Working Together to Improve Care, Communication, and Continuity for our Residents

A Quality Improvement Project Supported by the Commonwealth Fund

May, 2009
May, 2009

Re: Participation in the Commonwealth Fund Quality Improvement Project: *Interventions to Reduce Acute Care Transfers ("INTERACT II")*

Dear Nursing Home Staff,

We want to thank you for agreeing to participate in this exciting project. We look forward to working with you and your facility. The project will be carried out in 30 facilities over the next 8 months – 10 in Florida, 10 in Massachusetts, and 10 in New York. Participation will benefit your facility’s staff, residents, and families, and will help prepare you for changes in Medicare payment that will favor facilities with low rates of acute care transfers.

There are three goals of this project:

1. To utilize the INTERACT II tools in order to improve the early identification, evaluation, documentation, and communication about residents who have a change in status.

2. Allow nursing home staff in the participating facilities to provide feedback on how the tools can be improved for larger projects involving nursing homes across the U.S.

3. Monitor the rates of and reasons for acute care transfers that occur during the project period.

Your **project champion** will serve as a resource for you providing education on the project, and guidance on the use of the INTERACT II tools.

Again, we thank you for your participation and look forward to working with you and getting your input and how we can further improve the tools and the quality of care for our nursing home residents.

Sincerely,

Joseph G. Ouslander, M.D.  Gerri Lamb, Ph.D, R.N.
Project Director      Project Co-Director
What is INTERACT II?

INTERACT II is an acronym for “Interventions to Reduce Acute Care Transfers”. The interventions are designed to improve the identification, evaluation, and communication about changes in resident status.

INTERACT was first designed in a project supported by the Centers for Medicare and Medicaid Services (CMS). The current quality improvement project is supported by a grant from the Commonwealth Fund, and will involve a total of 30 nursing homes in the states of Florida, New York and Massachusetts. Many nursing homes across the country are using INTERACT II.

What is the purpose of the INTERACT II quality improvement program?

The overall goal of the INTERACT II project is to reduce the frequency of transfers to the acute hospital. Transfers to the hospital can be emotionally and physically difficult for residents, and result in numerous complications of hospitalization, and they are costly.

In the plans for health care reform, Medicare may financially reward facilities with lower hospitalization rates for certain conditions. By improving the identification, evaluation, and communication about changes in resident status, some, but not all acute care transfers can be avoided.

What are the INTERACT II tools and who should use them?

The INTERACT II tools are listed in the Tool Table. There are three basic types of tools: 1) Communication tools; 2) Care Paths or Clinical tools; and 3) Advance Care Planning tools.

The specific tools are designed for use by selected members of the care team. However, in order for the INTERACT II project to be successful, all members of the care team should be aware of all of the tools and their uses.

How are the INTERACT II tools used in every day work in your facility?

The INTERACT II project champion will assist facility staff in using the tools on a daily basis. The tools have been designed to help staff improve care, but not increase unnecessary paperwork.

The INTERACT II Overview Figure shows how the tools can be used in everyday work in caring for your residents.
Using the INTERACT II Tools in Every Day Work in the Nursing Home

Advances in Care Planning Tools

- New Resident Admission
- Resident Re-assessment

Change in Resident Status Noted

CNA Alerts LPN/RN

LPN/RN Evaluation

MD/NP/PA Notified?

Acute Care Transfer

Quality Improvement Meetings

Early Warning “Stop and Watch Tool”

CARE PATHS

- Acute Change in Condition
- File Cards

SBAR Form and Progress Notes

TRANSFER CHECKLIST Envelope

RESIDENT TRANSFER FORM

QUALITY IMPROVEMENT TOOL FOR REVIEW OF ACUTE CARE TRANSFERS
## INTERACT II Tools

<table>
<thead>
<tr>
<th>Communication Tools</th>
<th>Use</th>
</tr>
</thead>
</table>
| **Early Warning Tool**  
**“Stop and Watch”**  
Pocket Card and Report | Certified Nursing Assistants  
- Regular evaluation of and recognition of changes in residents under their care  
- Reporting changes to licensed nurses  
- May be produced as laminated cards or half sheets on colored paper |
| **SBAR Communication Tool and Progress Note** | All nursing home licensed nursing staff  
- Evaluation and communication of acute changes to MD, NP, and/or PA  
- Documentation of evaluation and communications  
- May be printed as two-sided with progress note on back |
| **Change in Condition File Cards** | All nursing home licensed nursing staff  
- At nurses station for quick reference  
- Provide guidance on when to communicate acute changes in status to MD, NP, and/or PA  
- May be laminated and placed in a file box at the nurses station or on the med cart, or cards may be spiral bound |
| **Resident Transfer Form** | All nursing home licensed nursing staff and emergency room staff  
- Standardized form completed at the time of acute care transfer  
- May be printed as two-sided or single sided on 3M paper |
| **Acute Care Transfer Envelope with Checklist** | All nursing home staff at time of transferring residents to acute care  
- Complete the checklist on the front of the envelope  
- Place copies of all documents in the envelope  
- Send with the resident to the acute care facility  
- Checklist may be printed on outside of a 11x14 or 15x20 envelope |
| **Quality Improvement Tool For Review of Acute Care Transfers** | This Communication tool is used for facility-based quality improvement focused on reducing the number of avoidable acute care transfers.  
Nursing home staff involved in Quality Improvement or Performance Improvement Committees; medical director, medical staff in building  
- Standardized form completed for every acute care transfer |

### Care Paths

- Mental status change  
- Fever  
- Symptoms of Lower Respiratory Infection  
- Symptoms of CHF  
- Symptoms of UTI  
- Dehydration  

All nursing home licensed nursing staff, administrative nurses, medical director, primary care physicians, nurse practitioners, physician assistants  
- Used as an educational tool and reference for guiding evaluation of specific symptoms that commonly cause acute care transfers  
- Care paths may be enlarged and printed as posters for nursing station or med room, or printed and placed in a binder

August 31, 2009
<table>
<thead>
<tr>
<th>Advance Care Planning Tools</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying Residents to Consider for Palliative Care and Hospice – Pocket Card</td>
<td>All nursing home staff</td>
<td>Educational tool for guidance on how to identify residents who may be appropriate for a palliative or comfort care plan, or hospice care</td>
</tr>
<tr>
<td>Advance Care Planning Communication Guide – File Cards</td>
<td>Social workers, licensed nurses, primary care providers (MDs, NPs, PAs)</td>
<td>Educational tool for guidance on how to communicate with residents and family members for those appropriate for a palliative or comfort care plan, or hospice care</td>
</tr>
<tr>
<td>Comfort Care Order Set – File Cards</td>
<td>Primary care providers (MDs, NPs, PAs), licensed nurses</td>
<td>Guidance on examples of orders that may be appropriate for residents on palliative or comfort care plans</td>
</tr>
<tr>
<td>Educational Information</td>
<td>Directed at Residents and families</td>
<td>Reprints on Advance Directives, Palliative Care, Artificial Nutrition</td>
</tr>
</tbody>
</table>

August 31, 2009
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 ________________________________

S eems different than usual
T alks or communicates less than usual
O verall needs more help than usual
P articipated in activities less than usual

A te less than usual (Not because of dislike of food)
N D rank less than usual

W eight change
A gitated or nervous more than usual
T iried, weak, confused, or drowsy
C hange in skin color or condition
H elp with walking, transferring, toileting more than usual

Staff_________________________________________________
Reported to ___________________________________________
Date _____ / _____ / ________  Time ________________

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.

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H elp with walking, transferring, toileting more than usual

Staff_________________________________________________
Reported to ___________________________________________
Date _____ / _____ / ________  Time ________________
**HERRAMIENTA DE ADVERTENCIA PRECOZ**  
“Pare y observe”

Si usted ha identificado un cambio importante al cuidar a un residente en el día de hoy, haga un círculo alrededor del cambio y discútalo con la enfermera a cargo antes de finalizar su turno.

<table>
<thead>
<tr>
<th>Nombre del residente</th>
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**Parece diferente de lo habitual**  
*Seems different than usual*

**Habla o se comunica menos de lo habitual**  
*Talks or communicates less than usual*

**En general, necesita más ayuda de la habitual**  
*Overall needs more help than usual*

**Participó en actividades menos de lo habitual**  
*Participated in activities less than usual*

**Y**

**Comió menos de lo habitual (y no porque no le gustaba la comida)**  
*Ate less than usual (Not because of dislike of food)*

**Bebió menos de lo habitual**  
*Drank less than usual*

**Cambió en el peso**  
*Weight change*

**Más agitado o nervioso de lo habitual**  
*Agitated or nervous more than usual*

**Pareció cansado, débil, confundido o somnoliento**  
*Tired, weak, confused, or drowsy*

**Tuvo un cambio en el color o en la condición de la piel**  
*Change in skin color or condition*

**Necesitó más ayuda para caminar, transferirse, asearse de lo habitual**  
*Help with walking, transferring, toileting more than usual*

Personal  _____________________________________________

Notificado a  _____________________________________________

Fecha _____ / _____ / ________  Hora ________________

---

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“Pare y observe”

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*Help with walking, transferring, toileting more than usual*

Personal  _____________________________________________

Notificado a  _____________________________________________

Fecha _____ / _____ / ________  Hora ________________
Si pandan wap bay yon rezidan swen ou remake chanjman enpòtan, tanpri ansèkle chanjman-an epi al pale ak enfimyè anchaj-la avan lè travay-ou bout.

