INTERACT Webinar Series

Session 4: Communication Tools (Part 1)
Stop & Watch & SBAR
Quality Improvement: PDSA Cycle

May 27, 2015
with presenters:
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Today’s Session Objectives

Welcome nursing homes from the New England region

Understand the Plan Do Study Act (PDSA) process

Understand how to use the Stop and Watch tool

Understand how to use the SBAR tool to improve communication between caregivers

Develop a plan of implementation for these two new tools

15 minute state-specific group discussion
NE QIN-QIO Care Transitions Teams

**Connecticut**
Florence Johnson  
Sheila Eckenrode  
Carol Dietz

**Rhode Island**
Kathleen Calandra  
Nelia Odom

**New Hampshire**
Joyce Johnson  
Margaret Crowley

**Vermont**
Liz Klepner  
Gail Harbour

**Massachusetts**
Lynne Chase  
Sheryl Leary  
Lori Nerbonne

**Maine**
Maureen Leary
Polling Question

Since the last webinar, our team has used the Quality Improvement tool to review a resident transfer:

Yes  No
Polling Question

Since the last webinar we have used the INTERACT medication reconciliation tool at least once:

Yes  No
Communication Tools

For Communication Within the Nursing Home
- Stop and Watch Early Warning Tool
- Stop and Watch Early Warning Tool - Spanish
- SBAR Communication Form and Progress Note
- Medication Reconciliation Worksheet for Post-Hospital Care

For Communication Between the Nursing Home and Hospital
- Engaging Your Hospitals - Tip Sheets
- Nursing Home Capabilities List
- NH - Hospital Transfer Form
- NH - Hospital Data List
- Acute Care Transfer Checklist
- Hospital - Post-Acute Transfer Form
- Hospital - Post Acute Data List

Decision Support Tools: Change in Condition File Cards and Care Paths

Acute Change in Condition File Cards
- Acute Change in Condition File Cards

Care Paths
- Acute Mental Status Change
- Change in Behavior, New or Worsening Behavioral Symptoms
Stop and Watch

Early Warning Tool

Communicates a change in condition

Nursing Communication Tool

Efficiently brings together all pertinent information
Stop and Watch / Early Warning Tool

Designed to be used by CNAs

Appropriate for everyone

Need a process for restocking/reordering

Need to educate nurses on how to respond upon receipt of these
Stop and Watch / Early Warning Tool

**Stop and Watch**

Early Warning Tool

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

- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities
- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual

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

**Patient/Resident**

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)

Nurse's Name
Polling Question

Have you implemented the Stop and Watch tool in your facility?

Yes

No
Target Audience

• CNA’s and other nursing staff, rehab therapists, dietary staff, housekeeping staff, activities staff, laundry staff, and any staff member with direct resident contact on a routine basis.

• Family and close friends with regular direct contact
Method of Use

When to report changes:

- During the shift in which the change occurs
- Part of daily routine care
Barriers to Success

• Inconsistent assignment
• Staff (CNA/Nurse) turnover
• Broken relationships and communication between nurse/CNA and between CNA/CNA
• Resistance to change verbal method of notification
• Used alone without comprehensive INTERACT Program
• Lack of leadership from clinical champion and unit nurses
SBAR Tool

Nursing Communication Tool

Communicates a change in condition

A means to efficiently bring together all pertinent information
The Purpose of the SBAR

- Improve communication
- Consistent language
- Standardized criteria
- Clear guidelines
- Communication that is efficient
- Communication that is effective
SBAR Communication Form
and Progress Note for RNs/LPN/LVN's

Before Calling the Physician / NP / PA / other Healthcare Professional:
☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below:
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O₂, saturation and finger stick glucose for diabetics
☐ Review Records: Recent progress notes, labs, medications, other orders
☐ Review an INTERACT Case Path or Acute Change in Condition File Card, if indicated
☐ Have Relevant Information Available when Reporting
   (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION
The change in condition, symptoms, or signs observed and evaluated is/are

This started on ______ / ______ / ______
Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom worse are _________________________________

Things that make the condition or symptom better are _________________________________

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode (if applicable) _________________________________

