**Modified SBAR tool template example**

Patient name:

NHI:

**Early alert assessment and communication**

Review resident record: Recent progress notes, labs, medication, other orders

Assess the resident using this form

Review/activate care pathway (if available)

Have relevant information available when reporting (ie, medical letters, blood test and investigations, ceiling of intervention orders, allergies, medication list)

**SITUATION**

**Prompts**

O = Onset

L = Location

D = Duration

C = Characteristics

A = Aggravating

R = Relieving

T = Treatment

S = Severity

The current change in condition, symptoms and problems are:

This condition, symptom or sign has occurred before: Yes No

Treatment for last episode: Effective?

**BACKGROUND**

**Resident description**

This resident is in the facility for:  Rest home  Hospital  Dementia  Other

Primary diagnoses:

Relevant medical/social history:

Allergies/alerts:

Medications (attach copy of medication sheet)

Currently on:

Warfarin: last INR:\_\_\_\_\_\_ Date:\_\_/\_\_/\_\_  Other anticoagulant  Oral hypoglycaemic  Insulin   
 Digoxin  Other:

Recent medication changes:

Resident and/or family **advance care planning/preferences for care:**

**Weight** **kg**:\_\_\_\_\_\_  Stable  Increased  Decreased by: \_\_\_ kg Over past:\_\_\_Days\_\_\_\_Week(s)\_\_\_Months

**Bowels:** Days since last motion: \_\_\_ Number of motions in last week: \_\_\_

Motions:  Pebbles  Normal/large/soft  Diarrhoea/runny

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assessment – acute deterioration eight steps (frailty care guides – Health Quality & Safety Commission New Zealand):**  Patient name:  NHI:  **1. Review possible cause 2. Take observations and review warning signs 3. Assess recent labs or other results  4. Review hydration status 5. Assess for delirium 6. Review pain status 7. Review for constipation or diarrhoea 8. Review goals of care**  **General appearance:**  **RR: HR: irreg/reg BP: Lying: Standing: BGL: Temp: \_\_\_\_\_\_\_\_\_**  **SpO2: \_\_\_\_\_\_\_ % on RA/O2\_\_\_\_\_\_\_\_l/min. Changes since last set of obs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Sepsis may be indicated if: known or suspected infection plus any two of the following: T > 37.5 or < 36, RR > 24,  HR > 100, acute mental state change, High or low WCC, hyperglycaemia** | | | | |
| **COGNITIVE**  Alert and orientated  Confusion  Fluctuating  Consistent  Other signs of delirium  4AT  Baseline MOCA:  Altered level of consciousness  Hyperalert  Sleepy/lethargic  Difficult to rouse  Unresponsive  No problems  **NEUROLOGICAL**  Headache  Dizziness  Numbness/tingling  Seizure  Face droop  Arm/body weakness  Speech changes  **If yes to three above time ? stroke**  Swallowing difficulty  No problems | **RESPIRATORY**  Shortness of breath  New  Increased  At rest  On exertion  SOB affecting sleep or speech  Cough  Productive  Colour:\_\_\_\_\_\_\_\_\_  Non-productive  Laboured  Rapid  Cheyne stroke  Wheeze  Crackles  No problems  **CVS**  Chest tightness  Pain  Dizzy/lightheaded  Oedema  Irregular pulse  Resting pulse > 100  or < 50  Tongue: Moist or dry  JVP ………cm  No problems | **ABDOMINAL**  Tenderness  Pain  Decreased food/fluid  Nausea  Vomiting  Constipation  Date of last BM:\_\_\_\_\_\_\_\_  Diarrhoea  Bowel sounds  Absent  Hyperactive  Bloody stool or vomit  Distended abdomen  Jaundice  PR\_\_\_\_\_\_\_  No problems  **GU**  Tenderness  Pain  Painful urination  Colour:\_\_\_\_\_\_\_  Blood  Urgency  Frequency  Nocturia  Decreased or no urine  New incontinence  SPC/IDC  No problems | **PAIN**  Yes  Site  New or  Increased  Onset…………………  Provoking…………….  Quality………………..  Radiating……………..  Severity 1–10:…………  Timing………………..  Non-verbal signs  No problems  **BEHAVIOURAL**  Mood changes  Social withdrawal  New aggression  Verbal  Physical  Personality change  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_  No problems  **MSK**  Decreased mobility  Increased weakness  Needing more assistance with ADL  Falls in last month  Symptoms of fracture  Site:  No problems | **SKIN**  Discolouration  Onset:  Site:  Redness  Heat  Tracking  Swelling  Contusion  Pus  Other skin conditions (eg, itch/rash)  Type:  Site:  Onset:  Pressure injury  Site:  Grade:  Onset:  Wound  Site:  Type:  Onset:  No problems |

**RECOMMENDATION/RESPONSE**

**Nursing diagnosis (what do you think is going on?):**

Nursing interventions (what are you going to do?):

Observations \_\_\_\_\_hourly for \_\_\_\_\_\_ hours  Urinalysis  Activate symptom management plan

Safety interventions  Additional assessment \_\_\_\_\_\_\_\_

PRN medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Increase oral fluids  Family discussion, place/goals of care

Other:

GP notified? Yes/No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations/plan from GP:

Ongoing monitoring every \_\_\_\_\_\_\_\_\_ hours and GP review in \_\_\_\_\_\_\_\_\_\_\_\_  Subcutaneous or IV fluids Oxygen Other

New or change medication/s:

Transfer to the hospital (non-emergency/emergency) – **goals of transfer:**

Staff name and designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (am/pm): \_\_\_\_\_\_\_\_\_\_\_

Name of family notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (am/pm): \_\_\_\_\_\_\_\_\_\_\_