Non rezidan-an ____________________________________

Pa sanble tankou li abitye ye
*Does not seem to be as usual*

Reponn enpe oswa pa kominike jan li abitye
*Responds a little or does not communicate as usual*

Asistans pi nesesè pou-li pase nòmal
*Needs more assistance than usual*

Neglije plis ankò patisipe nan aktivite
*Refrain from participating in activities more than usual*

Tanpere twòp sou manje (pa paske li pa renmen nouriti)
*Limit eating too much (not because he does not like food)*

Abandonnen abitid bwè pi plis pase anvan
*Neglect to drink more than before*

Note pwa kò-li chanje
*Notice weight change*

Gen tandans pi aji te oswa kontrarye pase nòmall
*Becomes more agitated or upset more than usual*

Anbwouye, bouke, fèb oswa andòmi
*Confused, tired, weak, or drowsy*

Dekolorasyon oswa chanjman nan kondisyon po
*Skin color or condition change*

Ede-li pi plis pou mache, deplase, ale nan twalèt
*Help him more to walk, move, go to the toilet*

Anplwaye _____________________________________________

Rapòte bay ___________________________________________

Dat _____ / _____ / ________  Lè __________________

KONPRANN Chanjman BONNÈ
KONPRANN Chanjman BONNÈ
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)

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 __________________________

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 __________________________

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)

REQUEST
I suggest or request:
- Provider visit (MD/NP/PA)
- Monitor vital signs (Frequency __________________________) and observe __________________________
- Lab work, x-rays, 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
Patient name __________________________

(Please see Progress Note on back of this Form)
Immediate Notification:
Any symptom, sign or apparent discomfort that is:

1. **Sudden** in onset
2. **A marked change** (i.e. more severe) in relation to usual symptoms and signs
3. **Unrelieved** by measures already prescribed

Sources:
*AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003.*
Ouslander, J, Osterweil, D, Morley, J. *Medical Care in the Nursing Home.* McGraw-Hill, 1996
# Vital Signs
*(Report Why Vital Signs Were Taken)*

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Report Immediately</th>
<th>Report on Next Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>• Systolic BP &gt; 210 mmHg, &lt; 90 mmHg</td>
<td>• Diastolic BP routinely &gt; 90 mmHg</td>
</tr>
<tr>
<td>Pulse</td>
<td>• Diastolic BP &gt; 115 mmHg</td>
<td>• Resting pulse &gt; 120 bpm on repeat exam</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>• Resting pulse &gt; 130 bpm, &lt; 55 bpm, or &gt; 110 bpm and patient has dyspnea or palpitations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Respirations &gt; 28, &lt; 10/minute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oral (electric thermometer) temperature &gt; 101°F</td>
<td></td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
<td>• New Onset of anorexia with or without weight loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5% or more within 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 10% or more within 6 months</td>
</tr>
</tbody>
</table>
## Laboratory Tests/Diagnostic Procedures
*(Report Why the Test or Procedure was Done)*

<table>
<thead>
<tr>
<th>Test/Procedure</th>
<th>Report Immediately</th>
<th>Report on Next Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count</td>
<td>• WBC &gt;12,000*</td>
<td>WBC &gt;10,000 without symptoms of fever</td>
</tr>
<tr>
<td></td>
<td>• Hemoglobin (Hb) &lt;8*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hematocrit &lt;24*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Platelets &lt;50,000*</td>
<td></td>
</tr>
<tr>
<td>Chemistry</td>
<td>• Blood/urea/nitrogen (BUN) &gt;60 mg/dl*</td>
<td>• Glucosse consistently &gt;200 mg/dl</td>
</tr>
<tr>
<td></td>
<td>• Calcium (Ca) &gt;12.5 mg/dl*</td>
<td>• Hb A1c (any value)</td>
</tr>
<tr>
<td></td>
<td>• Potassium (K) &lt;3.0, &gt;6.0 mg/dl</td>
<td>• Albumin (any value)</td>
</tr>
<tr>
<td></td>
<td>• Sodium (Na) &lt;125, &gt;155 mg/dl</td>
<td>• Bilirubin (any value)</td>
</tr>
<tr>
<td></td>
<td>• Blood glucose</td>
<td>• Cholesterol (any value)</td>
</tr>
<tr>
<td></td>
<td>• &gt;300 mg/dL in diabetic patient not using sliding-scale insulin</td>
<td>• Triglycerides (any value)</td>
</tr>
<tr>
<td></td>
<td>• &gt;430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin</td>
<td>• Other chemistry values</td>
</tr>
<tr>
<td></td>
<td>• &lt;70 mg/dL in diabetic patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• &lt;50 mg/dL in nondiabetic patient</td>
<td></td>
</tr>
<tr>
<td>Consult Reports</td>
<td>Consultant report recommending immediate action or changes in patient’s management by the MD</td>
<td>Routine consultant report recommending routine action or changes in patient’s management</td>
</tr>
<tr>
<td>Drug Levels</td>
<td>• Levels above therapeutic range of any drug (hold next dose)</td>
<td>• Any therapeutic or low level, unless resident shows evidence of possible adverse drug reaction despite therapeutic or low result</td>
</tr>
<tr>
<td>Prothrombin time (PT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>International normalized ratio (INR)</td>
<td>• All INRs should be reported on the day they are drawn</td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>• Abnormal result in patient with signs and symptoms possibly related to urinary tract infection or urosepsis (e.g., fever, burning sensation, pain altered mental status)</td>
<td>• Abnormal result in patient with no signs or symptoms</td>
</tr>
<tr>
<td>Urine culture</td>
<td>• &gt;100,000 colony count with symptoms</td>
<td>• Any colony count, no symptoms</td>
</tr>
<tr>
<td>X-ray</td>
<td>• New or unsuspected finding (e.g., fracture, pneumonia, CHF)</td>
<td>• Old or long-standing finding, no change</td>
</tr>
</tbody>
</table>

* Unless values are consistently at these levels and practitioner is aware.
<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>Abrupt onset severe pain or distention, OR with fever, vomiting</td>
<td>Moderate diffuse or localized pain, unrelieved by antacids or laxatives</td>
<td>Persistent mild to moderate discomfort, without associated symptoms</td>
</tr>
<tr>
<td>Abdominal distention</td>
<td>Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding</td>
<td>Progressive or persistent distension not associated with symptoms</td>
<td>Gradual increase in abdominal girth not associated with acute symptoms</td>
</tr>
<tr>
<td>Abdominal discomfort (e.g., bloating, cramps, etc.)</td>
<td>Associated with fever, continuous GI bleeding, or other acute symptoms</td>
<td>Persistent discomfort not associated with other acute symptoms</td>
<td>More than occasional discomfort but not persistent</td>
</tr>
<tr>
<td>Abrasion</td>
<td>Accompanied by significant pain or bleeding</td>
<td>If bleeding continues or if associated with evidence of local infection</td>
<td>N/A</td>
</tr>
<tr>
<td>Agitation or behavioral distribute</td>
<td>Abrupt onset of significant change from usual, OR associated with fever or new onset abnormal neurological signs</td>
<td>Continued progression or persistence of symptoms</td>
<td>Gradually progressive of unknown cause</td>
</tr>
<tr>
<td>Appetite, diminished</td>
<td>N/A</td>
<td>Significant decline in food and fluid intake of someone with marginal hydration and nutritional status</td>
<td>Frequent or persistent poor appetite with gradual weight loss</td>
</tr>
<tr>
<td>Asthma</td>
<td>Acute episode with wheezing, dyspnea, or respiratory distress</td>
<td>Self-limited episode that was more extensive or less responsive to treatment than the usual</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Signs & Symptoms

### B’s

<table>
<thead>
<tr>
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<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back, injuries and complaints</td>
<td>Abrupt onset of severe pain secondary to fall or injury, OR pain with new abnormal neurological signs</td>
<td>Persistent back pain not responding to existing analgesic orders</td>
<td>Gradually progressive or persistent back discomfort</td>
</tr>
<tr>
<td>Bleeding, rectal (melena)</td>
<td>Persistent, or accompanied by diaphoresis, tachycardia, significant orthostatic BP drop</td>
<td>Recent self-limited bleeding: tarry stool or melena without change in vital signs</td>
<td>Stool positive for occult blood on routine testing</td>
</tr>
<tr>
<td>Blisters</td>
<td>Secondary to any burn more than a minor one</td>
<td>New onset large tense blisters with fever</td>
<td>More than one or recurrent since last MD visit</td>
</tr>
<tr>
<td>Burns</td>
<td>Any burn other than a minor first degree burn with no significant pain</td>
<td>Minor first degree burn in past twenty-four hours</td>
<td></td>
</tr>
</tbody>
</table>
# C's

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<thead>
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<tr>
<td>Chest pain, pressure or tightness</td>
<td>New or abrupt onset, unrelieved by current medications, OR accompanied by diaphoresis, change in vital signs or new EKG changes</td>
<td>Relieved by antacids or nitroglycerin, without other symptoms, but recurring more often than usual</td>
<td>Gradual or persistent change in usual pattern, frequency, or nature of a chronic discomfort</td>
</tr>
<tr>
<td>Common cold</td>
<td>With marked swallowing or respiratory distress, severe cough, change in LOC, or T&gt;101 F.</td>
<td>Change in color of sputum or phlegm; persistent need for symptom relief</td>
<td></td>
</tr>
<tr>
<td>Complaint, medical, by family or patient</td>
<td>Demand to speak to a physician or have a medical assessment without delay</td>
<td>Any persistent or recurrent complaint that might need a physician’s attention</td>
<td>Resident or family complaint related to MD’s actions or responsiveness</td>
</tr>
<tr>
<td>Confusion *</td>
<td>Abrupt significant change from usual</td>
<td>Abrupt persistent change in confusion or LOC from usual with no other significant symptoms</td>
<td>Intermittent gradual progression of confusion or forgetfulness</td>
</tr>
<tr>
<td>Consciousness, altered*</td>
<td>Sudden change in level of consciousness or responsiveness</td>
<td>Gradual but persistent recent change in level of consciousness or responsiveness</td>
<td>Increase in duration or nature of fluctuations in level of consciousness or responsiveness</td>
</tr>
<tr>
<td>Constipation</td>
<td>Severe abdominal pain, rigid abdomen, absent bowel sounds</td>
<td>&lt;1 BM in a week</td>
<td>Persistent symptoms</td>
</tr>
<tr>
<td>Contusions</td>
<td>Accompanied by significant pain or bleeding</td>
<td>Associated with a recent fall with no other complications</td>
<td>Tendency towards increased or easier bruising</td>
</tr>
<tr>
<td>Convulsive disorder (seizures)</td>
<td>New onset seizure, OR prolonged or uncomfortable seizure in someone with known seizure disorder</td>
<td>Change in usual pattern of someone with seizure disorder</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>Associated with new hemoptysis, new sputum production, fever or respiratory distress</td>
<td>New or recent onset of persistent or nocturnal cough, causing discomfort or disturbing sleep</td>
<td>Gradual or progressive onset or change in unusual pattern</td>
</tr>
</tbody>
</table>

