PURPOSE:
The purpose is to ensure optimal communication between the 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 __ quadrants __ diminished 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 __
- Change in intake:  If applicable: __________________________
  If alternate nutrition recommended, resident/family wishes: __________________________
- Change in hydration: __________________________
- 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

<table>
<thead>
<tr>
<th>RESIDENT NAME (last, first)</th>
<th>SENT FROM: (Name of Facility) Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH:</th>
<th>Language:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE:</th>
<th>English □</th>
<th>Other □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Currently covered under Medicare Part A in SNF</th>
<th>yes □</th>
<th>no □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident is □ Short-term □ Long-term</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Phone #(______)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICIAN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr.</td>
</tr>
<tr>
<td>Phone #(______)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resident has:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ DNR □ Living will</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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___

Allergies________________ Precautions: □ MRSA as of____ □ VRE as of____ Site____ □ C-Diff as of____

DEVICES/SPECIAL TREATMENTS:  
□ IV/PICC/Mid-line □ Foley catheter □ Ostomy  
□ Pacemaker □ Internal defibrillator  
□ TPN □ Other:

RISK ALERTS:
□ None □ Falls □ Seizure  
□ Aspiration □ Elopement □ Skin breakdown  
□ Restraints □ Harmful to ___ self ___ others

IMMUNIZATIONS:

<table>
<thead>
<tr>
<th>Influenza</th>
<th>Given on_______ Refused on_______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcal</td>
<td>Given on_______ Refused on_______</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Given on_______ Refused on_______</td>
<td></td>
</tr>
</tbody>
</table>

SPECIAL TREATMENTS & FREQUENCIES:  
(Include dialysis, chemotherapy, radiation, hospice, etc. here)
### USUAL MENTAL STATUS:
- Alert
- Forgetful
- Disoriented
- Can
- Cannot follow instructions

### USUAL FUNCTIONAL STATUS:
- **Ambulates**: 
  - independently
  - With assist
- **ADLs**: 
  - Bathing
  - Toilet
  - Dressing
- **With device**
- **Non-ambulatory**
- **WBS**

### DIET:
- Assist needed
- Trouble swallowing
- Special consistency

<table>
<thead>
<tr>
<th>CONTINENCE:</th>
<th>IMPAIRMENTS:</th>
<th>DISABILITIES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinent</td>
<td>Speech</td>
<td>Amputation</td>
</tr>
<tr>
<td>Bowel</td>
<td>Hearing</td>
<td>Paralysis</td>
</tr>
<tr>
<td>Bladder</td>
<td>Vision</td>
<td>Contractures</td>
</tr>
</tbody>
</table>

### SKIN/WOUND CARE:
- High risk for pressure ulcer development
- Wound progress note attached
- Reddened areas/excoriations: Site
- Pressure ulcers: (Site, stage, size)

### Treatment:

### PAIN:
- Usual scale: (1-10)
- Site

### USUAL BEHAVIORS 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 not adjusted to illness
- Family
- is not supportive
- Resident
- 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?

(circle)

Was resident admitted?  Yes/No  If so, admitting Dx __________________________

What was the resident's status at the time of admission regarding the reason for discharge: (For example, if resident is transferred due to a low hemoglobin, what was the hemoglobin 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.

<table>
<thead>
<tr>
<th>Physician called</th>
<th>Labs done:</th>
<th>New meds ordered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician visited</td>
<td>X-ray(s) done:</td>
<td>Others</td>
</tr>
<tr>
<td>Oxygen administered</td>
<td>Ultrasound done:</td>
<td></td>
</tr>
<tr>
<td>O2 increased to ___ L</td>
<td>IVs given ___ meds fluids</td>
<td></td>
</tr>
<tr>
<td>Neb neb tx given</td>
<td>Antibiotics given:</td>
<td></td>
</tr>
<tr>
<td>NTG given ___</td>
<td>Calorie count done</td>
<td></td>
</tr>
</tbody>
</table>

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