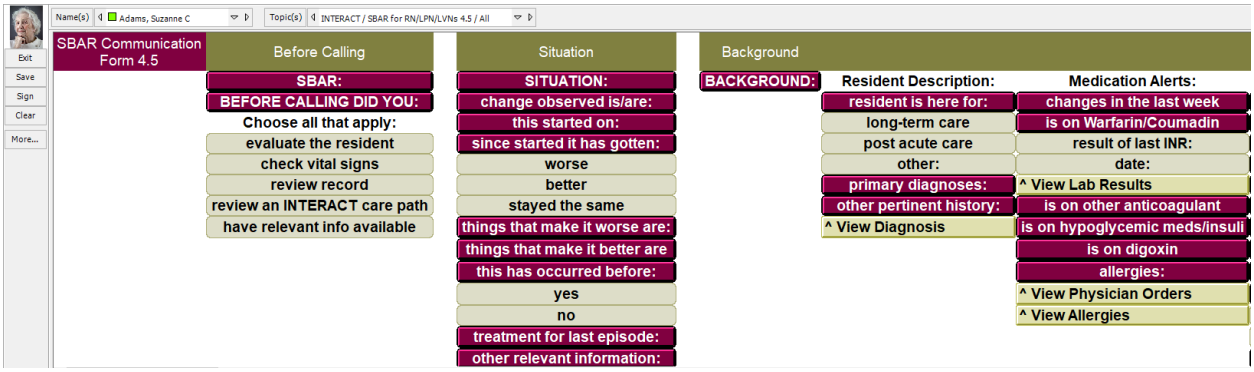
INTERACT® User Instructions

To learn more about INTERACT (Interventions to Reduce Acute Care Transfers), you can go to https://pathway-interact.com/.

SBAR Documenting Screen



Completing the SBAR (Using Access Screens)

1. Using the Easy Access screens, navigate to the **SBAR** button. The SBAR documentation screen will load. Use the screen to work from left to right and enter the SBAR information. Utilize the go-to buttons as needed to view documentation which may assist in completing the SBAR. Once completed, there are three options available:
    a. Click onto **Sign** to save and exit the screen.
    b. Click onto **^ Preview SBAR Form** to view the report based on the data that was just entered.
    c. Click onto **^ Hospital Transfer Packet** to view the report task which includes the Transfer & Referral Record, Nurses Notes (Last 48 Hours), and the last two weeks of MAR/TAR signatures.

View/Edit SBAR

1. Using the Easy Access screens, navigate to a **View Chart** button.
2. Select the resident name(s) and click **OK.**
3. Click onto **Topic** and navigate to the INTERACT (or Rehospitalizations) tab. Highlight the SBAR topic and click **OK.**
4. Enter in a **Date From** and **Date To**, if needed.
5. Click **Go** to view prior SBAR entries.
6. Utilize usual editing features depending on the adjustment needed. Some examples of edits needed may include:
    a. **Append** > add additional information to an existing SBAR
    b. **Discontinue/Archive** > documented the SBAR on the wrong resident

c. Copy One to Other Client > documented the SBAR on the wrong resident and are moving it to the correct one
d. Discontinue and Copy > needing to make an adjustment to a part of the SBAR (i.e., inverted the numbers of a vital sign).

Preview SBAR Report

1. Using the Easy Access screens, navigate to a Reports or More Reports button.
2. Select the resident name(s) and click OK.
3. Click onto Tasks and highlight the INTERACT – SBAR task and click Load.
4. Select the date the SBAR was completed and click OK to load the preview.

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

INTERACT Version 4.5 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

- ☐ **Evaluate the Resident/Patient:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 saturation and finger stick glucose for diabetics
- ☐ **Review Record:** Recent progress notes, labs, medications, other orders
- ☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card, if indicated**
- ☐ **Have Relevant Information Available when Reporting** *e.g., 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/Patient Description

This resident/patient 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, isolation for infection or communicable disease)*

_____

Medication Alerts

☐ Changes in the last week *(describe)* _____

Completing the SBAR (Not Using Access Screens)

1. Select the Write icon and the desired name. Click OK. Click the Topic button, click into the INTERACT tab and highlight the SBAR 4.5 topic, and click OK. The SBAR documentation screen will load. Use the screen to work from left to right and enter the SBAR information. Utilize the go-to buttons as needed to view documentation which

may assist in completing the SBAR. Once completed, there are three options available:

a. Click onto **Sign** to save and exit the screen.
b. Click onto **^ Preview SBAR Form** to view the report based on the data that was just entered.
c. Click onto **^ Hospital Transfer Packet** to view the report task which includes the Transfer & Referral Record, Nurses Notes (Last 48 Hours), and the last two weeks of MAR/TAR signatures.

View/Edit SBAR

1. Click onto the green **View** icon.
2. Select the resident name(s) and click **OK.**
3. Click onto **Topic** and navigate to the INTERACT (or Rehospitalizations) tab. Highlight the SBAR topic and click **OK.**
4. Enter in a **Date From** and **Date To**, if needed.
5. Click **Go** to view prior SBAR entries.
6. Utilize usual editing features depending on the adjustment needed. Some examples of edits needed may include:
    a. **Append** > add additional information to an existing SBAR
    b. **Discontinue/Archive** > documented the SBAR on the wrong resident
    c. **Copy One to Other Client** > documented the SBAR on the wrong resident and are moving it to the correct one
    d. **Discontinue and Copy** > needing to make an adjustment to a part of the SBAR (i.e., inverted the numbers of a vital sign).

Preview SBAR Report

1. Click onto the green **Reports** icon.
2. Select the resident name(s) and click **OK.**
3. Click onto **Tasks** and highlight the **INTERACT – SBAR** task and click **Load**.
4. Select the date the SBAR was completed and click **OK** to load the preview.