* See INTERACT Mental Status Change Care Path
## Signs & Symptoms

**D’s**

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressed affect</strong> (see “Suicide, potential”)</td>
<td>Acute suicidal ideation</td>
<td>Recent onset of significant mood decline, with anorexia, crying, and sleeplessness</td>
<td>Gradual progression of mood decline, or change from usual state</td>
</tr>
<tr>
<td><strong>Diabetes, poorly controlled</strong></td>
<td>Any diabetic with altered mental status, LOC, or an acute infection, OR hypoglycemic episode in someone on hypoglycemic medication or not responding to additional glucose</td>
<td>Usually stable diabetic with change in oral intake, thirst, or urination, OR hypoglycemic episode in someone not on hypoglycemic medication or that responded to additional glucose</td>
<td>Diabetic with fluctuating or gradually rising blood sugars on current regimen, or with progressive decline in sensory, neurological, or renal function</td>
</tr>
<tr>
<td><strong>Diarrhea</strong></td>
<td>Acute onset&gt;3 loose stools with change in LOC, T&gt;101 F., or altered vital signs (blood in stool)</td>
<td>Persistent multiple loose with stable vital signs, or with T&lt;101</td>
<td>Recurrent fecal impaction; periodic loose stools</td>
</tr>
<tr>
<td><strong>Dizziness or unsteadiness</strong></td>
<td>Abrupt onset, with slurred speech, change in LOC, or other focal neurological findings</td>
<td>Minor but persistent change over past 24 hours from usual pattern</td>
<td>Persistent change from usual over extended time period</td>
</tr>
<tr>
<td><strong>Dyspnea (shortness of breath)</strong></td>
<td>Acute onset of change from usual pattern, OR with chest pain, labored respirations, OR unstable vital signs</td>
<td>Recent intermittent change from usual pattern, OR only partial response to usual treatment regimen</td>
<td>More frequent or longer-lasting episodes since last visit, even if responding to treatment</td>
</tr>
<tr>
<td>Symptom or Sign</td>
<td>Immediate</td>
<td>Non-Immediate</td>
<td>Routine</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Earache</td>
<td>Severe ear pain, bleeding or discharge from canal</td>
<td>Progressive or persistent ear pain</td>
<td>Recurrent earaches</td>
</tr>
<tr>
<td>Edema</td>
<td>Abrupt onset unilateral leg edema, with tenderness, redness</td>
<td>Rapidly progressive unilateral or bilateral edema</td>
<td>Gradually progressive edema with weight gain</td>
</tr>
<tr>
<td>Eye injuries (foreign bodies; chemical burns; contusions)</td>
<td>Any eye injury</td>
<td>Any persistent redness of eyes not associated with known injury or infection</td>
<td></td>
</tr>
<tr>
<td>Fainting</td>
<td>Sudden loss of consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>With any suspected serious injury (e.g., fracture) any hip pain, or more than minor pain elsewhere</td>
<td>Fall with only insignificant injury</td>
<td>Number of falls in patient since last visit</td>
</tr>
<tr>
<td>Fever *</td>
<td>New onset T&gt;102 regardless of any other symptoms, OR T&gt;101 with other symptoms (unless under treatment already or physician already aware)</td>
<td>Gradual increase in temperature curve or recurrent daily temperature spikes for more than two days</td>
<td></td>
</tr>
<tr>
<td>Fractures and discolorations</td>
<td>Any suspected fracture or discoloration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gait disturbances</td>
<td>Abrupt onset with slurred speech, change in LOC, or other new focal neurological findings</td>
<td>Significant recent changes in gait without other symptoms or findings</td>
<td>Gradually progressive or persistent gait problems differing from usual pattern</td>
</tr>
</tbody>
</table>

* See INTERACT Fever Care Path
<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injuries</td>
<td>(Notify the attending or on-call MD, NP, or PA on call as soon as possible)</td>
<td>(Notify the attending or on-call MD, NP, or PA no later than the next work day)</td>
<td>(Notify the attending or on-call MD, NP, or PA no later than the next regular visit or phone or fax communication)</td>
</tr>
<tr>
<td>Headache</td>
<td>Abrupt onset or progression of severe headache with fever, change in LOC, or focal neurological abnormalities</td>
<td>Persistent nagging headache, unresponsive to standard analgesics</td>
<td>Change in number, frequency, or pattern of headaches from usual</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>Abrupt onset or progression of hearing loss with fever, change in LOC, or focal neurological abnormalities</td>
<td>Abrupt onset of significant hearing loss without other significant symptoms</td>
<td>Gradual progressive decline in hearing from usual</td>
</tr>
<tr>
<td>Hematuria</td>
<td>Gross hematuria with pain, fever or other signs of bleeding at other sites</td>
<td>New onset blood-tinged urine without fever or other signs of bleeding</td>
<td></td>
</tr>
<tr>
<td>Hypothermia</td>
<td>New onset T&lt;95, OR T more than two degrees below usual lower limits of normal, with change in LOC or other symptoms</td>
<td>New onset T&lt;95, OR T more than two degrees below usual lower limits of normal, without change in LOC or other symptoms</td>
<td></td>
</tr>
<tr>
<td>Incontinence of urine or stool</td>
<td>New onset of incontinence with fever, neurological abnormalities or other symptoms</td>
<td>New onset of incontinence, OR change in usual or customary patterns since last visit</td>
<td></td>
</tr>
<tr>
<td>Itching (pruritus)</td>
<td>Severe unremitting itching, OR occurring after recent change in medications</td>
<td>Persistent mild to moderate itching unrelieved by topical treatment or mild antihistamines</td>
<td></td>
</tr>
</tbody>
</table>
## Signs & Symptoms

**L, M, N**

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laceration</td>
<td>Any laceration requiring sutures</td>
<td>Minor laceration not requiring sutures</td>
<td></td>
</tr>
<tr>
<td>Medication error</td>
<td>Causing any new symptoms OR involving a cardiac, psychotropic, or other drug with potential for significant toxic side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication side effects</td>
<td>Any abrupt symptoms or significant changes in condition that might be associated with one or more medications</td>
<td>Any minor symptoms or changes in status that might be associated with one or more medications</td>
<td>PRN medications which are rarely or never used</td>
</tr>
<tr>
<td>Memory loss</td>
<td>Abrupt onset or progression of memory loss with fever, change in LOC, or focal neurological abnormalities</td>
<td>Noticeable abrupt deadline in memory or mental status without other apparent symptoms</td>
<td>Gradual progressive decline in memory</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>Marked localized bruising, swelling, or pain over joint or bone, with or without recent fall</td>
<td>Progressive</td>
<td></td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>Persistent or recurrent (two or more episodes within 12 hours) vomiting, with or without abdominal pain, bleeding, distension, or fever.</td>
<td>Intermittent recurrent nausea and vomiting</td>
<td>Occasional mild to moderate vomiting, with or without other symptoms</td>
</tr>
<tr>
<td>Nocturia</td>
<td>Marked increase in nocturia from usual pattern for &gt;2days</td>
<td>Gradual or moderate increase in nocturia from usual pattern</td>
<td></td>
</tr>
<tr>
<td>Nosebleed</td>
<td>Acute nosebleed which persists despite simple packing or pinching nostrils</td>
<td>Recent minor nosebleed with more than minor blood streaking</td>
<td></td>
</tr>
</tbody>
</table>
### Signs & Symptoms

**P, R**

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personality change</strong></td>
<td>Abrupt significant change from usual, associated with fever, new onset of abnormal neurological signs, or abnormal BUN or electrolytes</td>
<td>Recent minor but persistent change or fluctuation in behavior, LOC, memory, or mood from usual</td>
<td>Intermittent or gradual progression of personality change</td>
</tr>
<tr>
<td><strong>Pressure sore</strong></td>
<td>New onset&gt;101 F. in someone with Grade 2 or higher sore</td>
<td>New onset Grade 2 or higher pressure sore, OR progression of pressure sore despite interventions</td>
<td></td>
</tr>
<tr>
<td><strong>Puncture wounds</strong></td>
<td>Deep or open wound, OR with more than minor bleeding</td>
<td>Minor uncomplicated puncture wound</td>
<td></td>
</tr>
<tr>
<td><strong>Rash</strong></td>
<td>Rash in someone taking a new medication, OR one known to cause allergic reaction</td>
<td>Recent onset of localized or diffuse pruritic rash, OR any rash accompanied by other systematic symptoms</td>
<td>Unresolved or recurrent rashes</td>
</tr>
</tbody>
</table>
### Signs & Symptoms

#### S’s

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seizure activity</strong></td>
<td>(Notify the attending or on-call MD, NP, or PA on call as soon as possible)</td>
<td>(Notify the attending or on-call MD, NP, or PA no later than the next work day)</td>
<td>(Notify the attending or on-call MD, NP, or PA no later than the next regular visit or phone or fax communication)</td>
</tr>
<tr>
<td><strong>Shortness of breath (dyspnea)</strong></td>
<td>Any new onset seizure activity, OR persistent seizure in someone with known intermittent seizure activity</td>
<td>Self-limited seizure in past 24 hours of someone with known seizure activity who is already on an anticonvulsant</td>
<td>Gradual change in frequency or duration of episodes of SOB</td>
</tr>
<tr>
<td><strong>Sleep disturbance</strong></td>
<td>Abrupt onset of SOB with pain, fever, or respiratory distress</td>
<td>Recently progressive or persistent minor SOB without other symptoms, OR with progressive leg edema</td>
<td></td>
</tr>
<tr>
<td><strong>Sore throat</strong></td>
<td>Accompanied by respiratory distress or painful swallowing</td>
<td>With, mild to moderate symptoms of upper respiratory infection not responding to standard conservative treatments</td>
<td>Progressive or persistent sore throat or hoarseness without other signs of upper respiratory infection</td>
</tr>
<tr>
<td><strong>Speech, abnormality</strong></td>
<td>Abrupt change in speech, with or without other focal neurological findings</td>
<td></td>
<td>Gradual progressive change in speech from usual and customary</td>
</tr>
<tr>
<td><strong>Splinters/slivers</strong></td>
<td>If unable to remove readily, with OR accompanied by considerable pain or bleeding</td>
<td>If area appears to be getting infected, with erythema or purulent drainage, OR if no tetanus shot within past ten years</td>
<td></td>
</tr>
<tr>
<td><strong>Suicide, potential</strong></td>
<td>Makes a suicidal gesture, OR discusses a detailed plan for carrying out suicide</td>
<td>New onset of talking about wanting to die, but not making any specific suicidal threats</td>
<td>Increase in frequency or extent of discussions of wanting to die</td>
</tr>
<tr>
<td><strong>Swallowing, difficulty</strong></td>
<td>With new onset or progressive choking, aspiration</td>
<td>Decreased intake from dysphagia, with potential risk of dehydration malnutrition</td>
<td>Increase in frequency or duration of trouble swallowing over time</td>
</tr>
</tbody>
</table>
## Signs & Symptoms

### T, U, V

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toothache</td>
<td>Accompanied by fever, severe pain, redness, or swelling in mouth, cheek, or jaw</td>
<td>Persistent or progressive discomfort not responding to conservative measures</td>
<td>Progressive or persistent problems with dentition</td>
</tr>
<tr>
<td>Urinary hesitancy or retention</td>
<td>Abrupt decrease in urinary output, with lower abdominal distension or discomfort over bladder</td>
<td>Progressive marked decrease in urinary output over more than two days, OR new onset of post-void residual &gt;300cc.</td>
<td>Gradual progressive decrease in urinary output</td>
</tr>
<tr>
<td>Vaginal bleeding</td>
<td>Bleeding with clots that saturate one pad or more every two hours</td>
<td>Episode of bleeding that persists or that resolved spontaneously</td>
<td>New or recurrent intermittent bleeding</td>
</tr>
<tr>
<td>Vaginal discharge or spotting</td>
<td></td>
<td>New or recurrent discharge</td>
<td></td>
</tr>
<tr>
<td>Vision, partial or complete loss</td>
<td>Abrupt onset with pain, redness, or other symptoms</td>
<td>Recent significant change</td>
<td>Gradual progressive decline in vision</td>
</tr>
<tr>
<td>Vomiting blood (hematemesis)</td>
<td>New onset hematemesis with clots, OR accompanied by rapid pulse or orthostatic BP drop</td>
<td>New or recurrent blood-streaked vomiting without other significant symptoms</td>
<td></td>
</tr>
</tbody>
</table>
## Signs & Symptoms

