**Modified SBAR tool template example**

Patient name:

NHI:

**Early alert assessment and communication**

Review resident record: Recent progress notes, labs, medication, other orders

Assess the resident using this form

Review/activate care pathway (if available)

Have relevant information available when reporting (ie, medical letters, blood test and investigations, ceiling of intervention orders, allergies, medication list)

**SITUATION**

**Prompts**

O = Onset

L = Location

D = Duration

C = Characteristics

A = Aggravating

R = Relieving

T = Treatment

S = Severity

The current change in condition, symptoms and problems are:

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

Treatment for last episode: Effective?

**BACKGROUND**

**Resident description**

This resident is in the facility for: [ ]  Rest home [ ]  Hospital [ ]  Dementia [ ]  Other

Primary diagnoses:

Relevant medical/social history:

Allergies/alerts:

Medications (attach copy of medication sheet)

Currently on:

[ ]  Warfarin: last INR:\_\_\_\_\_\_ Date:\_\_/\_\_/\_\_ [ ]  Other anticoagulant [ ]  Oral hypoglycaemic [ ]  Insulin
[ ]  Digoxin [ ]  Other:

[ ]  Recent medication changes:

Resident and/or family **advance care planning/preferences for care:**

**Weight** **kg**:\_\_\_\_\_\_ [ ]  Stable [ ]  Increased [ ]  Decreased by: \_\_\_ kg Over past:\_\_\_Days\_\_\_\_Week(s)\_\_\_Months

**Bowels:** Days since last motion: \_\_\_ Number of motions in last week: \_\_\_

 Motions: [ ]  Pebbles [ ]  Normal/large/soft [ ]  Diarrhoea/runny

|  |
| --- |
| **Assessment – acute deterioration eight steps (frailty care guides – Health Quality & Safety Commission New Zealand):**Patient name:NHI:**1. Review possible cause 2. Take observations and review warning signs 3. Assess recent labs or other results 4. Review hydration status 5. Assess for delirium 6. Review pain status 7. Review for constipation or diarrhoea 8. Review goals of care** **General appearance:****RR: HR: irreg/reg BP: Lying: Standing: BGL: Temp: \_\_\_\_\_\_\_\_\_****SpO2: \_\_\_\_\_\_\_ % on RA/O2\_\_\_\_\_\_\_\_l/min. Changes since last set of obs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Sepsis may be indicated if: known or suspected infection plus any two of the following: T > 37.5 or < 36, RR > 24, HR > 100, acute mental state change, High or low WCC, hyperglycaemia** |
| **COGNITIVE**[ ]  Alert and orientated[ ]  Confusion[ ]  Fluctuating [ ]  Consistent[ ]  Other signs of delirium4AT[ ]  Baseline MOCA:[ ]  Altered level of consciousness[ ]  Hyperalert[ ]  Sleepy/lethargic[ ]  Difficult to rouse[ ]  Unresponsive[x]  No problems**NEUROLOGICAL**[ ]  Headache[ ]  Dizziness[ ]  Numbness/tingling[ ]  Seizure[ ]  Face droop[ ]  Arm/body weakness[ ]  Speech changes[ ]  **If yes to three above time ? stroke**[ ]  Swallowing difficulty[x]  No problems | **RESPIRATORY**[ ]  Shortness of breath [ ]  New [ ]  Increased [ ]  At rest [ ]  On exertion[ ]  SOB affecting sleep or speech[ ]  Cough [ ]  Productive [ ]  Colour:\_\_\_\_\_\_\_\_\_ [ ]  Non-productive [ ]  Laboured [ ]  Rapid[ ]  Cheyne stroke[ ]  Wheeze[ ]  Crackles[x]  No problems**CVS**[ ]  Chest tightness[ ]  Pain[ ]  Dizzy/lightheaded[ ]  Oedema[ ]  Irregular pulse[ ]  Resting pulse > 100 or < 50[ ]  Tongue: Moist or dry[ ]  JVP ………cm[x]  No problems | **ABDOMINAL**[ ]  Tenderness [ ]  Pain[ ]  Decreased food/fluid[ ]  Nausea[ ]  Vomiting[ ]  ConstipationDate of last BM:\_\_\_\_\_\_\_\_ [ ]  Diarrhoea[ ]  Bowel sounds[ ]  Absent [ ]  Hyperactive[ ]  Bloody stool or vomit[ ]  Distended abdomen[ ]  Jaundice[ ]  PR\_\_\_\_\_\_\_[x]  No problems**GU**[ ]  Tenderness [ ]  Pain[ ]  Painful urination[ ]  Colour:\_\_\_\_\_\_\_[ ]  Blood [ ]  Urgency [ ]  Frequency[ ]  Nocturia[ ]  Decreased or no urine[ ]  New incontinence[ ]  SPC/IDC[x]  No problems | **PAIN**[ ]  Yes [ ]  Site[ ]  New or [ ]  Increased[ ]  Onset…………………[ ]  Provoking…………….[ ]  Quality………………..[ ]  Radiating……………..[ ]  Severity 1–10:…………[ ]  Timing………………..[ ]  Non-verbal signs[x]  No problems**BEHAVIOURAL**[ ]  Mood changes[ ]  Social withdrawal[ ]  New aggression[ ]  Verbal [ ]  Physical[ ]  Personality change[ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_[x]  No problems**MSK**[ ]  Decreased mobility[ ]  Increased weakness[ ]  Needing more assistance with ADL[ ]  Falls in last month[ ]  Symptoms of fractureSite:[x]  No problems | **SKIN**[ ]  DiscolourationOnset:Site: [ ]  Redness [ ]  Heat [ ]  Tracking [ ]  Swelling[ ]  Contusion[ ]  Pus[ ]  Other skin conditions (eg, itch/rash)Type:Site:Onset:[x]  Pressure injurySite:Grade:Onset:[ ]  WoundSite:Type: Onset:[x]  No problems |

 **RECOMMENDATION/RESPONSE**

**Nursing diagnosis (what do you think is going on?):**

Nursing interventions (what are you going to do?):

[ ]  Observations \_\_\_\_\_hourly for \_\_\_\_\_\_ hours [ ]  Urinalysis [ ]  Activate symptom management plan

[ ]  Safety interventions [ ]  Additional assessment \_\_\_\_\_\_\_\_

[ ]  PRN medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Increase oral fluids [ ]  Family discussion, place/goals of care

[ ]  Other:

GP notified? Yes/No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations/plan from GP:

[ ]  Ongoing monitoring every \_\_\_\_\_\_\_\_\_ hours and GP review in \_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Subcutaneous or IV fluids [ ] Oxygen [ ] Other

[ ]  New or change medication/s:

[ ]  Transfer to the hospital (non-emergency/emergency) – **goals of transfer:**

Staff name and designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name of family notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (am/pm): \_\_\_\_\_\_\_\_\_\_\_