INTERACT: Interventions to Reduce Acute Care Transfers

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Objectives

1. Identify the purpose and goals for the various components of INTERACT.

2. Describe how INTERACT tools are integrated into care processes within and across organizations.

3. Restate how your organization can reduce admissions and readmissions by using INTERACT.
• Non-profit health quality consulting company
• Currently CMS Quality Innovation Network- Quality Improvement Organization for MD & VA
• Practice Transformation Network for Virginia
• Health IT Regional Extension Center for Virginia
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Maryland & Virginia
Quality Innovation Network

VHQCN

Patient Safety
Center
VHQC’s Care Transitions Project

Approach and Goals

• Engaging communities of clinical and local service/support partners

• Improve care for Medicare beneficiaries
  • Reduce 30-day re-hospitalizations by 20%
  • Reduce overall hospitalizations by 20%
  • Increase # of nights beneficiaries spend at “home” by 10%
  • Reduce adverse drug events (ADEs) by 35%
  • Effective community interventions >60%

• Build community capacity to qualify for formal program or grant funding

• Spread successful care transitions interventions (such as INTERACT)
Care Transitions Opportunities

- Early Identification of Changes
- Communication
- Advance Care Planning
- Data Collection
- Quality Improvement Process
What is INTERACT?

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

What is the purpose of INTERACT?

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.
• The INTERACT Program and Tools were initially developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare & Medicaid Services (CMS).

• The current versions of the INTERACT Program were developed by an interdisciplinary team under the leadership of Dr. Joseph G. Ouslander, M.D. with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU).

• Support for the further development, refinement, evaluation, and dissemination of the INTERACT Program for nursing homes has been provided by The Commonwealth Fund, the National Institutes of Health's National Institute for Nursing Research, CMS, the Retirement Research Foundation, PointClickCare (Westcom), and Medline Industries. Support for the development and testing of the INTERACT Program for assisted living and home health has been provided by a CMS Innovation Award.

• The INTERACT™ trademark is registered with the US Patent and Trademark Office by FAU and the INTERACT Program materials are copyrighted by FAU. These materials are provided for free and we welcome their use in clinical care.
INTERACT is an acronym for "Interventions to Reduce Acute Care Transfers".

“A quality improvement program designed to improve the identification, evaluation, and communication about changes in resident status.”

It includes clinical and educational tools and strategies for use in everyday practice in long-term care settings, assisted living facilities and home health agencies.
The overall goal of INTERACT “is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital.”
What are the Tools?

Four Basic Types

- Communication Tools
- Decision Support Tools
- Advanced Care Planning Tools
- Quality Improvement Tools
Communication Tools

• For Communication within the Nursing Home
  – Stop and Watch Early Warning Tool
  – SBAR Communication Form
  – Medication Reconciliation Worksheet (post hospital)

• For Communication between NH & Hospital
  – Capabilities List
  – Transfer Form (NH to H & H to NH)
  – Data List (NH to H & H to NH)
Decision Support Tools

• Acute Change in Condition File Cards
• Care Paths
  – Acute Mental Status Change
  – Change in Behavior – new or worse symptoms
  – Dehydration
  – Fever
  – GI Symptoms
  – Shortness of Breath
  – Symptoms of CHF
  – Symptoms of Lower Respiratory Illness
  – Symptoms of UTI
  – Fall
Quality Improvement Tools

• Tracking Hospitalization Rates
  – Acute Transfer Log Worksheet
  – Hospitalization Rate Tracking Tool – Excel Template

• Quality Improvement Reviews – RCA
  – QI Tool for Review of Acute Care Transfers
  – QI Summary Worksheet
Advance Care Planning Tools

• Advance Care Planning Tracking Tool
• Communication Guide
• Comfort Order Set
• Resources for residents & families & staff
  – Deciding about going to the hospital
  – Identifying those who may be appropriate for hospice or palliative care
• Education
  – CPR
  – Tube Feeding