### W's

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Walking, difficulty</strong></td>
<td>Acute onset accompanied by focal neurological signs</td>
<td>Recent onset not resolving spontaneously</td>
<td>Gradual progressive decline in ability to ambulate</td>
</tr>
<tr>
<td><strong>WBC (white blood cell) Count</strong></td>
<td>&gt;10,000 with change in condition, or fever, or increased neutrophils or bands</td>
<td>Lab report of elevated WBCs without specific current symptoms</td>
<td></td>
</tr>
<tr>
<td><strong>Weakness, arm or leg</strong></td>
<td>Abrupt onset of noticeable change in strength or use</td>
<td>Gradual recent onset not resolving spontaneously</td>
<td>Gradual progressive decline in strength or use of limb</td>
</tr>
<tr>
<td><strong>Weakness, general</strong></td>
<td>Abrupt onset general weakness with fever, change in LOC, or other acute symptoms</td>
<td>Abrupt onset general weakness without fever, change in LOC, or other acute symptoms</td>
<td>Gradual progressive weakness</td>
</tr>
<tr>
<td><strong>Weight, change in</strong></td>
<td></td>
<td></td>
<td>Weight loss of &gt;5% in 1 month; &gt;7.5% in 3 months; &gt;10% in 6 months</td>
</tr>
<tr>
<td><strong>Wounds</strong></td>
<td>Any wound that will not stop bleeding, OR that exposes subcutaneous tissue</td>
<td>Apparently minor recent wound now developing redness, swelling, or pain</td>
<td>Any wound that is very slow to heal</td>
</tr>
</tbody>
</table>
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)

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
Section 3: WHAT HAPPENED BEFORE THE TRANSFER?

Based on review the nurse’s notes, progress notes, and talking to staff that cared for resident in the few days prior to the transfer, CHECK YES OR NO FOR EACH ITEM:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in condition or new symptoms?</td>
<td></td>
</tr>
<tr>
<td>Change in behavior?</td>
<td></td>
</tr>
<tr>
<td>Change in mental status?</td>
<td></td>
</tr>
<tr>
<td>Change in vital signs?</td>
<td></td>
</tr>
<tr>
<td>Change in overall functional status or mobility?</td>
<td></td>
</tr>
<tr>
<td>Change in continence?</td>
<td></td>
</tr>
<tr>
<td>Change in appetite/po intake?</td>
<td></td>
</tr>
<tr>
<td>Was there one or more falls?</td>
<td></td>
</tr>
<tr>
<td>Change in participation in rehab (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Did family mention a concern about a change in condition?</td>
<td></td>
</tr>
<tr>
<td>Any medication changes?</td>
<td></td>
</tr>
<tr>
<td>Abnormal lab values reported?</td>
<td></td>
</tr>
</tbody>
</table>

Was there anything else that you noted on review of this transfer? Please describe:

What actions were taken before the transfer? (CHECK ALL THAT APPLY)
- □ Stop & Watch tool completed by nursing assistant
- □ SBAR completed (MD or NP: ________Called ________ Not Called)
- □ Care Path used (Which one? ________________________________)
- □ Physician onsite evaluation □ Nurse Practitioner onsite evaluation
- □ Discussion with family about change in condition
- □ Intravenous fluids initiated
- □ Lab tests done □ Xrays □ EKG/rhythm strip □ Other tests (describe)____________
- □ Medications given (describe)________________________________________________
- □ Other (please describe)___________________________________________________

What factors affected the transfer decision? (CHECK ALL THAT APPLY)
- □ Medical instability (e.g. unstable vital signs, change in mental status, etc.) Describe:
  - □ MD/NP/PA insisted (authorized transfer before or regardless of data provided)
  - □ MD/NP/PA unavailable/did not return call □ MD/NP/PA was unfamiliar with resident
  - □ Advance directives (eg. DNR, DNH not documented or not complete)
  - □ Family issues (e.g., family insisted or family in conflict)
  - □ Stat test or Xray not available in facility (specify) _________________________
  - □ Treatment option/equipment not available in facility (specify) _______________________
  - □ Nurse not familiar with resident (new to resident or unit, agency nurse)
  - □ Other (specify):
QUALITY IMPROVEMENT TOOL
For Review of Acute Care Transfers
Resident Last Name:                         First:  Date of QI Review: ____/____/____
____________________________   _____________________

Section 4: CONSIDER - COULD THIS TRANSFER HAVE BEEN AVOIDED?

In reviewing the events that occurred up to a few days before the transfer, were there opportunities to prevent or anticipate the immediate reason for the transfer? For example:

- The resident was transferred due to an infection (e.g. pneumonia or UTI). **Consider:** Did the resident have a change in functional status or appetite that could have provided a clue to earlier diagnosis?
- The resident fell and had a head laceration that led to the transfer. **Consider:** Were there signs of gait or balance changes that may have increased his risk for falls? Could fall precautions or some other intervention have possibly prevented the fall?
- Could the evaluation or treatment provided in the emergency room or hospital have been safely provided in your nursing home? **Consider:** were there other circumstances that contributed to the transfer that might have been addressed earlier, prior to the onset of an acute situation? (for example, resident or family preferences about hospital transfers or advance directives; family insistence on transfer)

BASED ON YOUR REVIEW OF THE DATA ABOUT THIS TRANSFER, COULD THIS TRANSFER HAVE BEEN AVOIDED? **Please check one option:**

- ___Yes   ___ Possibly   ___ No

If yes or possibly, what were your major reasons for this determination (CHECK ALL THAT APPLY)

- [ ] There were opportunities to prevent or anticipate the immediate reason for the transfer by earlier identification and management of a change in status
- [ ] The resident could have been cared for here if the provider had been available or returned calls earlier
- [ ] The MD may have kept the resident here with further discussion or additional information.
- [ ] The resident might have chosen to stay here with an earlier discussion about advance directives or the possibility of need to be transferred to the hospital
- [ ] Family members might have chosen for the resident to stay here with an earlier discussion about the possibility of need to be transferred to the hospital.
- [ ] The resident could have been cared for safely if the necessary tests or procedures (e.g. continuous IV) were available to be done here (Specify):____________________________________
- [ ] Other (Please write in) _____________________________________________________

**ACTION PLAN TO ADDRESS REASON(S) FOR POTENTIALLY AVOIDABLE TRANSFER**

What actions might be taken in your facility to improve the identification and management of changes in resident status based on this transfer?

Review tool completed by: Name ________________________ Position _____________________
RESIDENT TRANSFER FORM

**SENT TO:** (Name of Hospital)

**SENT FROM:** (Name of Nursing Home)

Date: __/__/____  Unit: ______

**RESIDENT:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

**DOB:** __/__/____

**Language:**
- ☐ English
- ☐ Other: ______

**Resident is:**
- ☐ SNF/rehab
- ☐ Long-term

**CONTACT PERSON:**

<table>
<thead>
<tr>
<th>(Relative, guardian or DPOA/Relationship)</th>
<th>name</th>
</tr>
</thead>
</table>

- Is this the health care proxy?  ☐ Yes  ☐ No
- Telephone: ( ) ______ - ______

- Notified of transfer:  ☐ Yes  ☐ No
- Aware of diagnosis:  ☐ Yes  ☐ No

**WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?**

<table>
<thead>
<tr>
<th>name</th>
<th>title</th>
<th>Telephone: ( ) ______ - ______</th>
</tr>
</thead>
</table>

**CODE STATUS:**

- ☐ DNR
- ☐ DNH
- ☐ DNI
- ☐ Full Code

**MD/NP/PA IN NURSING HOME:**

<table>
<thead>
<tr>
<th>☐ MD</th>
<th>☐ NP</th>
<th>☐ PA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>name</th>
</tr>
</thead>
</table>

- 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: ______ |

| ☐ None |
| ☐ Falls |
| ☐ Pressure |
| ☐ Ulcer |
| ☐ Aspiration |
| ☐ Wanderer |
| ☐ Elopement |

**AT RISK ALERTS:**

- 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:**

<table>
<thead>
<tr>
<th>name</th>
<th>title</th>
<th>signature</th>
</tr>
</thead>
</table>

**Report Called In By:**

<table>
<thead>
<tr>
<th>name</th>
<th>title</th>
</tr>
</thead>
</table>

**Report Called To:**

<table>
<thead>
<tr>
<th>name</th>
<th>title</th>
</tr>
</thead>
</table>
### Resident Transfer Form

**Additional Information**

(may be faxed to ED/hospital within 7-12 hours)

### Resident Name:

<table>
<thead>
<tr>
<th>Last:</th>
<th>First:</th>
<th>MI:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

Date transferred to the hospital: __/__/____

### Treatments and Frequency:

(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN, hospice)

### Skin / Wound Care:

- High risk for pressure ulcer: ☒ Yes ☐ No
- Pressure ulcers: (stage, location, appearance, treatments)

Wound care sheet attached: ☒ Yes ☐ No

### Immunizations:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td></td>
</tr>
<tr>
<td>Tetanus Tet-Diphtheria</td>
<td></td>
</tr>
</tbody>
</table>

### Diet:

- Needs assistance with feeding: ☐ Yes ☐ No
- Trouble swallowing: ☐ Yes ☐ No
- Special consistency: (thickened liquids, crush meds, etc.)

Tube feeding: ☐ Yes ☐ No

### Physical Therapy

- Resident is receiving therapy with goal of returning home: ☒ Yes ☐ No
- Patient is LTC placement: ☒ Yes ☐ No

Weight bearing status:

- ☐ Non-weight
- ☐ Partial weight
- ☐ Full weight

Fall risk: ☒ Yes ☐ No

Interventions:

### Disabilities:

(orthopedic, neurological, cardiac, respiratory)

### Impairments:

(cognitive, speech, hearing, vision, sensation)

### Continence:

- ☐ Bowel
- ☐ Bladder

Last bowel movement: Date: __/__/____

### Social Worker:

Telephone: (____) _______ - __________

### Behavioral or Social Issues and Interventions:

### Family Issues:

### Pain Assessment:

### Reason for Original SNF Admission:

Bed hold: ☐ Yes ☐ No
**Acute Mental Status Change**
- New or increased confusion / disorientation
- Decreased level of consciousness
- New or worsened physical and/or verbal agitation
- New or worsened delusions or hallucinations
- New or worsened severe depressed mood

**Take Vital Signs**
- Temperature
- BP, Pulse
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

**Nursing Assessment**
- Danger to self or others?
- Suicidal ideation with plan?
- Not eating or drinking?
- Temp > 102°F (> 38.9°C)
- BP < 90 or >210 systolic?
- Apical heart rate > 130 or < 50 bpm?
- Respiratory rate > 28 or < 10/min?
- Oxygen Saturation < 90%?
- Finger stick glucose < 70 or > 400?
- Other critical symptoms or signs?