Other relevant information _________________________________

BACKGROUND
Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Post Acute Care ☐ Other: _________________________________

Primary diagnoses _________________________________

Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) _________________________________

Medication Alerts
☐ Changes in the last week (describe):
☐ Resident is on Warfarin/Coumadin: Result of last INR: __________ Date: ______ / ______
☐ Resident is on other anticoagulant (Direct thrombin inhibitor or Plaquette Inhibitor)

Resident on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies _________________________________

Vital Signs
BP _______ Pulse _______ (or Apical HR _______ ) RR _______ Temp _______ Weight _______ lbs (date ______ / ______)

For CHF, edema, or weight loss: last weight before the current one was _________________________________

Pulse Oxymetry (if indicated) __________ % on: ☐ Room Air ☐ O₂ (_______)

Blood Sugar (Diabetics) _________________________________

Resident / Patient Name _________________________________

(continued)
**SBAR Communication Form**
and Progress Note for RNs/LPN/LVN (cont'd)

**Resident Evaluation**  
Note: Except for Mental and Functional Status evaluations, if the item is not relevant to the change in condition check the box for “not clinically applicable to the change in condition being reported”.

1. **Mental Status Evaluation (compared to baseline; check off changes that you observe)**  
   - Decreased level of consciousness (sleepy, lethargic)
   - Increased confusion or disorientation
   - Memory loss (new or worsening)
   - Describe symptoms or signs

   - New or worsened delusions or hallucinations
   - Other symptoms or signs of delirium (e.g., inability to pay attention, disorganized thinking)
   - Other (describe)
   - No changes observed

2. **Functional Status Evaluation (compared to baseline; check off changes that you observe)**  
   - Decreased mobility
   - Needs more assistance with ADLs
   - Falls (one or more)
   - Swallowing difficulty
   - Weakness (general)
   - Other (describe)
   - Other (describe)
   - No changes observed

3. **Behavioral Evaluation**  
   - Danger to self or others
   - Suicidal potential
   - Depression (crying, hopelessness, not eating)
   - Verbal aggression
   - Social withdrawal (isolation, apathy)
   - Physical aggression
   - Other (describe)
   - No changes observed

   - Describe symptoms or signs
   - Not clinically applicable to the change in condition being reported

4. **Respiratory Evaluation**  
   - Abnormal lung sounds (rales, rhonchi, wheezing)
   - Difficulty to eat or sleep due to SGB
   - Labored or rapid breathing
   - Shortness of breath
   - Other (describe)
   - No changes observed

   - Cough (___ Non-productive ___ Productive)
   - Describe symptoms or signs
   - Not clinically applicable to the change in condition being reported

5. **Cardiovascular Evaluation**  
   - Chest pain/tightness
   - Irregular pulse (area)
   - Edema
   - Labored or rapid breathing
   - No changes observed

   - Inability to stand without severe dizziness or light-headedness
   - Resting pulse >100 or <50
   - Not clinically applicable to the change in condition being reported

6. **Abdominal / GI Evaluation**  
   - Abdominal pain
   - Abdominal tenderness
   - Constipation
   - Diarrhea
   - (date of last BM ___ / ___ / ___)
   - GI bleeding (blood in stool or vomit)
   - Decreased/absent bowel sounds
   - Hyperactive bowel sounds
   - Other (describe)
   - No changes observed

   - Describe symptoms or signs
   - Not clinically applicable to the change in condition being reported

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**Resident/Patient Name**  
(continued)
7. GU/Urine Evaluation
   - [ ] Blood in urine
   - [ ] Decreased urine output
   - [ ] Lower abdominal pain or tenderness
   - [ ] Urinating more frequently or urgency with or without other urinary symptoms

   Describe symptoms or signs: ____________________________
   - [ ] Other (describe)
   - [ ] No changes observed

8. Skin Evaluation
   - [ ] Abrasion
   - [ ] Blisters
   - [ ] Burn
   - [ ] Contusion
   - [ ] Decubitus ulcer
   - [ ] Itching
   - [ ] Laceration
   - [ ] Pressure ulcer
   - [ ] Puncture
   - [ ] Rash
   - [ ] Split/macerated skin
   - [ ] Wound (describe)
   - [ ] Other (describe)
   - [ ] No changes observed