This material was prepared by VHQC, the Medicare Quality Innovation Network Quality Improvement Organization for Maryland and Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. VHQC/C.3.CT/2/5/2016/2377
Improving the Transition between Acute and Sub-Acute Care Utilizing INTERACT®

A Joint Presentation by the Charles E. Smith Life Communities and Suburban Hospital/Johns Hopkins Medicine
The Charles E. Smith Life Communities
Who are we?
Suburban Hospital/Johns Hopkins Medicine
Who are we?
Suburban Hospital/Johns Hopkins Medicine

• Founded in 1943
• 236-bed acute care hospital located in Bethesda, MD
• Patient population resides principally in Montgomery County, MD, and Northwest Washington, DC
• 13,861 admissions (FY 2015)
• 44,275 emergency visits
• 1,438 trauma visits

Staff includes approximately 1,800 full and part time (PRN) employees & >900 credentialed medical staff
SNF/NH Collaboration Historical Perspective

• **2005** the Nursing Home Collaborative was established by Suburban Hospital and included multiple nursing facilities. It was originally initiated out of the Medicine and Family Practice QA Committee as a way to better coordinate the care between facilities. It was a large and productive group as long as common concerns were addressed.

• **2010** Healthcare focus began changing with a focus on readmissions and care coordination. The meeting was transferred to Director of Care Coordination, 2010 to develop inter-facility groups focusing on readmissions.

• **2011** Collaborative effort initiated with Hebrew Home from the Charles E Smith Life Community to address readmissions and build more collaborative relationships between the physicians in both entities.
Getting to “Yes”
Readmissions become a Priority

This project was a collaboration between two unrelated organizations, each offering different levels of care.

Regular meetings between the two organizations initially started in January 2011.

Both organizations brought their own perspectives and priorities to the table.

Reduction of Readmissions was identified as a priority.

Critical stakeholders were identified and an effective choice was made with respect to staff from each organization to focus on Readmissions work.
Suburban Hospital and Hebrew Home Transition Team

Suburban Hospital:
Jackie Schultz, COO
Bob Rothstein, MD, Medical Director
Norma Bent, Corporate Director,
Care Coordination
Don Silver, Corporate Director
Behavioral Health Services
Barbara Jacobs, DON
Cathy Clark, Transition Guide Nurse
Margie Hackett, Transition Guide Nurse

Hebrew Home:
Pat Carter, COO
Barbara Hirsch, VP, Quality and Compliance
Elisa Gil-Pires, MD, Medical Director
Neal White, Administrator
Linda Rader, DON
Two areas of focus for readmissions:
(1) Heart Failure and (2) Sepsis
The Nursing Home/Subacute Perspective
Turn it into a QAPI Performance Improvement Plan(!)

Goal:
• To design an evidence-based CHF Clinical Pathway that will be utilized by the interdisciplinary team.

Desired Outcome:
• Readmissions and unplanned transfers to hospital as the result of heart failure will not occur.

Results to date:
• Discharge summaries from hospital faxed to DON/Admissions
• Daily Weight protocol established at Hebrew Home
• PI Managers reviewing lung auscultation with licensed staff on sub-acute units
• “Sam the Man” – Simulation Auscultation Mannikin sessions with licensed nurses
• Currently reviewing patient education used by local hospitals for this population.

Next Steps:
• Continue daily weights and address weight gains
• Finalize dietary regimen
• Finalize fluid management protocols
• Finalize CHF education materials
• Consider therapy component
• Follow-up meeting with Suburban/Johns Hopkins
INTERACT®

INTERACT (Interventions to Reduce Acute Care Transfers)

✓ a quality improvement program
✓ focuses on the management of acute change in resident condition
✓ includes clinical and educational tools and strategies for use in every day practice in long-term care
INTERACT® TOOLS

• STOP AND WATCH for GNAs
• Evaluation algorithms for nursing (fever; mental status change; sx of Lower Respiratory Infection, dehydration, CHF & UTI
• Change in Condition – when to notify the MD/NP
• SBAR communication format for MD/NP conversation
• Transfer log
• Transfer Assessment form
• Transfer envelope checklist
• End-of-life discussion materials
Heart Failure Readmission Initiative: How to Incorporate INTERACT®

**1. Thorough Hand-off between hospital and Sub-acute**
- Thorough hand-off between hospital and sub-acute care.
- Adequate clinical skill set in sub-acute staff.

