SBAR for Resident Change in Condition

CARE COORDINATION

In Case of Emergency, Call 9-1-1

SITUATION
- My name is _____ I'm calling from _____
- I need to discuss [first name/last name], age _____
- I'm concerned about [his/her] change in _____
_____ (signs/symptoms).

BACKGROUND
- The resident was admitted on _____ (date) with the
  diagnosis of _____ (current diagnosis).
  - Previous vital signs taken on _____ (date/time)
    BP _____ HR _____ RR _____ Temp _____
    SpO2 _____ (on room air or supplemental O2)
- This started on _____ (date).
- The resident is allergic to _____
- The resident's advance care directive is _____

ASSESSMENT (Describe Key Findings)
- My assessment is that the resident is _____ (state sign/symptom).
  Here are my findings.
  - Current vital signs taken on _____ (date/time)
    BP _____ HR _____ RR _____ Temp _____
    SpO2 _____ (on room air or supplemental O2)
  - The resident has voided _____ times in the last 8 hours.
  - Mental status is (changed OR unchanged) from baseline: _____
  - Other findings related to my concern are: _____

RECOMMENDATION
- Would you like to order blood work, diagnostic tests or treatments?
- How soon can you see this resident?
- If the resident deteriorates or continues to show signs/symptoms, what is
  the next step? Start an IV or bolus?
- The physician should confirm, clarify and request additional information and
  then work with the nurse to take appropriate action with this resident.

Before calling the physician, NP, PA or other health care professional:
- Evaluate the resident and complete this form.
- Check vital signs; be alert for changes from baseline.
- Review the resident record: recent hospitalizations, lab values, medications and progress notes.
- Note any allergies.
- Be aware of the resident's advance care wishes.

Early Warning Signs
Below list additional abnormal findings found in: exam details, signs, symptoms, diagnostic information, blood work/labs, observations, resident statements/complaints, pain, mental status, medication changes, diet, bodily function concerns, input/output, time of onset or other changes in condition that are of concern.

Nurse Name (Please print): _____ Date: _____

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