

# 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, O<sub>2</sub> 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 \_\_\_\_\_

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 platelet inhibitor)

Resident is 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 \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_

Pulse Oximetry (if indicated) \_\_\_\_\_% on  Room Air  O<sub>2</sub> ( \_\_\_\_\_ )

Blood Sugar (Diabetics) \_\_\_\_\_

Resident /Patient Name \_\_\_\_\_

(continued)

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

Describe symptoms or signs \_\_\_\_\_

#### 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 ( <i>describe</i> ) |
| <input type="checkbox"/> Needs more assistance with ADLs | <input type="checkbox"/> Weakness ( <i>general</i> ) | <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 ( <i>crying, hopelessness, not eating</i> ) | <input type="checkbox"/> Verbal aggression   | <input type="checkbox"/> Other behavioral changes ( <i>describe</i> ) |
| <input type="checkbox"/> Social withdrawal ( <i>isolation, apathy</i> )         | <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 ( <i>rales, rhonchi, wheezing</i> )                             | <input type="checkbox"/> Inability to eat or sleep due to SOB | <input type="checkbox"/> Symptoms of common cold                       |
| <input type="checkbox"/> Asthma ( <i>with wheezing</i> )  | <input type="checkbox"/> Labored or rapid breathing           | <input type="checkbox"/> Other respiratory changes ( <i>describe</i> ) |
| <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 ( <i>new</i> ) | <input type="checkbox"/> Other ( <i>describe</i> ) |
| <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<br>( <i>date of last BM ____ / ____ / ____</i> ) | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Other ( <i>describe</i> ) |
| <input type="checkbox"/> Decreased/absent bowel sounds                                 | <input type="checkbox"/> GI Bleeding ( <i>blood in stool or vomitus</i> ) | <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 \_\_\_\_\_

(continued)

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### 7. GU/Urine Evaluation

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Blood in urine                     | <input type="checkbox"/> New or worsening incontinence   | <input type="checkbox"/> Other ( <i>describe</i> ) |
| <input type="checkbox"/> Decreased urine output             | <input type="checkbox"/> Painful urination   | <input type="checkbox"/> No changes observed       |
| <input type="checkbox"/> Lower abdominal pain or tenderness | <input type="checkbox"/> Urinating more frequently or urgency with or without other urinary symptoms |  |

Describe symptoms or signs \_\_\_\_\_

- Not clinically applicable to the change in condition being reported

### 8. Skin Evaluation

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abrasion      | <input type="checkbox"/> Itching        | <input type="checkbox"/> Skin tear                 |
| <input type="checkbox"/> Blister       | <input type="checkbox"/> Laceration     | <input type="checkbox"/> Splinter/sliver           |
| <input type="checkbox"/> Burn          | <input type="checkbox"/> Pressure ulcer | <input type="checkbox"/> Wound ( <i>describe</i> ) |
| <input type="checkbox"/> Contusion     | <input type="checkbox"/> Puncture       | <input type="checkbox"/> Other ( <i>describe</i> ) |
| <input type="checkbox"/> Discoloration | <input type="checkbox"/> Rash           | <input type="checkbox"/> 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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal Speech                  | <input type="checkbox"/> Seizure                 | <input type="checkbox"/> Other neurological symptoms ( <i>describe</i> ) |
| <input type="checkbox"/> Decreased level of consciousness | <input type="checkbox"/> Weakness or hemiparesis | <input type="checkbox"/> No changes observed                             |
| <input type="checkbox"/> Dizziness or unsteadiness        |  |  |

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 \_\_\_\_\_

(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
- 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: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (am/pm) \_\_\_\_\_

Staff Name (RN/LPN/LVN) and Signature \_\_\_\_\_

Resident/Patient Name \_\_\_\_\_