   Describe symptoms or signs: ____________________________
   - [ ] Other (describe)
   - [ ] No changes observed

9. Pain Evaluation
   - [ ] Yes (describe below)
   - [ ] No
   - [ ] New
   - [ ] Worsening of chronic pain

   Intensity of Pain (rate on scale of 1-10, with 10 being the worst): ____________
   Description/location of pain: ____________________________________________

10. Neurological Evaluation
    - [ ] Abnormal Speech
    - [ ] Seizure
    - [ ] Decreased level of consciousness
    - [ ] Weakness or hemiparesis
    - [ ] Dizziness or unsteadiness

   Other neurological symptoms (describe): ________________________________
   - [ ] Other (describe)
   - [ ] No changes observed

   Describe symptoms or signs: ____________________________
   - [ ] Other (describe)
   - [ ] No changes observed

Advance Care Planning Information (the resident has orders for the following advanced care planning)
   - [ ] Full Code
   - [ ] DNR
   - [ ] DNI (Do Not Intubate)
   - [ ] DNI (Do Not Hospitalize)
   - [ ] No Enteral Feeding
   - [ ] Other Option or Living Will (specify)

Other resident or family preferences for care

Resident/Patient Name (continued)
SBAR Communication Form
and Progress Note for RNs/LPN/LVNs (cont'd)

APPEARANCE
Summarize your observations and evaluation:


REVIEW AND NOTIFY
Primary Care Clinician Notified: ___________________________ Date __ / __ Time (am/pm) _____________

Recommendations of Primary Clinicians (if any) ___________________________

b. Check all that apply

Testing
  □ Blood tests
  □ EKG
  □ Urinalysis and/or culture

Interventions
  □ New or change in medication(s)
  □ IV/SC/Intraperitoneal fluids
  □ Increase oral fluids
  □ Oxygen (if available)

  □ Transfer to the hospital (non-emergency) (send a copy of this form)
  □ Call for 911
  □ Emergency medical transport

Nursing Notes (for additional information on the Change in Condition)


Name of Family/Health Care Agent Notified: ___________________________ Date __ / __ Time (am/pm) _____________

Staff Name (RN/LPN/LVN) and Signature ___________________________

Resident/Patient Name ___________________________
Polling Question

Have you implemented the SBAR tool in your facility?

Yes  No
PDSA Cycle

1. Plan
   - Plan the intervention

2. Do
   - Try the intervention on a small scale

3. Study
   - Study the results of the small scale intervention
   - Refine the intervention.
   - Prepare for further implementation
Plan

Hypothesis - We can implement “Stop and Watch” on the west unit
Do

Staff development will present at next staff meeting

Pads will be kept in the nurse’s station and break room

Charge nurse will ask CNAs if they have any “Stop and Watch” slips at the end of shift sign off

Shift supervisor will ask for “Stop and Watch” during unit rounds, as well as care plan responding to the change in resident condition
Do cont.

“Stop and Watch” slips will be brought to morning report

Shift supervisor will report suggested plan back to unit nurse and CAN

“Stop and Watch” slips will be shared with APRN/MD that comes to evaluate the resident

? ?? Other ideas???
Study

- Number of “Stop and Watch” slips turned in
- Number of “Stop and Watch” slips that resulted in change in the resident care plan
- Staff feedback
- Unplanned readmissions
- ED visits
Act

- CNAs request “Stop and Watch” pads they can carry in their pockets
- “Stop and Watch” slips made available to MD/APRN for routine rounds
- Consider roll out to others (recreation staff, housekeeping)
In applying PDSA, ask yourself three questions:

• What are we trying to accomplish?

• What changes can we make that will result in an improvement?

• How will we know that a change is an improvement?
Plan -> Do -> Study -> Act

Plan: There is too much noise during literacy times.

Do:
- Go over and say, "Shh-hh."
- Go over and whisper, "Please be quiet."
- Not chit-chat when someone is talking.
- Ignore a talker.
- Move to another spot.