**Consider Contacting MD/NP/PA for Orders for Lab Testing**
- Blood work
  - Complete Blood Count
  - Basic Metabolic Panel
- Others if indicated by symptoms / signs or risk factors, e.g.,
  - Chest X-ray
  - Urinalysis
  - EKG

**Evaluate Lab Results and Re-assess**
- Critical lab values?
- Infiltrate or pneumonia on X-ray?
- Worsening clinical condition?

**Manage in Facility - Options**
- Monitor vital signs every 4-8 hours for 24-72 hours

**NOTIFY MD/NP/PA if any criteria for transfer met**
CARE PATH: Fever

Fever Definition
• One Temp > 100°F (>37.8°C)
• ≥ 2 Temps > 99°F (>37.2°C) oral, or > 99.5°F (>37.5°C) rectal
• Increase in Temp of 2°F (1.1°C) over baseline

Take Vital Signs
• BP, Pulse
• Respiration
• Oxygen saturation
• Finger stick glucose (diabetics)

Vital Sign Criteria
(Any Met?)
• Temp > 102°F (>38.9°C)
• Apical heart rate > 130 or < 50?
• Respiratory rate > 28/min or < 10/min?
  • BP < 90 or > 210 systolic?
  • Oxygen saturation < 90%?
• Finger stick glucose < 70 or > 400?

Further Nursing Assessment
• Mental Status
• Functional Status
• Respiratory
• Gastrointestinal
• Genitourinary
• Skin

Notify MD/NP/PA Immediately

Consider
• Lab tests as indicated
• Transfer to acute care facility as indicated

Evaluate Symptoms and Signs
• Acute mental status change?
  • Not eating or drinking?
• Acute decline in ADL abilities?
• New cough, abnormal lung sounds?
• Nausea, vomiting, diarrhea, abdominal distention or tenderness?
• New or worsened incontinence, pain with urination, blood in urine?
  • Very low urinary output?
• New skin condition, e.g., rash, redness suggesting cellulitis, signs of infection around existing pressure ulcer?

Manage in Facility - Options
• Monitor vital signs and urine output every 4-8 hours for 24-72 hours.
• Consider a complete blood count.*
• Do Not give acetaminophen unless necessary for comfort (it can mask a worsening fever) or until source of fever known.

NOTIFY MD/NP/PA if any criteria for transfer met

* Leukocytosis (>14,000 WBC/mm³), elevated % of neutrophils (>90%), make bacterial infection more likely.
CARE PATH: Symptoms of Lower Respiratory Infection

**Symptoms of Lower Respiratory Infection Noted**
- Labored breathing / shortness of breath
- New or worsened cough
- New or increased sputum production
- New or increased findings on lung exam (rales, wheezes)
- Chest pain with inspiration or coughing

**Take Vital Signs**
- Temperature
- BP, Pulse
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

**Vital Sign Criteria (Any Met?)**
- Temp > 102°F (> 38.9°C)
- Apical heart rate > 100?
- Respiratory rate > 30/min?
- BP < 90 systolic?
- Oxygen saturation < 90%?
- Finger stick glucose < 70 or >400?

**Notify MD/NP/PA Immediately**
- Portable chest X-ray
- Blood work
  - Complete Blood Count
  - Basic Metabolic Panel

**Consider Contacting MD/NP/PA for Orders for Lab Testing**
- Resident unable to eat or drink?

**Evaluate Lab Results and Re-assess**
- Results of chest X-ray show an infiltrate or pneumonia?
- Critical values in blood count or metabolic panel?

**Consider Transfer to Acute Care Facility**

**Manage in Facility - Options**
- Monitor vital signs every 4-8 hours
- Oral, IV or Sub Q Hydration as indicated
- Oxygen supplementation as indicated
- Nebulizer treatments and/or cough suppressants as indicated
- Antibiotic therapy (Check Allergies)
  Oral (7-14 days):
  - Levofloxacin 250-500 mg daily
  - Amoxicillin/Clavulanate 850 mg bid
  - Cefuroxime axetil 500 mg bid
  IM (2-3 days, then re-evaluate):
  - Ceftriaxone 500-1000 mg IM daily
  - Cefatoxime 500 mg IM bid

**NOTIFY MD/NP/PA if any criteria for transfer met**
CARE PATH: Symptoms of Congestive Heart Failure (CHF)

Symptoms or Signs of CHF in a resident with known CHF or Risk Factors for CHF *
- Unrelieved shortness of breath or new shortness of breath at rest
- Unrelieved or new chest pain
- Wheezing or chest tightness at rest
- Inability to sleep without sitting up
- Inability to stand without severe dizziness or light headedness
- Weight gain of > 5 lbs. in 3 days
- Worsening edema

Take Vital Signs
- Temperature
- BP, Pulse
- Apical heart rate
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

Consider Contacting MD/NP/PA for Orders for Lab Testing
- Portable chest X-ray
- Blood work
  - Complete Blood Count
  - Basic Metabolic Panel
- EKG (if available)

Evaluate Lab Results and Re-assess
- Results of chest X-ray suggestive of CHF or pneumonia?
- Critical values in blood count or metabolic panel?
- EKG shows new changes suggestive of an acute MI or arrhythmia?
- Worsening clinical condition?

Manage in Facility - Options
- Monitor vital signs q 4-8 hours, and urine output q24
- Oxygen supplementation as indicated
- Contact MD/NP/PA to consider
  - Initiating or increasing diuretic dose
  - Monitor electrolytes & kidney function
  - Initiating or modifying other cardiovascular medications

NOTIFY MD/NP/PA if any criteria for transfer met

* Risk Factors for CHF: Hypertension, Diabetes, Coronary Artery Disease, Valvular Heart Disease (e.g. aortic stenosis)
**CARE PATH: Symptoms of Urinary Tract Infection (UTI)**

**Symptoms or Signs of UTI**
- Painful urination (dysuria)
- Lower abdominal tenderness
- Blood in the urine
- New or worsening urinary – urgency – frequency – incontinence

**Take Vital Signs**
- Temperature
- B/P, Pulse
- Respiration
- Finger stick glucose (diabetics)

**Vital Sign Criteria (Any Met?)**
- Temp > 102°F (> 38.9°C)
- Apical heart rate > 100?
- Respiratory rate > 30/min?
- BP < 90 systolic?
- Finger stick glucose < 70 or >400?
- Resident unable to eat or drink?

**Notify MD/NP/PA Immediately**

**Consider Contacting MD/NP/PA for Orders for Lab Testing**
- Urinalysis
- Urine culture & sensitivity
  - Collect clean voided specimen if possible
  - In-and-out catheter only if necessary
  - For residents with indwelling Foley catheter:
    - Change the catheter
    - Send urine obtained from new catheter
  - Complete blood count
  - Basic metabolic panel

**Evaluate Lab Results and Re-assess**
- Critical values in blood count or metabolic panel?
  - WBC > 12,000?
- Persistent nausea or vomiting?
- Unstable vital signs?

**Consider Transfer to Acute Care Facility**

**Further Nursing Assessment**
- Resident meets minimum criteria for initiating antibiotics:
  - Dysuria alone
  - Fever > 100°F (37.9°C) or 2.4°F (1.5°C) increase above baseline, and one of the signs or symptoms listed above

**Monitor and Re-assess**
- Monitor vital signs and symptoms
- Check results of urinalysis and culture
- Consider antibiotic treatment if resident meets above criteria

**Manage in Facility - Options**
- Monitor vital signs every 4-8 hours
- Oral, IV or Sub Q Hydration as indicated
- Antibiotic therapy for at least 7 and up to 14 days (Check Allergies)
  - Oral (7-14 days):
    - Amoxicillin 500 mg tid
    - Cefuroxime 125-250 mg tid
    - Ciprofuroxacin 250-750 mg bid
    - Nitrofurantoin 100 mg bid (with adequate renal function)
    - Trimethoprim / Sulfamethoxazole 160/800 mg bid

**NOTIFY MD/NP/PA if any criteria for transfer met**

**Discontinue Antibiotic if Culture Negative**
Further Nursing Assessment
- Mental Status
- Functional Status
- Respiratory
- Gastrointestinal
- Genitourinary
- Skin

Manage in Facility - Options
- Monitor vital signs and urine output every 4-8 hours
- Check vital signs q 4-8 h for 24-72 h
- If on diuretic, consider holding
- Offer frequent small fluids (2-4 oz. q 2h)
- If on tube feeding, give more water with flushes
- Consider IV or subq fluids

NOTIFY MD/NP/PA if any criteria for transfer met

Vital Sign Criteria (Any Met?)
- Temp > 102°F (> 38.9°C)
- Apical heart rate > 130?
- Resipitory rate > 28/min?
- BP < 90 systolic or > 20mm drop systolic?
- Oxygen saturation < 90%?
- Finger stick glucose < 70 or > 400?

Notify MD/NP/PA Immediately
- Lab tests as indicated
- Transfer to acute care facility as indicated

CARE PATH: Dehydration (Potential for)

Evaluate Symptoms and Signs
- Acute mental status change?
- Not eating or drinking?
- Acute decline in ADL abilities?
- New cough, abnormal lung sounds?
- Nausea, vomiting, diarrhea, abdominal distention or tenderness?
- New or worsened incontinence, pain with urination, blood in urine?
- New skin condition, e.g., rash, redness suggesting cellulitis, signs of infection around existing pressure ulcer?

Further Nursing Assessment

NO
Advance Care Planning Communication Guide

Overview

The INTERACT II Advance Care Planning Communication Guide is designed to assist health professionals who work in nursing homes initiate and carry out conversations with residents and their families when there has been a decline in health status.

Communicating about advance care planning and end-of-life care involves all facility staff

- Physicians must communicate with residents and families about advance directives, but all staff need to be able to communicate about end-of-life care

This Guide should therefore be useful for:

- Nursing staff
- Primary care physicians, nurse practitioners, and physician assistants
- Social workers and social work designees
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:

- Advance Directives – such as a Durable Power of Attorney for Health Care document and Living Will
- Plans for care when a sudden, life-threatening condition is diagnosed - such as a stroke, heart attack, pneumonia, or cancer that has spread throughout the body
- Plans for care when a resident’s health is gradually deteriorating – such as progression of Alzheimer’s disease or other dementia; weight loss without an obvious medical cause; and worsening of congestive heart failure, kidney failure, or chronic lung disease
- Considering a palliative care plan or enrolling in a hospice program

Adapted from:
“The Palliative Response – Sharing the Bad News,” the Birmingham/Atlanta VA Geriatric Research, Education and Clinical Center


Advance Care Planning Communication Guide
Part 1 - Tips for Starting and Conducting the Conversation

Set the Stage

1. Get the facts – understand the resident’s conditions and prognosis.
2. Choose a private environment.
3. Determine an agenda for the meeting and who should be present.
4. Allow adequate time – usually these discussions take 20-30 minutes.
5. Turn beeper/cell phone to vibrate to avoid interruptions and demonstrate full attention.
6. If the resident is involved, sit at eye level with them.
7. Have tissues available.

