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

*CHF, DM, COPD)*

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

**SBAR Communication Form**

*and Progress Note for RNs/LPN/LVNs*

**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, 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 suchas 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 HF, DM, COPD)*

**Medication Alerts**

* Changes in the last week *(describe)*
* Resident/patient is on *(Warfarin/Coumadin)* Result of last INR: Date / /
* Resident/patient is on other anticoagulant *(direct thrombin inhibitor or platelet inhibitor)*

Resident/patient is on:

Hypoglycemic medication(s) / Insulin

Digoxin

Allergies

**Vital Signs**

BP Pulse (or Apical HR ) RR Temp Weight lbs *(date* / / *)*

For HF, edema, or weight loss: last weight before the current one was on / /

Pulse Oximetry (*if indicated*) % on  Room Air

 O2 ( )

Blood Sugar *(Diabetics)*

**Resident /Patient Name**

*(continued)*

 Altered level of consciousness *(hyperalter, drowsy but easily aroused, difficult toarouse)*

Memory loss *(new or worsening)*



Verbal aggression 

Physical aggression



*(date of last BM* \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_ *)*

Decreased/absent bowel sounds

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**SBAR Communication Form**

*and Progress Note for RNs/LPN/LVNs (cont’d)*

**Resident/Patient 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)***

New or worsened delusions or hallucinations  Other *(describe)*

Altered level of consciousness *(hyperalert, drowsy but easily aroused, difficult to arouse)*

Other symptoms or signs of delirium *(e.g. inability to payattention, disorganized thinking)*

Unresponsiveness

 **No changes observed**

 Increased confusion or disorientation

Memory loss *(new or worsening)*

Describe symptoms or signs

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

* Decreased mobility
* Needs more assistance with ADLs
* Falls (one or more)
* Swallowing difficulty
* Weakness *(general)*
* Other *(describe)*

# No changes observed

Describe symptoms or signs

# Behavioral Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Personality change
* Other behavioral changes *(describe)*

# No changes observed

* Danger to self or others
* Depression *(crying, hopelessness, not eating)*
* Social withdrawal *(isolation, apathy)*
* Suicide potential

Verbal aggression Physical aggression

Describe symptoms or signs

# Respiratory Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Abnormal lung sounds *(rales, rhonchi, wheezing)*
* Asthma *(with wheezing)*
* Inability to eat or sleep due to SOB
* Labored or rapid breathing
* Shortness of breath
* Symptoms of common cold
* Other respiratory changes *(describe)*

# No changes observed

* Cough (  Non-productive
* Productive )

Describe symptoms or signs

# Cardiovascular Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Other *(describe)*

# No changes observed

* Chest pain/tightness
* Edema
* Inability to stand without severe dizziness or lightheadedness
* Irregular pulse *(new)*
* Resting pulse >100 or <50

Describe symptoms or signs

# Abdominal / GI Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Abdominal pain
* Abdominal tenderness
* Constipation
* Distended abdomen
* Decreased appetite/fluid intake
* Diarrhea
* GI Bleeding *(blood in stool or vomitus)*
* Hyperactive bowel sounds
* Jaundice
* Nausea and/or vomiting
* Other *(describe)*

# No changes observed

*(date of last BM \_\_\_\_ / \_\_\_\_ / \_\_\_\_)*

Decreased/absent bowel sounds

Describe symptoms or signs

**Resident/Patient Name**

*(continued)*

or without other urinary symptoms

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*drowsy but easily arousable, difficult to arouse, unarousable*)

 Dizziness or unsteadiness

**SBAR Communication Form**

*and Progress Note for RNs/LPN/LVNs (cont’d)*

# GU/ Urine Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Blood in urine
* Decreased urine output
* Lower abdominal pain or tenderness
* New or worsening incontinence
* Painful urination
* Urinating more frequently or urgency with
* Other *(describe)*

# No changes observed

or without other urinary symptoms

Describe symptoms or signs

# Skin Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Itching
* Laceration
* Pressure ulcer/pressure injury
* Puncture
* Rash
* Skin tear
* Splinter/sliver
* Wound *(describe)*
* Other *(describe)*

# No changes observed

* Abrasion
* Blister
* Burn
* Contusion
* Discoloration

Describe symptoms or signs

# Pain Evaluation

* + **Not clinically applicable to the change in condition being reported**

**Does the resident have pain?**

* No

**Is the pain?**

* New
* Yes *(describe below)*
* Worsening of chronic pain

Description/location of pain:

**Intensity of Pain** *(rate onscale 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, newchange in behavior)*

Other information about the pain

# Neurological Evaluation

* + **Not clinically applicable to the change in condition being reported**
* Other neurological symptoms *(describe)*

# No changes observed

* Abnormal Speech
* Altered level of consciousness (*hyperalert,*
* Seizure
* Weakness or hemiparesis

*drowsy but easily arousable, difficult to arouse, unarousable)*

Dizziness or unsteadiness

Describe symptoms or signs

**Advance Care Planning Information *(the resident/patient 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/patient or representative preferences for care**

**Resident/Patient Name** *(*\_*c*\_*o*\_*n*\_*ti*\_*n*\_*u*\_*ed*\_*)*

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**SBAR Communication Form**

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**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 or subcutaneous fluids
* Venous doppler
* X-ray
* Other *(describe)*
* Increase oral fluids
* Oxygen *(if available)*
* Other *(describe)*
* Transfer to the hospital (non-emergency) *(send a copyof 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**