

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs



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 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**
(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 Foul urine odor and increased confusion

This started on 05 / 09 / 18 Since this started it has gotten: Worse Better Stayed the same

Things that make the condition or symptom **worse** are N/A

Things that make the condition or symptom **better** are N/A

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 S/P BKA PE

Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) DM, HTN, HLD, Seizures

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 platelet inhibitor)

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

Allergies NKA

Vital Signs

BP 123/75 Pulse 76 (or Apical HR _____) RR 17 Temp 98.5 Weight 160 lbs (date 5 / 7 / 18)

For CHF, edema, or weight loss: last weight before the current one was _____ on ____/____/____

Pulse Oximetry (if indicated) 97 % on Room Air O₂ (_____)

Blood Sugar (Diabetics) 120

Resident /Patient Name Patient UTI

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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 all changes that you observe)

- | | | |
|---|---|--|
| <input type="checkbox"/> Decreased level of consciousness (sleepy, lethargic) | <input type="checkbox"/> New or worsened delusions or hallucinations | <input type="checkbox"/> Other (describe) |
| <input checked="" type="checkbox"/> Increased confusion or disorientation | <input type="checkbox"/> Other symptoms or signs of delirium (e.g. inability to pay attention, disorganized thinking) | <input type="checkbox"/> No changes observed |
| <input type="checkbox"/> Memory loss (new or worsening) | <input type="checkbox"/> Unresponsiveness | |

Describe symptoms or signs Alert and oriented X2 to self and place

2. Functional Status Evaluation (compared to baseline; check all that you observe)

- | | | |
|--|--|--|
| <input type="checkbox"/> Decreased mobility | <input type="checkbox"/> Swallowing difficulty | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Needs more assistance with ADLs | <input type="checkbox"/> Weakness (general) | <input type="checkbox"/> No changes observed |
| <input type="checkbox"/> Falls (one or more) | | |

Describe symptoms or signs _____

3. Behavioral Evaluation

- | | | |
|--|--|--|
| <input type="checkbox"/> Danger to self or others | <input type="checkbox"/> Suicide potential | <input type="checkbox"/> Personality change |
| <input type="checkbox"/> Depression (crying, hopelessness, not eating) | <input type="checkbox"/> Verbal aggression | <input type="checkbox"/> Other behavioral changes (describe) |
| <input type="checkbox"/> Social withdrawal (isolation, apathy) | <input type="checkbox"/> Physical aggression | <input type="checkbox"/> No changes observed |

Describe symptoms or signs _____

Not clinically applicable to the change in condition being reported

4. Respiratory Evaluation

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal lung sounds (rales, rhonchi, wheezing) | <input type="checkbox"/> Inability to eat or sleep due to SOB | <input type="checkbox"/> Symptoms of common cold |
| <input type="checkbox"/> Asthma (with wheezing) | <input type="checkbox"/> Labored or rapid breathing | <input type="checkbox"/> Other respiratory changes (describe) |
| <input type="checkbox"/> Cough (<input type="checkbox"/> Non-productive <input type="checkbox"/> Productive) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> No changes observed |

Describe symptoms or signs _____

Not clinically applicable to the change in condition being reported

5. Cardiovascular Evaluation

- | | | |
|---|--|--|
| <input type="checkbox"/> Chest pain/tightness | <input type="checkbox"/> Irregular pulse (new) | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Resting pulse >100 or <50 | <input type="checkbox"/> No changes observed |
| <input type="checkbox"/> Inability to stand without severe dizziness or lightheadedness | | |

Describe symptoms or signs _____

Not clinically applicable to the change in condition being reported

6. Abdominal / GI Evaluation

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Distended abdomen | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Abdominal tenderness | <input type="checkbox"/> Decreased appetite/fluid intake | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Constipation
(date of last BM ____ / ____ / ____) | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Decreased/absent bowel sounds | <input type="checkbox"/> GI Bleeding (blood in stool or vomitus) | <input type="checkbox"/> No changes observed |
| | <input type="checkbox"/> Hyperactive bowel sounds | |

Describe symptoms or signs _____

Not clinically applicable to the change in condition being reported

Resident/Patient Name Patient UTI

(continued)

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7. GU/Urine Evaluation

- Blood in urine
- Decreased urine output
- Lower abdominal pain or tenderness
- New or worsening incontinence
- Painful urination
- Urinating more frequently or urgency with or without other urinary symptoms
- Other (describe)
- No changes observed

Describe symptoms or signs Foul odor

Not clinically applicable to the change in condition being reported

8. Skin Evaluation

- Abrasion
- Blister
- Burn
- Contusion
- Discoloration
- Itching
- Laceration
- Pressure ulcer
- Puncture
- Rash
- Skin tear
- Splinter/sliver
- Wound (describe)
- Other (describe)
- No changes observed

Describe symptoms or signs _____

Not clinically applicable to the change in condition being reported

9. Pain Evaluation

Does the resident have pain?

- No
- Yes (describe below)

Is the pain?

- New
- Worsening of chronic pain

Description/location of pain: _____

Intensity of Pain (rate on scale of 1-10, with 10 being the worst): _____

Does the resident show non-verbal signs of pain (for residents with dementia)?

- No
- Yes (describe) _____
(restless, pacing, grimacing, new change in behavior)

Other information about the pain _____

Not clinically applicable to the change in condition being reported

10. Neurological Evaluation

- Abnormal Speech
- Decreased level of consciousness
- Dizziness or unsteadiness
- Seizure
- Weakness or hemiparesis
- Other neurological symptoms (describe)
- No changes observed

Describe symptoms or signs _____

Not clinically applicable to the change in condition being reported

Advance Care Planning Information (the resident has orders for the following advanced care planning)

- Full Code
- DNR
- DNI (Do Not Intubate)
- DNH (Do Not Hospitalize)
- No Enteral Feeding
- Other Order or Living Will (specify)

Other resident or family preferences for care _____

Resident/Patient Name Patient UTI

(continued)

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APPEARANCE

Summarize your observations and evaluation: Patient with increased confusion, dark, foul urine.

REVIEW AND NOTIFY

Primary Care Clinician Notified: Dr. Smith Date 5/9/18 Time (am/pm) 8am

Recommendations of Primary Clinicians (if any) U/A and U/C Call with results.

b. Check all that apply

Testing

- Blood tests
- EKG
- Urinalysis and/or culture
- Venous doppler
- X-ray
- Other (describe) _____

Interventions

- New or change in medication(s)
- IV or subcutaneous fluids
- Increase oral fluids
- Oxygen (if available)
- Other (describe) _____

- 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: Mrs. Patient UTI Date 5/9/18 Time (am/pm) 8am

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

Resident/Patient Name _____