

# Audience Response 1

I primarily represent (choose one):

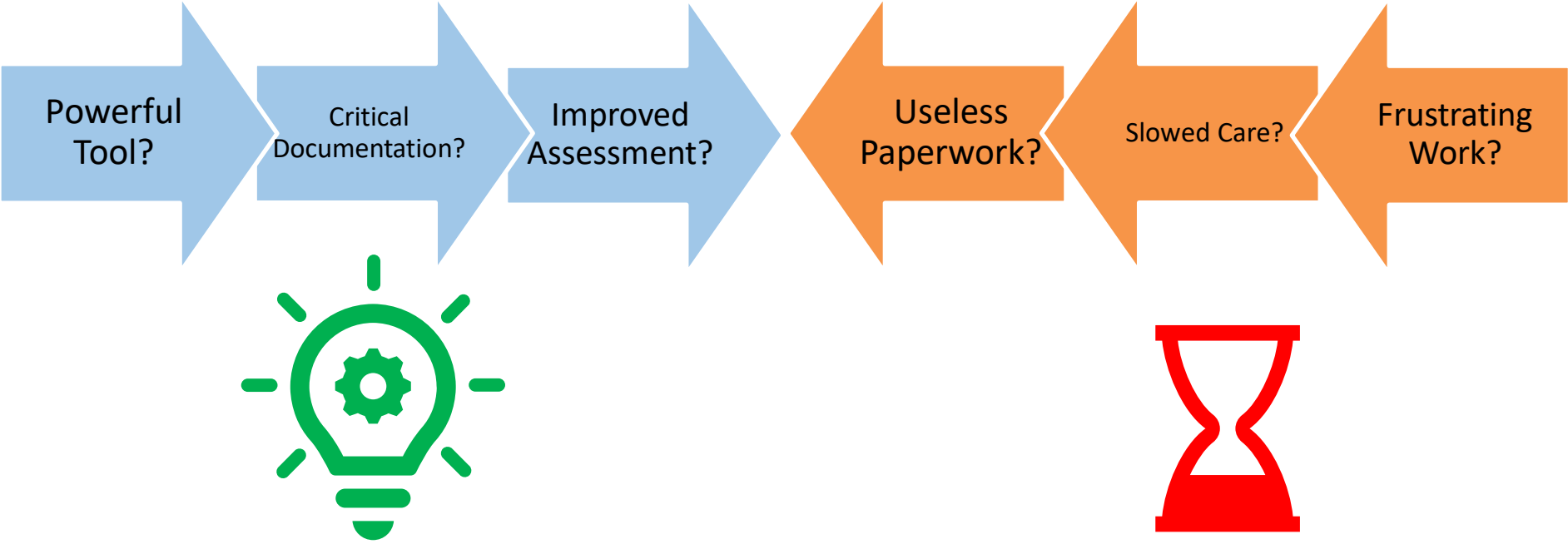
- A. Nursing home leadership (Admin, DON, etc.)
- B. Nursing home front care delivery
- C. Physician, NP, or PA care provider
- D. Hospital leadership
- E. Hospital care delivery
- F. Public health or other government office
- G. Other (type in chat)

# Audience Response 2

I currently (multiple choice):

- A. Understand how to use SBARs
- B. Understand barriers to communication in SNFs
- C. Go out of my way to encourage SNF nurses to use SBAR communication
- D. Use SBAR for all change of conditions
- E. All of the above
- F. None of the above