Initiate the Discussion

1. Describe the purpose of the meeting.
2. Identify whether the resident wants or already has a spokesperson and who it is.
3. Ask what the resident/family understands about advance care planning, and the condition and prognosis.
4. Ask about their goals for care:
   • Most nursing home residents and their families are more concerned about comfort than life prolongation. This opens the door to discuss palliative care and comfort care plans.
   • Attempt to understand underlying rationale for the goals (i.e., “I’ve lived long enough, now I’m ready to meet God,” or “I want to keep on living until my granddaughter graduates college next spring.”). This provides insight into specific decisions that are made.

Initiate the Discussion

1. Use simple language.
2. Briefly discuss:
   a. Cardiopulmonary arrest and CPR
   b. Artificial Hydration/Nutrition
   c. Palliative care, comfort care orders, and hospice if appropriate

Cardiopulmonary Arrest and CPR

1. Initiate discussion of Cardiopulmonary Resuscitation (CPR) e.g.:
   • “Sometimes when peoples’ hearts stop, doctors and nurses try to delay the dying process … Have you considered whether you would want this or not?”
2. Discuss some facts:
   • Cardiopulmonary arrest is the final common pathway for everyone when they die. Not all deaths should involve CPR.

(cont’d on reverse)
Advance Care Planning Communication Guide
Part 1 - Tips for Starting and Conducting the Conversation

Initiate the Discussion (cont'd)

- The possibility of surviving CPR in a nursing home is very low, and CPR often results in broken ribs and the need for a respirator (“breathing machine”) in an intensive care unit.
- A request to not perform CPR (a Do Not Resuscitate (DNR) or Allow Natural Death (AND)) Order does not alter care – it only prevents CPR if the resident is found without a heart beat or not breathing.

Artificial Hydration/Nutrition

1. Initiate discussion of feeding tubes:
   - “Many nursing home residents gradually lose the ability to eat, drink, and swallow. In this situation a tube can be placed in the stomach to provide water and nutrition. Have you considered whether you would want this or not?”
2. Discuss some facts:
   - Feeding tubes have not been shown to prevent pneumonia or prolong life for most nursing home residents.
   - Placement of a tube requires minor surgery, and can have some complications.
   - A request to not place a tube does not alter care – residents will be provided oral fluid and nourishment as long as it is comforting for them.
   - People who do not get feeding tubes generally gradually slip into a comfortable coma within a few days and die comfortably.

Palliative Care and Comfort Care Orders

1. Review overall goals for care and the importance of comfort and quality of life regardless of advance directives.
2. If the goal of care is comfort:
   a. Offer to review NHPCO educational materials on palliative care with them
   b. Describe examples of comfort care orders.
   c. Discuss limiting hospitalization only for the purpose of improving comfort, not to prolong life.
   d. If appropriate, provide information about palliative hospice care.

End the Discussion

1. Ask: “Do you have any questions?”
2. Emphasize that the role of the nursing home is to ALWAYS provide comfort no matter what the goals of care.
3. Offer to have a follow-up meeting if indicated.
4. Stand – an effective way to end the conversation.
**Advance Care Planning Communication Guide**  
**Part 2 – Communication Tips**

<table>
<thead>
<tr>
<th>Tips</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Establish Trust** | “Tell me what you understand about your illness.”  
“Help me get to know you better tell me about your life before you came to this nursing home.”  
“How are you coping with your illness?” |
| **Encourage Residents and Families to Talk** | “I understand that you didn’t feel heard by other doctors/nurses. I’d like to make sure you have a chance to voice all of your concerns.”  
“It sounds like Dr. X left you very hopeful for a cure. I’m sure he really cares for you, and it would have been wonderful if things would have gone as well as he/she wished.” |
| **Recognize Resident and Family Concerns, but Do Not Put Down Other Health Care Providers** | “You are absolutely right. Four days was too long to wait for that [test or procedure].” |
| **Acknowledge Mistakes** | “I really appreciate what you have shared with me about the medication we prescribed. It is clear that it is not right for you.” |
| **Be Humble** | “I am so impressed by how involved you have been with your [relative] throughout this illness. I can tell how much you love her/him.” |
| **Demonstrate Respect** | “We’ve just had a very difficult conversation, and you and your family have a lot to think about. Let’s schedule another meeting and see how you feel about things then.” |
| **Do Not Force Decisions** | “Is talking about these issues difficult for you?”  
“Making these decisions is not easy.” |
| **Attend to Emotions** | “I bet it’s hard to imagine life without your [relative] – I can see how close you are to him.” |

(cont’d on reverse)
**Advance Care Planning Communication Guide**

**Part 2 – Communication Tips**

<table>
<thead>
<tr>
<th>Tips</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attend to Emotions (cont’d)</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Legitimize Feelings           | “It’s quite common for someone in your situation to have a hard time making these decisions – it can feel like an enormous responsibility.”  
 |                               | “Of course talking about this makes you feel sad - it wouldn’t be normal if it didn’t.” |
| Explore                       | “You’ve just told me you feel scared. Can you tell me more about what scares you most?” |
| Offer Support                 | “No matter what the road holds ahead, I’m going to be there with you.” |
| **Communicate with Hope**     |                                                                          |
| Hope for the Best, But        | “Have you thought about what might happen if things don’t go as you wish? Sometimes having a plan to prepare for the worst makes it easier to focus on what you hope for most.” |
| Prepare for the Worst         |                                                                          |
| Reframe Hope                  | “I know you hope your illness will improve. Are there other goals you want to focus on?” |
| Focus on the Positive         | “Some treatments are really not going to help and may make you feel worse or uncomfortable. But there are a lot of things we can do to help you – let’s focus on those.”  
 |                               | “What sorts of things are left undone for you? Let’s talk about how we might be able to make these happen.” |

This material from JAMA was adapted by GMCF, the Medicare Quality Improvement Organization for Georgia, 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. Publication No. 8SOWGA-NHSS-07-19

## Issue Helpful Language

<table>
<thead>
<tr>
<th>Identify other decision makers</th>
<th>“Is there anyone you rely on to make important decisions?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define goals for care</td>
<td>“What do you hope for most over the next few months?”</td>
</tr>
<tr>
<td></td>
<td>“Is there anything that you are afraid of?”</td>
</tr>
<tr>
<td>Reframe goals</td>
<td>“I wish we could guarantee you will be alive for your [event], but unfortunately we can’t. Perhaps we can work on a letter to read on that day, so people will know you are there in spirit in case you cannot be there.”</td>
</tr>
<tr>
<td>Identify needs for care?</td>
<td>“What types of treatments do you think will help you the most?”</td>
</tr>
<tr>
<td>Summarize and link goals with care needs</td>
<td>“I think I understand that your main goals are to be comfortable and alert enough to spend time with your family. We have several ways we can help you.”</td>
</tr>
<tr>
<td>Introduce palliative care and/or hospice</td>
<td>“One of the best ways to meet your needs would be a comfort care plan.”</td>
</tr>
<tr>
<td></td>
<td>“One of the best ways to give you help is a program called hospice. The hospice program can provide extra support and the hospice has a lot of experience in caring for seriously ill people.”</td>
</tr>
<tr>
<td>Acknowledge response</td>
<td>“You seem surprised to learn how sick you are.”</td>
</tr>
<tr>
<td></td>
<td>“I can see it is not easy for you to talk about end-of-life care.”</td>
</tr>
<tr>
<td>Empathize</td>
<td>“I can imagine how hard this is for all of you to talk about – you care about each other so much.”</td>
</tr>
<tr>
<td>Explore concerns</td>
<td>“Tell me what is upsetting you the most.”</td>
</tr>
</tbody>
</table>
### Explain comfort care or hospice goals

<table>
<thead>
<tr>
<th>Issue</th>
<th>Helpful Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Comfort/hospice care does not help people die sooner – it helps people die naturally.”</td>
<td></td>
</tr>
<tr>
<td>“Comfort/hospice care helps people live as well as they can for as long as they can.”</td>
<td></td>
</tr>
</tbody>
</table>

### Reassure

<table>
<thead>
<tr>
<th>Issue</th>
<th>Helpful Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The goal of comfort/hospice care is to improve your quality of life as much as possible for whatever time you have left.”</td>
<td></td>
</tr>
<tr>
<td>“Comfort/hospice care can help you and your family make the most of the time you have left.”</td>
<td></td>
</tr>
</tbody>
</table>

### Reinforce commitment to care

<table>
<thead>
<tr>
<th>Issue</th>
<th>Helpful Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Why don’t you think this over? I think comfort/hospice care is the best choice for you right now, but the decision is yours. You know we will continue to care for you whatever you decide.”</td>
<td></td>
</tr>
</tbody>
</table>
Residents at High Risk of Entering the Actively Dying Process

The following characteristics should prompt proactive advance care planning, and consideration of a Palliative Care plan, Comfort Care Orders, and/or enrollment in Hospice:

- Frequent Emergency Room visits and/or hospitalizations over the last 6 months
- Semi-comatose state
- Minimal oral intake (or receiving continuous IV hydration or tube feeding)
- Inability or difficulty with taking oral medicines
- Major decline in functional status with no identified reversible cause
- Mottling of extremities
- Primary diagnosis of metastatic cancer
- Primary diagnosis of advanced dementia
- Existing DNR order
### Examples of COMFORT CARE INTERVENTIONS

<table>
<thead>
<tr>
<th>Order Type</th>
<th>Examples and Helpful Tips</th>
</tr>
</thead>
</table>
| **Diet**                         | 1. Order a diet – it may improve the desire to taste food  
2. Full liquid rather than clear liquid if necessary and advance as tolerated  
3. May have food brought in by family  
4. Allow resident to sit up for meals and provide assistance |
| **Activity**                     | 1. Allow resident to sit in chair and/or use a bedside commode if capable and desired  
2. Other activities as tolerated  
3. Allow family to stay in room |
| **Vital Signs**                  | Minimum frequency allowed by policy –  
a. Frequent monitoring and numbers can alarm resident and family.  
b. Limit physician/NP notification parameters. |
| **IV Orders**                    | 1. If IV fluids used, suggest a time limited trial, e.g., 1000 cc of D5 1/2 N Saline over 6 hours  
a. Starting IV is often difficult and painful – and usually of limited benefit  
b. Edema indicates resident is not volume depleted  
c. Oral hydration a reasonable approach  
d. Subcutaneous injections of small volumes of medicines using a small butterfly needle under the skin of the thigh or abdomen may avoid the need for IV |
| **Orders for Dyspnea and Shortness of Breath** | 1. Oxygen 2-4 L by nasal cannula; avoid mask  
2. Avoid monitoring oxygen saturations  
3. Blow air on face with a bedside fan  
4. Turn and reposition  
5. Nebulizers may be helpful  
6. Use opioids for persistent dyspnea |

