of most recent admission to nursing home: ____/____/_____

Resident hospitalized in the past year? ☐ No ☐ Yes **If yes**, list dates and reasons below:

Resident status at time of transfer: ☐ Long stay(LTC) ☐ Short stay(SNF)

Payer was: ☐ Medicaid ☐ Private Pay ☐ Medicare Part A ☐ Evercare ☐ Other managed care

Section 2: TRANSFER INFORMATION

Date of transfer: ____/____/_____ Day of week _____ Time of transfer ___:___ AM/PM
Nurse involved in transfer: _____ Sent by 911? ☐ Yes ☐ No
MD/NP authorizing transfer: _____ ☐ Resident's Primary ☐ Covering Provider

What symptoms or signs prompted the transfer?

Was the resident admitted to the hospital? ☐ No Yes☐

If yes – what was the admitting diagnosis: _____

What happened on the day of the transfer?
(Briefly describe the clinical scenario ***ON THE DAY of the transfer*** - use ***SBAR for reference***)

What was the resident's code status at the time of transfer? ☐Full code ☐ DNR ☐Other

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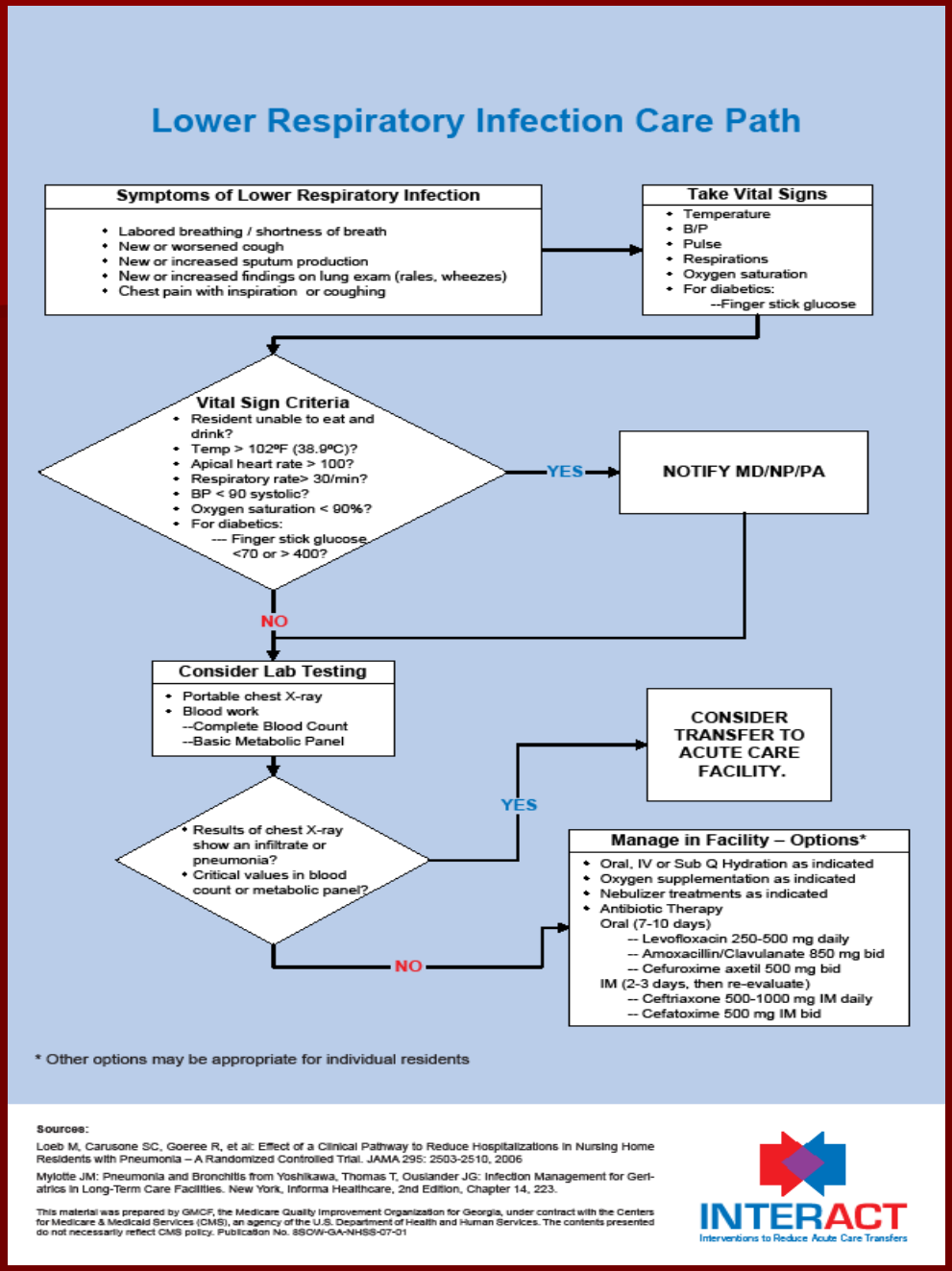
"My initial determination was based on the fact that ….if the patient was admitted….I automatically felt is was unavoidable…..but I've had a culture change with my thought process"…



- 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

Lessons so far....