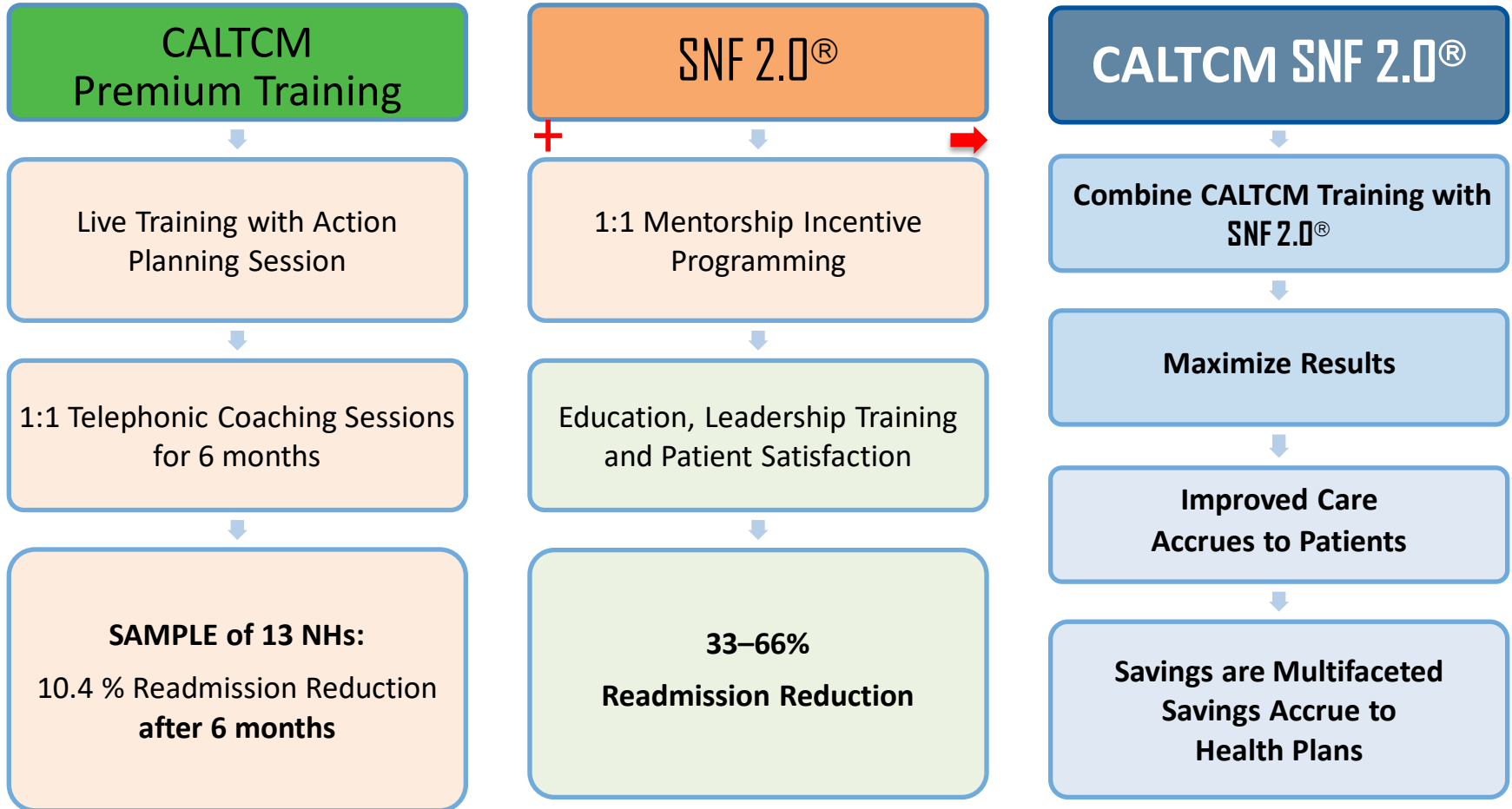
# What Is the SBAR?