Study:
This week we will tally it out. We will tally each time we forget.
15-Minute Sharing Session – State Specific

Connecticut Nursing Homes

[who have signed an INTERACT participation agreement as part of a Community of Care]

Please stay on the line
Sharing Session

- Review issues from last month’s homework
- Discuss successes and barriers during 15 minute sharing session
- Discuss this month’s homework
INTERACT Participation Certification

- Minimum participation viewing the INTERACT webinars: 75% (at least 7 webinars)
  
  and

- Send monthly readmission data to Qualidigm for at least three months

  or

- Enter data into the Advancing Excellence tool: ‘Safely Reducing Hospitalization Tracking Tool’ and sign the Data Use Agreement (DUA) document allowing Qualidigm to access your readmission data for three months
Accessing the INTERACT Webinars after each session

• Click on the ‘Events’ tab
• Scroll down to the ‘Previous Events’ link
• Click on the webinar recording link
Polling question

Did your team perform a Root Cause Analysis using the INTERACT QI tool on at least one unplanned readmission in the past month?

Yes  No
Polling question

My facility has started inputting data into the:

1) Advancing Excellence ‘Safely Reduce Hospitalizations Tracking Tool’

2) INTERACT Readmission Tracking Tool using a computer

3) INTERACT Readmission Tracking Tool using a paper tool

4) Our facility is using another readmission tracking tool

5) Our facility has not started tracking readmission data yet
Homework from Session #3

Prior to your next INTERACT team meeting:

- The team leader will download the Quality Improvement Tool for Review of Acute Care Transfers and the Medication Reconciliation Tool from the INTERACT website and make copies of the tools for the team to review.

- The team leader will download the QI tool and the Med Rec tool to a facility computer on a shared drive.
Homework from Session #3

During your next team meeting:

- Review the two INTERACT tools
- Discuss how and when the staff nurses, supervisors and leadership/medical director will be educated on the use of the two tools
- Decide which unit will begin to use the QI tool and Med Rec tool
- Develop a timeline The plan will include a debrief by the team and the participating staff as to how things went after the tools are used for the first time
Homework from Session #3

During the team meeting:

- The team will discuss any issues with the data entry into the ‘Safely Reduce Hospitalizations Tracking Tool’ (submission of April readmission data to Qualidigm team should begin in the beginning of June)

- The team needs to be prepared to talk about what INTERACT tools they have started using at the next community meeting
Group Discussion

Do you have any lessons learned, successes, or barriers that you want to share as you:

- developed the process for educating your staff on the new INTERACT tools and implementing these tools?
- used the tools for the first time?
- met with your team to debrief after the tools are used for the first time?
- talked with your leadership?
- talked with your Medical Director?
- discussed this initiative with your community?
Homework for Session #4

Prior to your next INTERACT team meeting:

- The team leader will download the Stop & Watch and the SBAR tool from the INTERACT website and make copies of the tools for the team to review.

- The team leader will download the Stop & Watch and the SBAR tool to a facility computer on a shared drive.
Homework for Session #4

During your next team meeting:

• Review the two INTERACT tools

• Discuss how and when the staff nurses, supervisors and medical director/APRNs will be educated on the use of the SBAR tool (staff should practice using the tool during this education)

• Decide which unit will begin to use this tool and where copies of the tool will be located

• A timeline will be developed by the team

• Plan will include a debrief by the team and the participating staff as to how things went after the tool is used for the first time
Homework for Session #4

During your next team meeting:

- Discuss how and when the entire staff will be educated on the use of the Stop & Watch tool
- Decide which unit will begin to use this tool
- A timeline will be developed by the team
- Plan will include a debrief by the team and the participating staff as to how things went after the tool is used for the first time
Homework for Session #4

During the team meeting:

➢ Team will discuss any issues with the data entry into the ‘Safely Reduce Hospitalizations Tracking Tool’

➢ Begin to review the readmission reports (submission of April readmission data to Qualidigm team should begin in the beginning of June)

➢ Team needs to be prepared to talk about what INTERACT tools they have started using at the next community meeting
Questions?
Contact Information

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