POLICY & PROCEDURE

SBAR COMMUNICATION TOOL

Date initiated 1/10 Revised
Medical Director initial_____

PURPOSE:

To assure optimal communication between nurse and physician when there is a significant change in a resident's condition.

PROCEDURE:

1. Utilize the SBAR form when a significant change is identified in a resident.
2. Note the onset and history of the symptoms noted.
3. Review the resident's medical background.
4. Complete an evaluation of the resident in regards to the identified concern.
5. Contact the physician.
6. Document outcome of communication with the physician.
7. Document any pertinent additional information on the back of the SBAR form.
8. File the SBAR in the medical record under "Interdisciplinary Resident Progress Notes" section.

SBAR: NURSE/PHYSICIAN COMMUNICATION TOOL & PROGRESS NOTE

***Resident*_____ *Room*_____**

Before calling the physician:

- □ Evaluate the resident: Take vital signs, and other appropriate tools: (accucheck, lung sounds, bowel sounds, pedal pulses, etc.)
- □ Review chart (recent falls, recent labs, recent nurses' notes, advanced directives, etc.)
- □ Have the information available when you call the physician.

S Situation

The problem/symptom being reported is related to:
__Resp __GI __AMS __Pain __Chg in Fx __Chg in intake __Chg in skin condition __Labs
If applicable:
This started on_____ and has: __gotten better__gotten worse __stayed the same.

B Background

This resident's primary diagnosis on admission:

The resident's pertinent medical history includes: (Check or write in applicable information)

- □ Allergies: __yes __no If yes:_____
- □ Recent fall(s) on_____
- □ Medication changes recently? If yes, state:_____
- □ If pertinent, advanced directives:_____

A Appearance

Vital signs: BP_____ T_____ P_____ R_____ Accucheck_____
Oxygen sat_____% on __room air __on oxygen @ 2L __on oxygen @___L via __N/C__mask

- □ **Respiratory**-If applicable:__dyspnea __congested__rales __rhonchi__pallor __cyanosis
- □ **GI**- If applicable __nausea __vomited x___ amount_____description_____
  Bowel sounds-present x___quandrants __diminshed Abdomen __distended __ soft/nontender
- □ **Change in mental status**, If applicable: __forgetful __confused __agitated __lethargy
  Other_____
- □ **Pain level** If applicable: Location_____ Scale score____Frequency: __constant __intermittent
  Intervention_____
- □ **Change in function**, If applicable; __decline __improvement in_____
- □ **Change in intake**, If applicable_____
  If alternate nutrition recommended, resident/family wishes:_____
- □ **Change in hydration**, If applicable_____
- □ **Change in skin/wound condition**:

Other things occurring with the resident include:

R Request (check what nurse is requesting of physician)

- □ Visit by physician/ARNP
- □ New lab/X-ray, other tests _____
- □ Medication changes_____
- □ IV fluids_____
- □ Observe and report

Reported to Dr._____ on_____ at_____ by __phone __fax __in person
by_____. RN/LPN
Response by_____ on_____ at_____ by __phone __fax __in person
received by_____. RN/LPN New orders received include:

Responsible party_____ notified of chg in condition on_____ at_____ by _____

Document further pertinent information on back of SBAR form.

RESIDENT TRANSFER FORM

RESIDENT NAME (last, first)	*SENT FROM*: (Name of Facility) Date_____
DATE OF BIRTH: Language: *AGE*: □ English □ Other:	Unit_____ Phone #(_____)_____-_____ Contact person:
Currently covered under Medicare Part A in SNF ___yes ___no	*SENT TO*: (name of hospital) Phone #(_____)_____-_____
Resident is □ Short-term □ Long-term	

CONTACT PERSON:	*PHYSICIAN*:
Name_____ □ HCS □ HCP □ POA □ DPOA □ Guardian □ Other Phone #(_____)_____-_____ Notified of transfer __yes __no Aware of Diagnosis __yes __no	Dr._____ Phone #(_____)_____-_____ Resident has: □ DNR (Attached __yes __no) □ Living will (Attached __yes __no)

The **following are attached:** □ Face sheet □ Current orders □ Bed hold policy □ Labs/ X-rays

***REASON FOR TRANSFER*: (Be specific)**

Route of transport ___Ambulance Ambulance service called_____ ___ W/C van ___Car

DIAGNOSES:

V/S: BP_____ T_____P_____R_____ Accucheck_____ O2 sat_____% on __RA__O2 at___L

Allergies_____Precautions: □ MRSA as of___ (date) □ VRE as of___ (date) Site_____ □ C-Diff as of___ (date)

DEVICES/SPECIAL TREATMENTS:	*RISK ALERTS:*
□ IV/PICC/Mid-line □ Foley catheter □ Ostomy □ Pacemaker □ Internal defibrillator □ TPN Other:	□ None □ Falls □ Seizure □ Aspiration □ Elopement □ Skin breakdown □ Restraints □ Harmful to __self __others