# Background



# Plan for Success



# SNF 2.0<sup>®</sup>: The 5 Principles

## CALTCM SNF 2.0<sup>®</sup> Train the Mentor Principles

**Principle 1:** See every moment as a **teaching moment**.

**Principle 2:** Promote Accountability in a "**No shame, No blame**" environment.

**Principle 3:** Never allow someone to do a **first SBAR/provider call** alone.

**Principle 4:** Learn to **walk others through** the process.

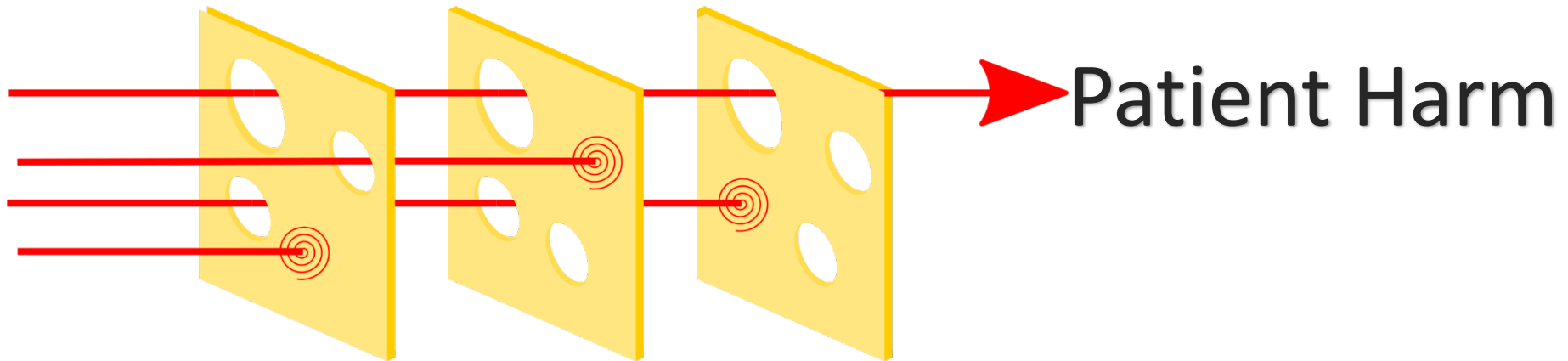
**Principle 5:** **Show appreciation**.

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# The Problem

- “You know, when they call me in the middle of the night, they tend to ramble, it’s **not very clear** what their assessment is, I don’t know what they want most of the time, and most of the calls, quite frankly, are of **no use.**”

# How Patient Harm Happens





# SBAR Background

- Developed by Michael Leonard, MD; Doug Bonacum; and Suzanne Graham at Kaiser Permanente Colorado in 2002

# Where Did the SBAR Come From?



**Doug Bonacum**

Vice President, Quality, Safety, and Resource Management  
Kaiser Permanente, Oakland, CA  
June 1994–March 2016

Environmental, Health, and Safety Manager  
Tyco, North American Printed Circuits  
April 1992–June 1994

Officer  
U.S. Submarine Force  
June 1983–February 1991

# Elements of the Original SBAR

## SBAR report to physician about a critical situation

**S**

**Situation**

I am calling about <patient name and location>.

The patient's code status is <code status>

The problem I am calling about is \_\_\_\_\_.

I am afraid the patient is going to arrest.

I have just assessed the patient personally:

Vital signs are: Blood pressure \_\_\_\_\_ / \_\_\_\_\_, Pulse \_\_\_\_\_, Respiration \_\_\_\_\_ and temperature \_\_\_\_\_

I am concerned about the:

Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual

Pulse because it is over 140 or less than 50

Respiration because it is less than 5 or over 40.

Temperature because it is less than 96 or over 104.

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# Elements of the Original SBAR (cont.)

# B

## Background

The patient's mental status is:

- Alert and oriented to person place and time.
- Confused and cooperative or non-cooperative
- Agitated or combative
- Lethargic but conversant and able to swallow
- Stuporous and not talking clearly and possibly not able to swallow
- Comatose. Eyes closed. Not responding to stimulation.

The skin is:

- Warm and dry
- Pale
- Mottled
- Diaphoretic
- Extremities are cold
- Extremities are warm

The patient is not or is on oxygen.