- Leadership “buy in” is important
- “This is great…we would love to do this at our facility”
- Morning meeting
- Quarterly QI Agenda item
- Morning RN report

But...

The frontlines are where it happens

The Champion is key

- “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 am going to elicit an alliance”
- “I’m seeing it happen…walking on the units and seeing the nurses using the SBAR…it’s great.”

Training: What we did

- 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

Training: What we did

- Champion able to observe both teaching strategies and content several times
- Champion introduced and endorsed by project team
- Champion then finished up with staff who missed initial training session

Relationships matter: Who to include in your training sessions

- “Our NP told me she couldn’t believe how much the nursing assessments have improved since we started this”
- “Does the ED staff know about this project? They keep calling to ask about the forms.”
- Involving the medical director
- “It’s all about teamwork”

Feedback on the training

- Team approach from the beginning
- Frequent repeats
- Small groups
- 1:1
- “It’s about more than just the tools”

Implementation Strategies Think About

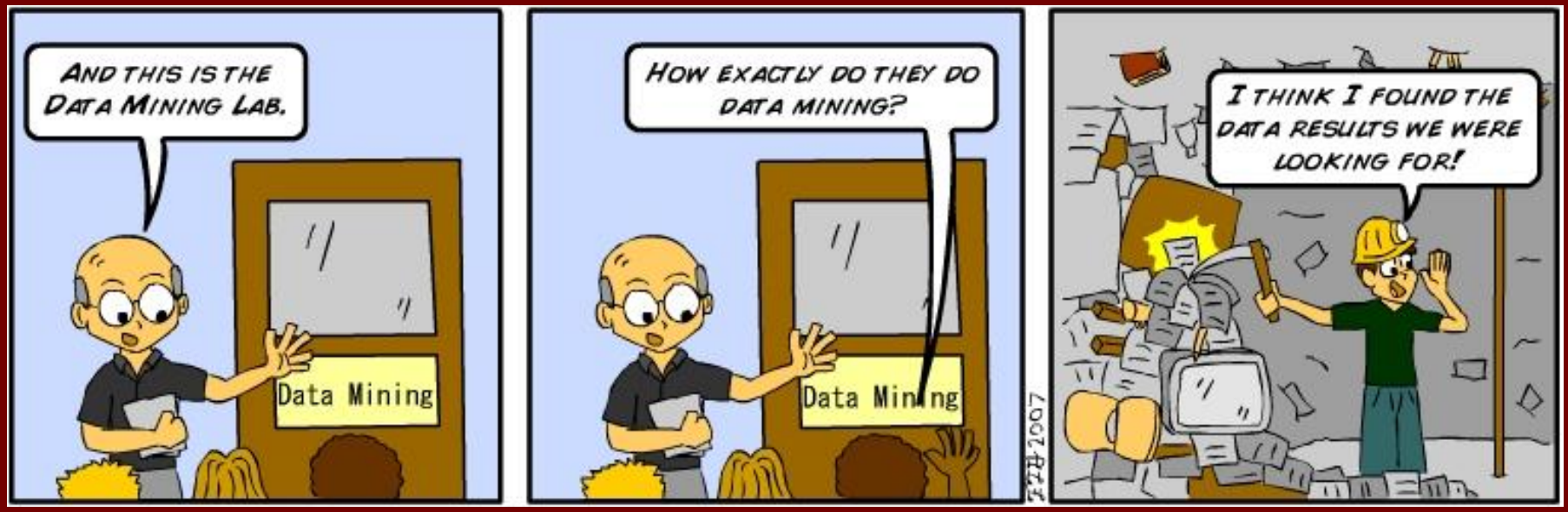
- “Starting with SBAR on the subacute unit”
- ”I think the majority of staff are missing early warning signs. It is not a matter of not using Stop and Watch but overall warning signs that are small are missed. What we recognize is the huge LEAP from warning to... probably gone too far... and now can 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

Implementation Strategies Think About



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”

Staying on Track: Have a Plan

1. I encourage myself and managers to remind nurses and aides every day every shift to report: Is anyone different today? Anyone not themselves? Everyone eating OK today? Anyone not wanting to go to activities or Hairdresser? Anyone different in transfer? (Pretty much what is on Stop and Watch)

   If yes to any, encourage SBAR. (I get a copy of each SBAR)

2. I am going to provide education on three Care Maps:
   - FEVER
   - UTI
   - LOWER RESPIRATORY INFECTION

3. Will try to get staff to think of symptoms earlier and maybe we can treat at facility. Will include aides in this education. Will be done by SDC in combination with managers and supervisors.
   Incentive program not effective More education will be helpful.

   It is hoped that staff will get more education and then be proud of the resident we successfully treated at facility and prevented trip to ER. I am going to mention daily on my rounds how much I want to REDUCE Acute Care Hospitalizations.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ANDREW

- Blue Cross/Blue Shield of MA
- DPH
- Accountable Care Organizations

Why It Matters

Thank You!