IMMUNIZATIONS:	*SPECIAL TREATMENTS & FREQUENCIES:*
Influenza Given on_____ Refused on_____ Pneumococcal Given on_____ Refused on_____ Other_____ Given on_____ Refused on_____	(Include dialysis, chemotherapy, radiation, hospice, etc. here)

RESIDENT TRANSFER FORM

USUAL MENTAL STATUS:	***USUAL FUNCTIONAL STATUS:***	***DIET:***
□ Alert □ Forgetful □ Disoriented □ Can □ Cannot follow instructions	Ambulates □ independently □ With assist □ With device □ Non-ambulatory ADLs: **I**=indep **A**= Assist **D**=depen ___Bathing ___Dressing ___Toilet ___Transfer WBS __full __partial __non	□ Assist needed □ Trouble swallowing □ Special consistency_____ (Thickened liquids, pureed, crush meds) □ Tube feeding Time of last meal_____

CONTINENCE:	***IMPAIRMENTS:***	***DISABILITIES:***
Incontinent □ Bowel □ Bladder Currently on retraining □ yes □ no Last bowel movement on_____	□ Speech □ Hearing □ Vision □ Sensation Other:	□ Amputation_____ □ Paralysis_____ □ Contractures_____

SKIN/WOUNDCARE:

High risk for pressure ulcer development □ yes □ no Wound progress note attached □ yes □ no
Reddened areas/excoriations: Site_____
Pressure ulcers: (Site, stage, size)

Treatment:

PAIN: Usual scale (1-10)_____ Site_____ Present scale (1-10)_____ Site_____
Specifics, if applicable**:**

USUAL BEHAVORS EXHIBITED AND INTERVENTIONS (if applicable)***:***

SOCIAL SERVICE INFORMATION:

Social worker_____ Phone #_____
Reason for original admission to SNF_____
Discharge plan □ Return home □ LTC □ Bed hold
Resident □ is □ is not adjusted to illness
Family □ is □ is not supportive
Resident □ is □ is not self motivated

Form completed by: Signature_____ RN/LPN

Report called to _____ By_____ RN/LPN

POLICY & PROCEDURE

QI TOOL FOR REVIEW OF ACUTE CARE TRANSFERS

Date initiated 1/10 Revised
Medical Director initial_____

PURPOSE:

To assure medical necessity when residents are transferred to the hospital.

PROCEDURE:

1. Upon a resident's transfer to the hospital a QI TOOL FOR REVIEW OF ACUTE CARE TRANSFERS will be completed by the facility's Director of Nurses (DON).

2. All areas will be completed.

3. The DON will determine if the transfer was avoidable and why the determination was reached.

4. The DON will try to identify any actions the facility can implement to improve management of resident changes in condition.

5. The DON will fax each completed QI Tool to the Director of Clinical Services at the management company office within a week of the transfer.

6. The DON will complete a brief summary of the QI Tool findings for each month for review at each Quality Assurance meeting.

QI TOOL FOR REVIEW OF ACUTE CARE TRANSFERS

Facility: (Circle) Broward Plantation Springtree Tamarac Pinecrest Ocean View

IT IS IMPERATIVE YOU FILL OUT ALL AREAS COMPREHENSIVELY

Resident name_____ **Admission date**_____

Resident status at time of transfer □ **Long-term** □**Short-term**
Pay status: □ **Medicare** □ **HMO, type**_____ □ **Medicaid** □ **Private pay**

Admission diagnosis:

Date transferred to hospital_____ **Physician ordering transfer: Dr.**_____

Transfer ___**was**___**was not via 911** **BP**_____**T**____**P**____**R**____**PULSE OX**____**%**

What prompted transfer to hospital?

Was resident admitted? (circle) **Yes/No** **If so, admitting Dx**_____

What was the resident's status at the time of admission <u>regarding the reason for discharge:</u> (For example, if resident is transferred due to a low hemaglobin, what was the hemaglobin at the time of admission)

What interventions did the facility employ in an attempt to prevent the resident from having to return to the hospital? Check what applies or write in below. Be specific.

	Physician called		Labs done:_____		New meds ordered:_____
	Physician visited		Xray(s) done:_____		Others
	Oxygen administered		Ultrasound done_____		
	O2 increased to ___L		IVs given ___meds___fluids		
	Jeb neb tx given		Antibiotics given:_____		
	NTG given x____		Calorie count done		

Could this transfer have been avoided? __Yes __Possibly __No Give reasons below:

□ There were opportunities to prevent/anticipate with earlier identification and/or management, such as
_____
_____

□ The facility was unable to provide necessary care and services:_____
□ The physician may have kept the resident in the facility if provided with further information/discussion.
□ The resident may not have been transferred if the physician had returned calls.
□ The facility could have provided further care and services but
___physician insisted on transfer
___resident or family insisted on transfer

What actions are you implementing to prevent re-hospitalizations as a result of this transfer?

Date_____ **Signature**_____**,DON**