**2. Sub-acute Protocols in place comparable to hospital**
- Robust patient education and discharge planning from sub-acute.
- Critical thinking and assessment skills.

**3. STOP AND WATCH**
- Daily weights
- Weight gain follow-up
- Fluid restriction
- Low Na diet
- Medications follow-up appointments
- Daily weights

**4. END OF LIFE DISCUSSION**
- What can SNF handle?
- D/C summary communicated before transfer?
- End of life discussion

**Capabilities**
- Daily weights
- End of life discussion
- Critical thinking and assessment skills
- Medications follow-up appointments
- Daily weights
Use the INTERACT® CHF Care Path
INTERACT® CHF Care Path: Monitoring Daily Weights
Recognizing Care Path “Signs & Symptoms”

Learning to listen with “Sam the Man”
Use the INTERACT® STOP AND WATCH Tool

Stop and Watch Early Warning Tool

If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less

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

☐ Check here if no change noted while monitoring high risk patient

Patient/Resident

Your Name

Reported to Date and Time (am/pm)

Nurse Response Date and Time (am/pm)

Nurse’s Name

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STOP AND WATCH

Not just for Geriatric Nurses’ Aides!

Include the entire team in education:

✓ Licensed nurses
✓ Medical staff
✓ Housekeeping staff
✓ Admissions department
✓ Social Workers
✓ Activities
✓ Dietary
✓ Family Members
<table>
<thead>
<tr>
<th>STOP and WATCH</th>
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<tr>
<td><strong>Stop and Watch</strong></td>
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<td><strong>Early Warning Tool</strong></td>
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<td>Seems different than usual</td>
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<tr>
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<tr>
<td>Weight change</td>
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<tr>
<td>Agitated or nervous more than usual</td>
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<tr>
<td>Tired, weak, confused, or drowsy</td>
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<tr>
<td>Change in skin color or condition</td>
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<tr>
<td>Help with walking, transferring, toileting more than usual</td>
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</tbody>
</table>
STOP AND WATCH in Practice

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; participated less in activities

Ate less
No bowel movement in 3 days; or diarrhea
Drank less

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
Use the INTERACT® SBAR Tool
SBAR is an Acronym

Situation
- Concise statement of the problem
- *What is happening now?*

Background
- Brief and pertinent information related to the situation
- *What had happened?*

Assessment
- Analysis and consideration of options
- *What do you see or think is going on?*

Recommendation
- Suggest/recommend action
- *What do you want to happen?*
What Goes Wrong?

• **CONCERN** was expressed - BUT
• The **PROBLEM** was not stated clearly
• A **DECISION** was not reached
• And the needed **ACTION** didn’t happen
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<thead>
<tr>
<th>S</th>
<th><strong>Situation</strong></th>
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<td>A concise statement of the problem</td>
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<tr>
<td>B</td>
<td><strong>Background</strong></td>
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<tr>
<td></td>
<td>Pertinent and brief information related to the problem</td>
</tr>
<tr>
<td>A</td>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td></td>
<td>What you found out – e.g. vital signs, other data</td>
</tr>
<tr>
<td>R</td>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td></td>
<td>Action requested/recommended – what you want/need</td>
</tr>
</tbody>
</table>
Hi Dr. Benson. I am calling about Senta Goldberg. She is having some shortness of breath. Her ankles are a bit more swollen this morning.

You know her – she was admitted 4 days ago post hip replacement.

She is afebrile but her respiratory rate is 26. Her lungs were clear earlier but now I hear some rales. And, her weight is up this morning – she gained 2 pounds from yesterday.