(cont’d on reverse)
### Examples of COMFORT CARE INTERVENTIONS (cont’d)

<table>
<thead>
<tr>
<th>Order Type</th>
<th>Examples and Helpful Tips</th>
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| **Hygiene**          | 1. Avoid Foley catheter if possible  
|                      |   a. May be helpful in selected residents who are immobile and have pain with movement  |
|                      | 2. Check regularly for stool impaction  
|                      |   a. Suppositories may be helpful                                                          |
| **Pain and Dyspnea** | 1. Opioids usually most effective  
|                      | 2. Usually stop sustained preparations and switch to immediate release Morphine concentrate 20mg/ml  
|                      | 3. Start with equivalent dose as previous regimen  
|                      |   – at least 5mg PO every 2 hours  
|                      | 4. Offer routinely, and let the resident refuse                                             |
| **Anorexia, Asthenia, Depression, Pain, Dyspnea** | 1. Corticosteroids can have many beneficial effects  
|                      | 2. Use Dexamethasone 4-8 mg PO/SubQ at breakfast and lunch(avoid the mineralocorticoid effects of prednisone) |
| **Nausea and Delirium** | 1. Haloperidol 0.5-2mg PO or 0.5-1mg SubQ every 2 hours X 3 doses or until settled; then every 6-8 hours PRN |
| **Anxiety and Seizures** | 1. Lorazepam for anxiety 0.5-1mg PO/SubQ every 6-8 hours  
|                      | 2. Must be given IV or SubQ for seizures                                                   |
| “Death Rattle”         | 1. Keep back of throat dry by turning head to the side  
|                      | 2. Stop IV fluids or tube feedings  
|                      | 3. Use a Scopolamine patch; Atropine drops 2-3 in the mouth every 4 hours until patch effective  
|                      | 4. Avoid deep suctioning  
|                      | 5. Family can cleanse mouth with sponge sticks                                             |
| **Comfort and Safety** | 1. Reposition, massage, sit and speak with resident.  
|                      | 2. Avoid sensory overload (e.g. loud TV); use soft music  
|                      | 3. Avoid use of restraints, bedrails, and alarms                                           |

This material was adapted from the Birmingham VA Safe Harbor Project (CMS)
Overview for Champions
Getting Started on INTERACT II

To Interact II Champions:

Thank you so much for playing a critical role in the Interact II Program. As you get started, we wanted to share a few thoughts and ideas with you about coaching your nursing home to use the Interact II Toolkit.

In your role as an Interact II Champion, you will be learning about the Interact II Program and Tools and teaching your colleagues in the nursing home about them and importantly, encouraging them to use the tools on a daily basis.

Asking people to try out new ways of doing work or trying new tools can be challenging. Some people quickly embrace new ideas or different ways of doing things – and other take longer, and some resist changing altogether. We expect that you may have all of these reactions – especially during the first few weeks of this program. Some strategies that might help introduce the Interact II Toolkit and have people use the tools regularly:

- Consider what you know is important to staff in your nursing home and talk about how the use of Interact II tools will help. This might include talking about the benefits to residents of reducing how often they are transferred to the hospital or the benefits to teamwork of using the Interact II communication tools.

- Look for staff members who are usually the first ones to try out new things and ask them to work with you. This might be just one or two people initially. These staff members may offer invaluable assistance in reducing reluctance of others to try out the Interact II tools.

- Use strategies introducing new practices or tools that have worked for you or for project teams in your nursing home in the past.

- Contact the Interact II Program Team if you hit a roadblock or need suggestions for dealing with implementation issues. We’ll learn together.

- Laurie Herndon, MSN, GNP-BC: Project Coordinator: laurieherndon@yahoo.com
  Alice Bonner, PhD, RN: Project Collaborator: abonner@massseniorcare.org
**INTERACT II**
*Early Warning Tool*

**Purpose:**

The purpose of the Early Warning Tool is to help you identify when one of the residents you care for has changed. Such changes can result in the resident getting sicker if further evaluation is not done. This tool gives you a way to document what you see and to inform the nurse taking care of the patient.

Consistent use of this tool will help you and your nursing home:

- Identify and document changes in residents under your care
- Communicate changes to other nursing staff
- Identify possible opportunities to prevent sending your residents to the hospital
- Improve the overall level of care provided for residents

**When to use:**

The Early Warning Tool should be completed for all changes in resident status on a shift-by-shift basis by staff members who have direct contact with a resident. More than one change may be noted on each form.

It is important to get into the habit of documenting changes in status. The tool will provide the most useful information if it is completed during or at the end of your shift.

**Who to involve:**

This tool may be used by CNA’s, food service staff, therapists, nursing staff, and other critical staff who have direct resident contact. What is most important is that the tool is completed for all residents with a change in status, that it is completed during the shift in which the change was noted, and that the change is reported to the nurse taking care of the resident.

**Helpful Hints:**

- **Keep the pocket card with you at all times.** The tool is designed to help guide you through a brief but complete review of early changes that often lead transfers of residents to the hospital.
- **Complete the Early Warning Tool form during or at the end of each shift in which a change was noted, and give it to the nurse taking care of the resident.**
INTERACT II
Instructions for the SBAR
Communication Tool and Progress Note

Purpose:
The purpose of the SBAR Communication Tool and Progress Note is to improve communication between nurses and primary care providers (physicians, nurse practitioners, physician assistants) by encouraging all health care team members to use the same language in communicating with one another. By creating standardized criteria and clear guidelines for communication around resident change in condition, more efficient and effective transmission of important information can occur. The SBAR form can also be used in place of a progress note.

Consistent use of this tool will help your nursing home:
- Communicate effectively with MDs, NPs, and PAs when a resident has had an acute change in condition
- Document communication with MDs, NPs, and PAs efficiently

When to use:
- Prior to contacting the provider when a resident has had a change in condition
- On residents who have had a change in condition or for shift to shift communication among nursing staff

Who to involve:
Before completing the SBAR, the nurse should check with other staff members who have regular contact with the resident to obtain an accurate history. Staff members who can provide useful information about the SITUATION include the CNA, rehab staff, social workers, and activities staff. A conversation with a family member or health care proxy may also be indicated to clarify advance directives

Helpful Hints:
- Before completing the tool, review the resident’s chart (Diagnosis, Medications, Recent Progress Notes from MD/NP as well as most recent nurses notes)
- Bring form with you when talking to staff and family members about the resident as a reminder about data you are seeking.
- Refer to Care Paths or Acute Change in Status File Cards if indicated
- Complete every section of the SBAR prior to calling the MD/NP/PA
- Have chart available when making the call to the MD/NP/PA
- Use SBAR and Progress Note to guide your change of shift report
Purpose:

The purpose of the Care Paths and Change In Condition File Cards is to help guide the assessment and management of common changes in resident status that result in acute care transfers. The 6 Care Paths in the INTERACT II Toolkit are for conditions that commonly result in acute care transfers.

Consistent use of these tools will help your nursing home:

- Provide evidence-based and expert-recommended assessment and management of common conditions
- Insure timely assessments, contacts with primary care providers, and transfers to the hospital when indicated
- Manage residents in the nursing home when feasible and safe
- Improve the overall level of care provided for residents with acute changes in status

When to use: Use the Care Paths and Change in Condition File Cards as a reference and guide when assessing residents with acute changes in status, and determining when to contact the primary provider.

They also are meant to be a resource for completing an SBAR Form and Progress Note.

Who to involve:

These tools are intended to be resources for all licensed nursing staff, as well as primary care physicians, nurse practitioners, and physician assistants. They may also be used by the facility interdisciplinary team to incorporate various aspects into policies and procedures related to clinical care.

Helpful Hints:

- Utilize these tools for educational in-services and refining policies and procedures.
- Do not get hung up on the specifics – you can modify the specific recommendations based on input from your facility’s interdisciplinary team.
- Hang the poster with the Care Paths where it is readily accessible when assessing acute changes in status and refer to it as needed.
- Keep one-page copies of each Care Path available in a notebook or on a clip board at each nursing station.
- Put the Change in Condition File Cards at each nursing station near the telephones for ready referral.
- Use a log or other strategy to notify primary care physicians of changes that do not require immediate notification.
**INTERACT II**

*Instructions for Resident Transfer Form*

**Purpose:**
This form is completed on every resident who is transferred to the emergency department for evaluation and treatment. The purpose is to provide information about the resident’s change in condition, a short narrative about what happened and the reason why the resident is being transferred (e.g., “short of breath, no improvement after 3 days of antibiotics,” “fell and now has change in mental status.”

Consistent use of this tool will help your nursing home:
- Provide essential information to emergency department staff that will lead to the most appropriate evaluation of your residents
- Insure the safe handoff of your residents to the emergency department

**When to complete:**
Page 1 of this form should always be completed and sent in the transfer envelope with the resident, since it contains essential information that the emergency department staff may need to make decisions about the resident. Page 2 also contains important information, but may be faxed to the hospital after the resident has been transferred, in the case of a 911 transfer or resident in unstable condition, or it may be sent along with the page 1.

**Who to involve:**
Generally, the nurse has discussed the transfer with a physician/PA/NP (primary or covering) prior to transfer. It is helpful to include any clinical information from the provider in the Reason for Transfer section. The name of the provider, and how to reach him or her should always be included. The nurse completing the form should sign it, even if another nurse (e.g., a supervisor) is listed as the person to contact for questions about the resident. The staff nurse might complete the form; she should then sign it. The supervisor might be the right person to contact for questions later, if the staff nurse is going home. A Provider to Provider (physician/NP/PA) telephone call is strongly recommended, so that the medical details can be shared among the nursing home and emergency department staff. A nurse to nurse telephone call is also strongly recommended, so that specific nursing issues and changes in resident status can be communicated. Complete the section of the form that asks who made this call and who at the ED received the call. If a resident returns to the nursing home after an emergency department evaluation, a telephone call from the ED nurse to the nursing home nurse is strongly encouraged.

**Helpful Hints:**
- **Complete all sections of the tool:** The tool is designed to help guide you write a brief but comprehensive summary of the resident’s situation.
- **Do not rewrite information that exists elsewhere that is being sent with the resident.** If the SBAR form has been completed, write “see SBAR” for sections with similar information.
**Purpose:**
This checklist (on the outside of the transfer envelope) is completed on every resident who is transferred to the emergency department for evaluation and treatment. The purpose is to provide a single envelope with all the necessary forms inside that the emergency department staff need to evaluate and manage the resident.

Consistent use of this tool will help your nursing home:
- Provide essential information in one, easily recognizable place, to emergency department staff that will lead to the most appropriate evaluation of your residents
- Insure the safe handoff of your residents to the emergency department

**When to complete:**
Use the checklist to systematically determine that all of the necessary paperwork has been sent with the resident. As each document is placed in the envelope, check off the appropriate box on the outside to indicate that the document has been included.

