SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

INTERACT®
Version 4.0 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 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 such as 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 Description
This resident is in the facility for: ☐ Long-Term Care ☐ Post Acute Care ☐ Other: _____

Primary diagnoses _____

Other pertinent history *(e.g. medical diagnosis of CHF, DM, COPD)* _____

Medication Alerts
☐ Changes in the last week *(describe)* _____

☐ Resident is on *(Warfarin/Coumadin)* Result of last INR: _____ Date _____/_____ /_____

☐ Resident is on other anticoagulant *(direct thrombin inhibitor or platelet inhibitor)*

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

Allergies _____

Vital Signs

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

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

Pulse Oximetry (*if indicated*) _____% on ☐ Room Air ☐ O_2 (_____)

Blood Sugar *(Diabetics)* _____

Resident /Patient Name _____

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Resident 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)*

- ☐ Decreased level of consciousness *(sleepy, lethargic)*
- ☐ Increased confusion or disorientation
- ☐ Memory loss *(new or worsening)*
- ☐ New or worsened delusions or hallucinations
- ☐ Other symptoms or signs of delirium *(e.g. inability to pay attention, disorganized thinking)*
- ☐ Unresponsiveness
- ☐ Other *(describe)*
- ☐ No changes observed

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 _____

3. Behavioral Evaluation

- ☐ Danger to self or others
- ☐ Depression *(crying, hopelessness, not eating)*
- ☐ Social withdrawal *(isolation, apathy)*
- ☐ Suicide potential
- ☐ Verbal aggression
- ☐ Physical aggression
- ☐ Personality change
- ☐ Other behavioral changes *(describe)*
- ☐ No changes observed

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

4. Respiratory Evaluation

- ☐ Abnormal lung sounds *(rales, rhonchi, wheezing)*
- ☐ Asthma *(with wheezing)*
- ☐ Cough (☐ Non-productive ☐ Productive)
- ☐ 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

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

5. Cardiovascular Evaluation

- ☐ Chest pain/tightness
- ☐ Edema
- ☐ Inability to stand without severe dizziness or lightheadedness
- ☐ Irregular pulse *(new)*
- ☐ Resting pulse >100 or <50
- ☐ Other *(describe)*
- ☐ No changes observed

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

6. Abdominal / GI Evaluation

- ☐ Abdominal pain
- ☐ Abdominal tenderness
- ☐ Constipation *(date of last BM ____ / ____ / ____)*
- ☐ Decreased/absent bowel sounds
- ☐ 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

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

Resident/Patient Name _____

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7. GU/Urine Evaluation

☐ Blood in urine
☐ Decreased urine output
☐ Lower abdominal pain or tenderness
☐ New or worsening incontinence
☐ Painful urination
☐ Urinating more frequently or urgency with or without other urinary symptoms
☐ Other *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

8. Skin Evaluation

☐ Abrasion
☐ Blister
☐ Burn
☐ Contusion
☐ Discoloration
☐ Itching
☐ Laceration
☐ Pressure ulcer
☐ Puncture
☐ Rash
☐ Skin tear
☐ Splinter/sliver
☐ Wound *(describe)*
☐ Other *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

9. Pain Evaluation

Does the resident have pain?
☐ No ☐ Yes *(describe below)*

Is the pain?
☐ New ☐ Worsening of chronic pain

Description/location of pain: _____

Intensity of Pain *(rate on scale 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, new change in behavior)

Other information about the pain _____
☐ Not clinically applicable to the change in condition being reported

10. Neurological Evaluation

☐ Abnormal Speech
☐ Decreased level of consciousness
☐ Dizziness or unsteadiness
☐ Seizure
☐ Weakness or hemiparesis
☐ Other neurological symptoms *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

Advance Care Planning Information *(the resident 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 or family preferences for care _____

_____

Resident/Patient Name _____

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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
☐ Venous doppler
☐ X-ray
☐ Other *(describe)* _____

Interventions

☐ New or change in medication(s)
☐ IV or subcutaneous fluids
☐ Increase oral fluids
☐ Oxygen *(if available)*
☐ Other *(describe)* _____

☐ Transfer to the hospital (non-emergency) *(send a copy of 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 _____

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