I need you to come see her. I think this might be her CHF.
The Hospital Perspective
Suburban’s Bundle of Strategies to Prevent Readmissions

- Early Risk Screening
- Interdisciplinary Care Planning
- Patient and Family Education
- Medication Management
- Primary Provider Handoff
- ED Workgroup
- Transitions of Care
Suburban’s Bundle of Strategies to Prevent Readmissions

• Early Risk Screening
  – Need to identify those at high risk
  – Early Screen for Discharge Planning Tool
Suburban’s Bundle of Strategies to Prevent Readmissions

• Interdisciplinary Care Planning
  – Daily Rounds
  – DON from CESLC attended hospital rounds
  – Hospital input on INTERACT pathways
Suburban’s Bundle of Strategies to Prevent Readmissions

• Patient and Family Education
  – Coordination of education materials
  – Get Well Kit shared with CESLC
Suburban’s Bundle of Strategies to Prevent Readmissions

• Medication Management
  – Medication reconciliation at discharge by hospital pharmacist (Cardinal Grant)
  – Pain Management at discharge
  – C2-C5 medications
  – Transition Guide RNs utilized INTERACT® Medication Reconciliation Worksheet for Post Hospital Care
Suburban’s Bundle of Strategies to Prevent Readmissions

• Primary Provider Handoff
  – Hospitalists visited Hebrew Home
  – Nursing Homes Capabilities List
  – CESLC/SH physician collaboration
  – Access to hospital EMR
Suburban’s Bundle of Strategies to Prevent Readmissions

• ED Work Group
  – CESLC can call to discuss need for transport
  – INTERACT® Transfer Form
  – Return vs Admit
  – Nursing Homes Capabilities List
Suburban’s Bundle of Strategies to Prevent Readmissions

- Transitions of Care
  - Real time exchange of information when patient readmitted
  - Warm handoff hospital RN to SNF RN
  - Hospital Educators assistance
  - Quarterly clinical case reviews with clinical teams from each entities
- Palliative Care
- Transition Guide Nurses available for follow up with high risk patients after SNF discharge <30 days from hospital discharge
INTERACT Use at Suburban (NH Capabilities List)

## Nursing Home Capabilities List

This list is for hospital emergency rooms, hospitals, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

### Facility

<table>
<thead>
<tr>
<th>Address</th>
</tr>
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</table>

### Tel (_____) |

Circle "Y" for yes or "N" for no to indicate the availability of each item in your facility.

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Clinician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility three or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility four or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stat BLD tests with turnaround less than 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stat X-rays with turnaround less than 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>EKG</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bladder Ultrasound</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Venous Doppler</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cardiac Echo</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Jaw/Neck Studies</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Consultations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Wound Care</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other Physician Specialty Consultations</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Social and Psychology Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Social Worker</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Psychological Evaluation and Counseling by a Licensed Clinical Psychologist</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Therapies on Site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Physical</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Speech</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Key Contact</strong></td>
<td></td>
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</tbody>
</table>

### Capabilities

- **Nursing Services**
  - Frequent vital signs (e.g., every 2 hr)
  - Vital signs and output (VO) monitoring
  - Daily weights
  - Accurate assessments of glucose at least every shift
  - INR
  - O2 saturation
  - Nasal cannula treatments
  - Invasive monitoring

- **Interventions**
  - Ntropenic ventilations and monitoring
  - N Antibiotics
  - V Meds – Other (e.g., Antacids)
  - PICC Infection
  - IV: Re-IV: Management
  - Total Parenteral Nutrition (TPN)
  - Isolation (for MSA, VRE, etc.)
  - Surgical drain management
  - Tracheostomy management
  - Nvasive pumps
  - Dialysis
  - Advanced CPR/ACE (capable)
  - Automatic Defibrillator

### Pharmacy Services

- Emergency kit with common medications for acute conditions available
- New medications filled within 2 hours
- Other Specialized Services (specify)
### INTERACT® Use at Suburban (SBAR)

#### SBAR Communication Form and Progress Note

**Before Calling MD / NP / PA:**
- Evaluate the Resident: Complete relevant aspects of the SBAR form below.
- Check Meds: Old meds, allergy status, interactions, ionization, electrolytes, and fluids
- Document: Recent symptoms, vital signs, lab, etc.
- Review Risk: Current risk status, allergies, lab, etc.
- Review an INTERACT Care Plan or Nurse Changes in Condition File Card (if indicated)
- Note Relevant Information Available when Receiving
- (e.g., medical record, previous symptoms, all changes such as lab and/or any other relevant history, allergies, medications list)

#### SITUATION

The changes in condition, symptoms, or signs are called above.