The patient has been on \_\_\_\_\_ (l/min) or (%) oxygen for \_\_\_\_\_ minutes (hours)

The oximeter is reading \_\_\_\_\_%

The oximeter does not detect a good pulse and is giving erratic readings.

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# Elements of the Original SBAR (cont.)

**A**

## Assessment

This is what I think the problem is: <say what you think is the problem>  
The problem seems to be cardiac infection neurologic respiratory \_\_\_\_\_  
I am not sure what the problem is but the patient is deteriorating.  
The patient seems to be unstable and may get worse, we need to do something.

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# Elements of the Original SBAR (cont.)

<b>R</b>	<b><u>Recommendation</u></b>
	<p><b>I suggest or request that you &lt;say what you would like to see done&gt;.</b></p> <ul style="list-style-type: none"><li>transfer the patient to critical care</li><li>come to see the patient at this time.</li><li>Talk to the patient or family about code status.</li><li>Ask the on-call family practice resident to see the patient now.</li><li>Ask for a consultant to see the patient now.</li></ul> <p><b>Are any tests needed:</b></p> <ul style="list-style-type: none"><li>Do you need any tests like CXR, ABG, EKG, CBC, or BMP?</li><li>Others?</li></ul> <p><b>If a change in treatment is ordered then ask:</b></p> <ul style="list-style-type: none"><li>How often do you want vital signs?</li><li>How long to you expect this problem will last?</li><li>If the patient does not get better when would you want us to call again?</li></ul>

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# Usage

- Used in some hospitals and some SNFs
- Hospitals use SBAR:
  - Structured method of gathering relevant patient information
  - Giving the nurse opportunity to organize this information before calling the physician
  - A method for clearly communicating what is needed for the patient to continue optimal care

# Hospital SBAR Usage

Several areas for usage:

- Critical/stable patient situations
- For interdepartmental transfers, post-acute transfers, and inter-shift handoff report
- Electronic health record (EHR) is built with SBAR handoff methodology, pulling relevant data from the medical record



# Nursing Differences

## Hospital

- 1:2 to 1:8 nurse to patient ratio
- Multidisciplinary teams including social work, pharmacists, therapists, techs, and physicians
- Frequent CEU and educational opportunities
- Top pay opportunities
- Physicians more present
- Warm handoffs standard

## Nursing Facilities

- 1:20 to 1:40 nurse to patient ratio
- Fragmented patchwork of teams
- Infrequent educational opportunities
- Pay 1/2 to 2/3 of hospital
- Physicians minimally present
- Warm handoffs may not be standard

# SNF SBARs



Key to improved assessments



Key to improved communication

# SBAR in SNFs

- Key component of the INTERACT<sup>®</sup>\* program developed by:
  - Joseph Ouslander, MD
  - Gerri Lamb, PhD, RN
  - Laurie Herndon, GNP
  - Ruth Tappen, EdD, RN
  - Jo Taylor, RN
  - And many others

\*Interventions to Reduce Acute Care Transfers

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Materials available from Pathway Health <http://www.pathway-interact.com/interact-tools/>

- Checklist
- Description
- Background History
- Medications
- Vitals

**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<sub>2</sub> saturation and finger stick glucose for diabetics
- Review Records:** 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<sub>2</sub>: (\_\_\_\_\_) \_\_\_\_\_

Blood Sugar *(Diabetics)* \_\_\_\_\_



- Mental
- Function
- Behavior
- Resp
- Cards
- Abd/GI

**1. Mental Status Evaluation (compared to baseline; check all changes that you observe)**

<input type="checkbox"/> Altered level of consciousness ( <i>hyperalert, drowsy but easily aroused, difficult to arouse</i> )	<input type="checkbox"/> New or worsened delusions or hallucinations	<input type="checkbox"/> Other ( <i>describe</i> )
<input type="checkbox"/> Increased confusion or disorientation	<input type="checkbox"/> Other symptoms or signs of delirium ( <i>e.g. inability to pay attention, disorganized thinking</i> )	<input type="checkbox"/> <b>No changes observed</b>
<input type="checkbox"/> Memory loss ( <i>new or worsening</i> )	<input type="checkbox"/> Unresponsiveness	