**Who to involve:**
The person completing the checklist should sign it and request a signature from the EMS or ambulance personnel who accept the envelope, indicating that all required documents have been sent.
Instructions for Advance Care Planning Tools

Purpose:

The purpose of the Advance Care Planning Tools is to provide guidance on how to approach conversations about end-of-life care, advance directives, and comfort or palliative care.

Consistent use of these tools will help your nursing home:

- Communicate effectively with residents and their loved ones about sensitive issues related to end-of-life and comfort care plans.
- Provide residents with comfort and dignity measures as they are in the dying process.
- Assure that residents receive the level of care that is consistent with their wishes.
- Increase the dialogue among staff about end-of-life care, advance directives, and comfort or palliative care

When to use:

The Advance Care Planning Tools are intended to use as a reference and guide when communicating with residents and their loved ones about advance directives, comfort or palliative care, and end-of-life decisions.

They are also meant to help staff identify when residents are in the dying phase of life, and to provide comfort care during that time.

The tools should be used when assessing advance care planning and advance directives at the time of admission, and when residents deteriorate and may be candidates for comfort or palliative care.

Who to involve:

These tools are intended to be resources for all licensed nursing staff, social services staff, clergy involved in the facility, and primary care physicians, nurse practitioners, physician assistants. They may also be useful for all staff in the facility who communicate with residents and their loved ones.

Helpful Hints:

- Utilize these tools for educational in-services and refining policies and procedures.
- Keep the pocket cards readily accessible at the nursing stations, on medication carts, and in your pockets whenever possible.
- Keep copies of the educational materials available in a notebook at the nursing stations.
- Make copies of the educational materials and provide them to residents and family members at the time of admission and/or when the resident's condition deteriorates.

April 3, 2009
Instructions for the Quality Improvement Tool for Review of Acute Care Transfers

- Obtain list of all ER transfers from Business Office on 2nd and 4th Tuesday of each month
- Record all transfers on the Acute Care Transfer Log
- Complete the QI Review tool for 2-3 transfers per week
- Return Copies of Completed forms to Project Staff on 2nd and 4th Tuesday of every month: Alissa Weintraub: aweintraub@massseniorcare.org
  Phone: 617-558-0202 x239
  Fax: 617-558-3546

Purpose:
This tool is used to review acute care (non-elective) transfers of residents to an emergency department or for direct admission to the hospital. The questions on the tool guide you through: What was going on when the resident was transferred? What factors influenced the decision to transfer the resident to the emergency room or hospital? Could this transfer have been avoided? How? What could we do differently next time?

Consistent use of this tool will help your nursing home:
- Understand the reasons for acute care transfers of your residents
- Identify possible opportunities to prevent avoidable transfers

When to complete:
The tool should be completed for 2-3 acute care transfers per week. You are looking for common patterns among your acute care transfers to help you identify possible ways to reduce avoidable transfers and improve care for your residents. In order to detect common patterns, it’s important to get into the habit of analyzing each and every transfer.

The tool will provide the most useful information if it is completed within 24-48 hours after a resident is transferred to the emergency room or admitted to the hospital. People involved in the review are more likely to remember details of the transfer and the factors
that influenced it if the review closely follows the event. These insights will be invaluable in generating ideas for improving care in the future.

**Who to involve:**
There are a variety of ways to carry out the review process. You can integrate this tool within your nursing home’s usual quality improvement process – or you might convene a new group to focus on acute care transfers. What is most important is that the tool is completed for all residents with unplanned acute care transfers and that it is completed soon after the transfer occurs.

**Helpful Hints:**
- **Complete all sections of the tool:** The tool is designed to help guide you through a brief but comprehensive analysis of key factors that often lead to unplanned and potentially avoidable transfers.
- **Complete each section in order:** There is an underlying order to the questions in the tool. The analysis starts with the events of the transfer and helps analyze important factors leading up to it.
- **Involve staff who affect the process in the review:** Staff who are involved in the transfer process may provide critical information about what worked, what didn’t, and how to improve transfers in the future.
Case Study: Hospital Transfer

Jack Thompson is an 88 year old resident who came to live at the LTC facility two years ago, after the death of his wife of 50 years. He is generally alert and oriented and can make his immediate needs known. He is fiercely independent and described by some of the staff as “difficult.” Despite being forgetful and occasionally confused, Jack refuses to accept much help with ADLs from the staff. However, he does have a “favorite” CNA, Helena, and he will generally agree to medications, treatments or activities when she is on duty.

Jack’s medical problems include congestive heart failure, with multiple hospitalizations for acute shortness of breath each year; atrial fibrillation, hypertension, chronic obstructive pulmonary disease, degenerative joint disease, falls, dizziness, insomnia and depression. His medications include: regularly-scheduled digoxin, furosemide, warfarin, metoprolol, albuterol MDI, and fluoxetine as well as trazodone as needed for sleep.

One day, Helena comes in to work 7-3, and Jack is still in bed (he is usually up at 6:00 am). When she goes to awaken him, he asks to stay in bed, because he is feeling “very tired.” It is very unusual for Jack to skip breakfast, the only meal he looks forward to. Helena wonders if
something may be going on, and pulls an Early Warning Tool out of her pocket, completes the tool and brings it to the nurse.

The nurse agrees with Helena that Jack’s behavior is different from usual. The nurse decides to review his list of diagnoses, medications, and other orders. She notes that Jack has been hospitalized several times for CHF and exacerbations of COPD, noting that both of these conditions can present with respiratory difficulty. The nurse asks Helena to watch for any signs or symptoms of respiratory problems, such as shortness of breath, limited ability to ambulate usual distances or limited activity tolerance.

It is now 1:00 pm. Helena comes to find the nurse, to report that Jack ate almost nothing at lunchtime, and drifted off, falling asleep during the meal. The nurse decides that an SBAR Form and progress note would be helpful to complete before calling the MD, NP, or PA. She takes the form out at the nurse’s station, and reviews the information needed in more detail. She asks Helena to help Jack into bed so that she can examine him. On exam, she finds that he has a temperature of 99.1, HR of 92, RR of 28, BP 90/60 and pulse ox of 89%. She listens to his lungs and finds crackles bilaterally, with scattered wheezes. She examines his legs and finds 2+ edema. She asks Helena, who reports that last week, he had virtually no edema. The nurse returns to the desk and reviews the information on the care path for congestive heart failure (CHF).
The nurse completes the information requested on the SBAR form and contacts the nurse practitioner. After discussing the case, the nurse practitioner orders a CXR, CBC, BMP, and O2 at 2 liters. She asks the nurse what advance directives are listed in the chart. The nurse says that there is an order for DNR, but nothing further. The nurse also comments, “the last few times we sent him out, he asked us not to go to the hospital again.” But no orders had been written addressing that request.

The nurse practitioner asked the nurse if she would be comfortable having a brief discussion with Mr. Thompson, about returning to the hospital if his condition were to worsen. The nurse practitioner referenced the INTERACT Advance Directives communication guide and suggested that some of the information might guide the nurse’s conversation. The nurse practitioner offered to follow up with Mr. Thompson in the morning, and document any new advance directives, such as “do not hospitalize.” The nurse stated that she would be comfortable having that discussion, since she knows the resident very well (after two years) and would keep the NP informed. The nurse reviewed the advance directives materials and went to speak with the resident.

Upon returning to the room, the nurse found Mr. Thompson to be in severe distress. His respiratory rate was now 40, and he was gasping for breath. He seemed very anxious and frightened. The nurse could not reassure him. She asked Helena to stay with the resident, and paged the NP back and informed her of the change in condition. The nurse practitioner had been trying to reach the resident’s daughter, his health care proxy; however she was not at home.
Without a “Do not hospitalize” order in place, and being unable to stabilize the resident, the nurse and NP decided to transfer the resident to the ED. Because she had already completed the SBAR form, the nurse was able to quickly complete the Transfer Checklist and Resident Transfer Form, copy a few essential documents (MAR, SBAR with reason for transfer, code status, list of diagnoses) and send the resident to the ED with the essential paperwork.

The nurse later called the ED, spoke with a physician, and asked if there was any other documentation that the ED needed to care for this resident. She also gave the ED physician a brief report on the resident’s baseline and change in status. She explained to the ED physician that the nursing facility had the capability to provide IV antibiotics, PO or IM furosemide, nebulizers, oxygen, and that the NP was onsite at least twice weekly. Later that evening the resident (now stable) was transferred back to the nursing home, on increased p.o. lasix, nebulizers Q4hr, Qshift vital signs, daily weights and follow up with the NP within 24 hours.

The next day, the facility INTERACT Champion completed the Transfer Review Tool and reviewed the case with all nursing staff on the unit. The NP spoke with the resident later that week, he elected “no further hospitalizations,” and the nursing home care plan was updated.
Case Study: No Hospital Transfer

Angela Jiminez is an 84 year old resident who came to live at the LTC facility three years ago. She has significant dementia, but the staff has gotten to know her behavior patterns.

One evening, the CNAs notice that Angela is leaning to the side in her chair. She doesn’t get up and dance and clap with the music activity the way she usually does. The CNA completes an Early Warning Tool and brings it to the nurse.

On the ten o’clock med pass, the nurse notices that Angela is much less responsive than usual; the nurse is afraid to attempt to give her usual medications. She gets an SBAR Tool, begins to review the chart, and assesses the resident, including taking her vital signs. Angela’s BP is 90/60, whereas it is normally about 140/80. Her HR is 92; RR 24, oxygen saturation 93% on room air. Her skin turgor is poor, and she feels slightly warm. Her temp is only 99, but her usual temperature is 97. The nurse decides to review the Care Paths for possible dehydration and fever, then she contacts the NP.

The NP asks the nurse about advance directives. The resident has a DNR/DNI order in place, but no advance directives regarding hospitalizations. The nurse gives the NP the contact information for the health care proxy, which has been invoked. The nurse reviews with the NP that stat labs can be drawn, an IV nurse can be called to place an IV within a few hours, and the emergency kit contains both p.o. and I.V. antibiotics.
The NP contacts the resident’s family and explains that the resident can be treated in the nursing home, since the lab results will come back within 4-8 hours; the nursing home can maintain an IV for IV fluids until the lab results are back. IV antibiotics and oxygen, if needed, can be administered. The family elects not to transfer the resident to the emergency room, expressing a preference for the plan of care in the nursing home.

The labs are drawn, the IV nurse places a peripheral line, and the nurse determines that a CNA will sit with the resident for a while, since the resident may become agitated and try to remove the IV line. IVF at 80 cc/hr are initiated, as well as IV ceftrixone 1 gm every 24 hours.

The labs come back remarkable for an elevated BUN (50) but no other major abnormal findings. After 24 hours, the resident looks much better, and is back to close to baseline. After 48 hours, the resident’s urine culture comes back “no growth,” so the antibiotics are stopped. The IV fluids are also d/c’d, and oral rehydration is continued.