**The changes:**
- Things that make the condition or symptom worse:
  - Things that make the condition or symptom better:

**BACKGROUND**

- Resident Description: This is the resident’s status:
  - Primary diagnosis:
  - Other relevant history (e.g., medical diagnosis of CHF, CHF, COPD)

**Medication Alerts:**

- Changes in last week (when indicated):
- Allergy status:

**Vital Signs:**

- BP, Pulse, Apical Rhythm:
- Temp, Weight, Respiration:
- Systolic, Diastolic, Heart Rate:

#### SBAR Communication Form and Progress Note (contd)

For the next 3 items, complete only those relevant to the change in condition, if the item is not relevant, check “NA” for not applicable.

1. **Mental Status Changes compared to baseline:**
   - Normal:
   - Increased confusion
   - Decreased confusion
   - Worsening behavior

2. **Functional Status Changes compared to baseline:**
   - Normal:
   - Increased mobility
   - Decreased mobility
   - Other (please specify)

#### ASSESSMENT (RN) OR APPEARANCE (LPN)

What is the resident doing? (e.g., ambulation, eating, sleeping, etc.)

**For RNs:**

- Respiratory status:
  - Blood gas analysis:
  - labs:
  - medications:
  - allergies:

**For LPNs:**

- Nursing: The resident appears to:
  - Very well
  - Fairly well
  - Poorly

**REQUEST**

- Interventions requested (check all that apply):
  - Intramuscular (IM) medication
  - Oral medication
  - Laboratory test
  - Medication
  - Physical therapy
  - Social services
  - Physical plant issues

**Nursing Notes:**

- Additional notes related to the changes in condition:

**Staff Name (RN/LPN) and Signature**

- Date:
- Time:
- Signature:

**Residents Name**

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Hebrew Home Readmission Rate as tracked by Suburban Hospital

Readmission Trends

- Based on internally tracked data and has not been risk adjusted (Raw data)

**Fiscal Year**

*FY 2016 based on first 6 months data
** Change in EMR at hospital
CHF Readmissions Overall Trends
2013 - 2015
Lessons Learned

• Communication and Collaboration is essential
• Takes investment of time and people
• Must include a variety of staff not just leadership
• Both sides need to be willing to share
Sepsis Initiative

• Suburban transition team queried the Hebrew Home about what they might be doing about Sepsis cases.
• As a result, SNF set out to convert the INTERACT® Sepsis Clinical pathway into SBAR guide for staff to use when they call the physician.
• Reviewed with Nursing Leadership and Medical Staff to obtain feedback.
• Shared SBAR guide with Hospital transition team
Using your Quality Model when embarking on your INTERACT® Projects
INTERACT® Fever Care Path

CARE PATH

Fever

Fever Definition
- One temp > 100°F (> 37.8°C)
- Two temps > 99°F (< 32°C) and/or > 96°F (> 35.5°C) rectal
- Increase in temp of 2°F (1°C) over baseline

Take Vital Signs
- HR, pulse, respirations
- Oxygen saturation
- Finger stick glucose

Vital Sign Criteria (any met?)
- Temp > 100°F
- Clinical heart rate > 100 or < 50
- Respiratory rate > 25/min or < 10/min
- BP < 90 or > 200 systolic

Evaluate Symptoms and Signs for Immediate Notification*
- Acute mental status change
- Not eating or drinking
- Acute decline in ADLs, abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Resolution of confusion or tenderness
- New or worsened incontinence, pain with urination, blood in urine
- Very low urinary output
- New skin condition (e.g., rash, lesions suggesting cellulitis, signs of infection around/during wound/pressure area)
- Unrelieved pain

Notify MD/NP/PA

If YES to any criteria, notify MD/NP/PA.