Describe symptoms or signs \_\_\_\_\_

**2. Functional Status Evaluation (compared to baseline; check all that you observe)**

<input type="checkbox"/> Decreased mobility	<input type="checkbox"/> Swallowing difficulty	<input type="checkbox"/> Other ( <i>describe</i> )
<input type="checkbox"/> Needs more assistance with ADLs	<input type="checkbox"/> Weakness ( <i>general</i> )	<input type="checkbox"/> <b>No changes observed</b>
<input type="checkbox"/> Falls (one or more)		

Describe symptoms or signs \_\_\_\_\_

**3. Behavioral Evaluation**

<input type="checkbox"/> <b>Not clinically applicable to the change in condition being reported</b>		
<input type="checkbox"/> Danger to self or others	<input type="checkbox"/> Suicide potential	<input type="checkbox"/> Personality change
<input type="checkbox"/> Depression ( <i>crying, hopelessness, not eating</i> )	<input type="checkbox"/> Verbal aggression	<input type="checkbox"/> Other behavioral changes ( <i>describe</i> )
<input type="checkbox"/> Social withdrawal ( <i>isolation, apathy</i> )	<input type="checkbox"/> Physical aggression	<input type="checkbox"/> <b>No changes observed</b>

Describe symptoms or signs \_\_\_\_\_

**4. Respiratory Evaluation**

<input type="checkbox"/> <b>Not clinically applicable to the change in condition being reported</b>		
<input type="checkbox"/> Abnormal lung sounds ( <i>rales, rhonchi, wheezing</i> )	<input type="checkbox"/> Inability to eat or sleep due to SOB	<input type="checkbox"/> Symptoms of common cold
<input type="checkbox"/> Asthma ( <i>with wheezing</i> )	<input type="checkbox"/> Labored or rapid breathing	<input type="checkbox"/> Other respiratory changes ( <i>describe</i> )
<input type="checkbox"/> Cough ( <input type="checkbox"/> Non-productive <input type="checkbox"/> Productive)	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> <b>No changes observed</b>

Describe symptoms or signs \_\_\_\_\_

**5. Cardiovascular Evaluation**

<input type="checkbox"/> <b>Not clinically applicable to the change in condition being reported</b>		
<input type="checkbox"/> Chest pain/tightness	<input type="checkbox"/> Irregular pulse ( <i>new</i> )	<input type="checkbox"/> Other ( <i>describe</i> )
<input type="checkbox"/> Edema	<input type="checkbox"/> Resting pulse >100 or <50	<input type="checkbox"/> <b>No changes observed</b>
<input type="checkbox"/> Inability to stand without severe dizziness or lightheadedness		

Describe symptoms or signs \_\_\_\_\_

**6. Abdominal / GI Evaluation**

<input type="checkbox"/> <b>Not clinically applicable to the change in condition being reported</b>		
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Distended abdomen	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Abdominal tenderness	<input type="checkbox"/> Decreased appetite/fluid intake	<input type="checkbox"/> Nausea and/or vomiting
<input type="checkbox"/> Constipation ( <i>date of last BM ___/___/___</i> )	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Other ( <i>describe</i> )
<input type="checkbox"/> Decreased/absent bowel sounds	<input type="checkbox"/> GI Bleeding ( <i>blood in stool or vomitus</i> )	<input type="checkbox"/> <b>No changes observed</b>
	<input type="checkbox"/> Hyperactive bowel sounds	

Describe symptoms or signs \_\_\_\_\_

- GU

**7. GU/Urine Evaluation**

Not clinically applicable to the change in condition being reported

- |   |  |
|---|--|
| <input type="checkbox"/> Blood in urine                     | <input type="checkbox"/> New or worsening incontinence   |
| <input type="checkbox"/> Decreased urine output             | <input type="checkbox"/> Painful urination   |
| <input type="checkbox"/> Lower abdominal pain or tenderness | <input type="checkbox"/> Urinating more frequently or urgency with or without other urinary symptoms |

