

QUALITY IMPROVEMENT TOOL



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

Section 1: BACKGROUND INFORMATION

Resident's Last Name	First Name	Age	Unit/Room #
a. Date of most recent admission to nursing home: _____/_____/_____			
b. Resident hospitalized in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list dates and reasons below:			

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

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

a. Check **all** that apply:

CHANGE IN:

- Appetite/intake
- Behavior
- Function
- Skin or a wound

NEW CONDITION:

- Bleeding
- Breathing difficulty or SOB
- Constipation
- Diarrhea
- Fall
- Pain (new or worsened)
- Other (specify)

NEW SYMPTOM(S)/SIGNS OF:

- Altered mental status
- Congestive heart failure
- Dehydration
- Fever
- Lower respiratory infection
- Urinary tract infection

OTHER CHANGE:

- Abnormal lab value(s)
- Abnormal vital signs
- Family concern
- Other (specify)

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

Section 3: EVALUATION AND MANAGEMENT

a. Check *all* that apply:

TOOLS USED:

- Stop and Watch
- SBAR Progress Note
- Care Path
- Change in Condition Cards

MEDICAL EVALUATION:

- Telephone only
- On-site visit - MD
- On-site visit - NP or PA

TESTING:

- Blood tests
- Urinalysis or culture
- Xray
- Other (specify)

INTERVENTIONS:

- New medication
- IV or SC fluids
- Other (specify)

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

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

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

Section 4: TRANSFER INFORMATION

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

MD authorizing transfer: Primary MD Covering MD Other (_____)

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

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

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

Section 5: OPPORTUNITIES FOR IMPROVEMENT

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

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

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

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

Name of person completing form

Date of completion