Consider Contacting MD/NP/PA for orders for further evaluation and management
- Portable chest X-ray
- Urinalysis and UA if indicated
- Blood work (Complete Blood Count, Basic Metabolic Panel)
- Stool/answers for culture and C. Diff ilex assay (platinum)
- Nasal/flue type smears for influenza

Tests Ordered

Evaluate Results
- Critical values in blood count or metabolic panel
- WBC < 4,500 mm³
- Neutrophils > 60%
- Influenza or pneumonia (chest X-ray)
- Positive C. Diff
- Positive flu result
- UTI results suggest infection and symptoms or signs present

Manage in Facility
- Monitor vital signs, fluid intake/urine output every 4-6 hrs for 24-72 hrs
- Do not give acetaminophen unless necessary for comfort
- If patient history, or until unsure if fever known
- If on diuretic, consider holding
- Oral, IV or subcutaneous fluids if needed for hydration
- Update advance care plans and directions if appropriate

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

* Refer also to other INTERACT Care Paths as indicated by symptoms and signs
The Hebrew Home “Fever SBAR”

FEVER (Change in condition)

BEFORE you call the physician/NP
- Evaluate the resident and fill out this SBAR form below.
- Confirm that all of the information is the most current.
- Leave all information in front of you when you call the physician/NP.
- When speaking on the phone, remember to slow down.

SITUATION: IMPORTANT: IF YOU ARE LEAVING A VOICEMAIL MESSAGE, LEAVE THE "SBAR" INFORMATION IN YOUR VOICEMAIL MESSAGE.
- Name (Dr.)
- This is from Unit. I am calling about the resident, My/.
- Higher normal baseline temp is
- He has a temperature of
- He is now at

BACKGROUND
- Has the resident ever had:
- (Ask in PCC. List the most recent diagnosis of what you assess to be related to the fever)
- Recent history includes:
  - Hospitalization
  - Surgery
  - Pain
  - Does resident have infants?
  - Allergic
  - Suprapubic Catheter
  - Foley Catheter
  - IV line

ASSESSMENT / APPEARANCE
- VITAL SIGNS: HR ___________ RR ___________ BP ___________ Temp ___________
- Pulse Oximetry: __% on RA, __% on OA at __ min via (nasal cannula, mask)
- Labs: Check PCC for most recent WBC results and date(s)
- Finger stick glucose __ (if diabetic or reticotic)
- Report only "New" findings in situation
- Mental Status:
  - Acute mental status change?
  - New or worsened incontinence?
  - Pain with Urination?
  - Blood in Urine?
  - Loss urinary output?
  - Tendency to infection of suprapubic area?
  - Gastrointestinal: Not eating or drinking?
  - Abdominal distention or tenderness?
  - Respiratory: New cough?
  - Abnormal breath sounds?
  - ABGs: Acute decline in ABG s available?
  - Rash/redness suggesting cellulitis?
  - Surgical incision or other wound infection?
  - Unilateral lower extremity edema, erythema, pain (DVT)?
  - Shaking/chills?

REQUEST/RECOMMENDATION
- The physician/NP will advise you of the next steps
  - Care Management: Monitor vital signs and assess:
    - hydration
    - Medication
    - Any allergies? List:
  - Consider Physician Orders:
    - If physician orders a medication, need to know if allergic
    - UNA and CBC
    - Bloodwork (LDLC, FREE T4, TSH, ECG, Metabolic Panel)
    - Transfer out to another hospital

MARYLAND Patient Safety CENTER
Working with your Skilled Nursing Facilities

• Know what the Skilled Nursing Facility is capable of – get their INTERACT® Capabilities list

• Meet with them to review Readmissions from their organization to your hospital

• Be sure to identify the nature of the readmissions that your are experiencing and discuss preparing SBAR guides with them

• Revision of Facility Transfer form used from hospital to facility. Including palliative care notes, PT/OT evals and most recent notes
Questions?

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