- Other (describe) \_\_\_\_\_  
 No changes observed



Describe symptoms or signs \_\_\_\_\_

- Skin

**8. Skin Evaluation**

Not clinically applicable to the change in condition being reported

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abrasion      | <input type="checkbox"/> Itching                        | <input type="checkbox"/> Skin tear           |
| <input type="checkbox"/> Blister       | <input type="checkbox"/> Laceration                     | <input type="checkbox"/> Splinter/sliver     |
| <input type="checkbox"/> Burn          | <input type="checkbox"/> Pressure ulcer/pressure injury | <input type="checkbox"/> Wound (describe)    |
| <input type="checkbox"/> Contusion     | <input type="checkbox"/> Puncture                       | <input type="checkbox"/> Other (describe)    |
| <input type="checkbox"/> Discoloration | <input type="checkbox"/> Rash                           | <input type="checkbox"/> No changes observed |

Describe symptoms or signs \_\_\_\_\_

- Pain

**9. Pain Evaluation**

Not clinically applicable to the change in condition being reported

**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 \_\_\_\_\_

- Neuro

**10. Neurological Evaluation**

Not clinically applicable to the change in condition being reported

- |  |  |
|--|--|
| <input type="checkbox"/> Abnormal Speech   | <input type="checkbox"/> Seizure                   |
| <input type="checkbox"/> Altered level of consciousness ( <i>hyperalert, drowsy but easily arousable, difficult to arouse, unarousable</i> ) | <input type="checkbox"/> Weakness or hemiparesis   |
|  | <input type="checkbox"/> Dizziness or unsteadiness |

- Other neurological symptoms (describe) \_\_\_\_\_  
 No changes observed

Describe symptoms or signs \_\_\_\_\_

- Appearance

- Notification

- Orders

- Notes

### APPEARANCE



Summarize your observations and evaluation: \_\_\_\_\_

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### REVIEW AND NOTIFY

Primary Care Clinician Notified: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (am/pm) \_\_\_\_\_

Recommendations of Primary Clinicians (if any) \_\_\_\_\_

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#### b. Check all that apply

##### Testing

- COVID Test
- If yes – check all that apply:*
  - Viral PCR (Nasal Swab)
  - Viral PCR (Saliva Swab)
  - POC Antigen Test
  - Antibody Test

- 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)

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# Key Differences SNF SBAR vs. Hospital SBAR

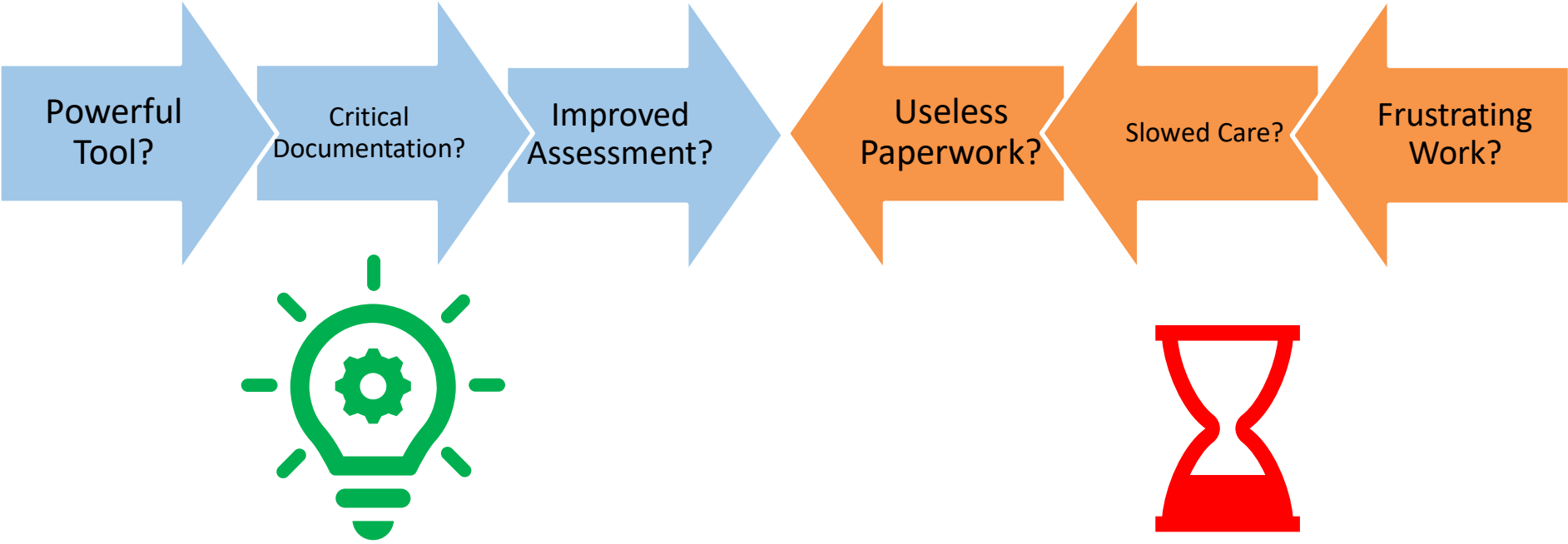
- Longer
- More detailed
- More documentation
- Greater emphasis on assessment
- More cumbersome
- Less focused
- More paperwork/  
computer work
- Less effective for MD  
communication



# Why?

- Longer
- More detailed
- More documentation
- Greater emphasis on assessment
- 1:20 to 1:40 nurse to patient ratio
- Fragmented patchwork of teams
- Infrequent educational opportunities
- Pay 1/2 to 2/3 of hospital
- Physicians minimally present
- Warm handoffs may not be standard

# What Is the SBAR?



# What Can We Do?

## Hospitals

- Publicly support and encourage accurate assessments from SNFs
- Engage physicians in promoting good SNF care
  - Avoid cutting off nursing reports
  - Ask questions
  - Encourage and express appreciation for the effort
- Own an HSAG hospital collaborative

## SNFs

- Publicly support and encourage your nursing and non-nursing staff in their SBAR communication
- Be persistent
- Look for partners to reinforce the efforts
  - HSAG hospital collaboratives
  - Health plans
  - Progressive medical groups
  - CALTCM, others

# Audience Response 3

Now I (multiple choice):

- A. Understand how to use SBARs
- B. Understand barriers to communication in SNFs
- C. Will go out of my way to encourage SNF nurses to use SBAR communication
- D. Will use SBAR for all change of conditions
- E. All of the above
- F. None of the above

# Stop and Watch Early Warning Tool

## Stop and Watch Early Warning Tool



If you have identified a change while caring for or observing a resident/patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- S** Seems different than usual; Symptoms of new illness
  - T** Talks or communicates less
  - O** Overall needs more help
  - P** Pain – new or worsening; Participated less in activities
  - a** Ate less
  - n** No bowel movement in 3 days; or diarrhea
  - d** Drank less
  - W** Weight change; swollen legs or feet
  - A** Agitated or nervous more than usual
  - T** Tired, weak, confused, or drowsy
  - C** Change in skin color or condition
  - H** Help with walking, transferring, toileting more than usual
- Check here if no change noted while monitoring high risk patient

\_\_\_\_\_  
*Patient / Resident*

\_\_\_\_\_  
*Your Name*

\_\_\_\_\_  
*Reported to*

\_\_\_\_\_  
*Date and Time (am/pm)*

\_\_\_\_\_  
*Nurse Response*

\_\_\_\_\_  
*Date and Time (am/pm)*

\_\_\_\_\_  
*Nurse's Name*

Thank you!

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