Daytime Communication SBAR

Complete this form prior to calling / faxing the MRP

For contacting the MRP during regular office hours (routine & urgent concerns)

HAVE READY ☐ **COVID-19 Screening **** ☐ Completed SBAR ☐ Chart & MOST ☐ MAR		**Resident Name**	
Staff Name ☐LPN ☐RN	**Call/Fax Time:**	**Resident DOB** (DD/MM/YYY) D D M M Y Y Y Y	**Resident PHN** (10)
Facility:	**Call/Fax Date:**	**MRP**	
Phone / Fax:	**Local:**	**Resident's Primary Contact**	

INFLUENZA-LIKE ILLNESS SCREENING: ☐ Fever; ☐ Cough (new or worsening); ☐ Sore throat; ☐ Arthralgia; ☐ Myalgia; ☐ Headache; ☐ Prostration

COVID-19 SCREENING:

S&S (Typical & Atypical): ☐ Abd pain; ☐ Change in LOC; ☐ Cough *(new or worsening)* ☐ SOB; ☐ Confusion; ☐ Fatigue or weakness; ☐ Conjunctivitis; ☐ GI concerns; ☐ Loss of smell/taste; ☐ Fever *(unknown origin)*; ☐ Acute Functional decline; ☐ Rhinorrhea; ☐ Sore throat; ☐ Finger/toe discoloration; ☐ Rash

COVID-19 Positive: ☐ Suspected ☐ Confirmed

COVID-19 Swab Collected: ☐ No ☐ Yes

COVID-19 confirmed / suspected in other resident(s) or contact: ☐ No ☐ Yes

Any staff members showing symptoms of COVID-19? ☐ No ☐ Yes

Isolation precautions ☐ No ☐ Yes: Contact ☐ / Droplet ☐

Infection Control aware of COVID status? ☐ N/A ☐ No ☐ Yes

Are any facility residents utilizing AGMPs? ☐ No ☐ Yes

(includes: O2 >5L NP, nebulizers, BiPAP, CPAP, suctioning – excluding oral)

SITUATION

Reason for Call

☐ Abdominal pain
☐ Agitation
☐ Cardiac
☐ Change in LOC
☐ Chest pain
☐ Confusion
☐ Cough
☐ COVID symptoms
☐ Death (unnatural)
☐ Delirium
☐ Diabetes
☐ Fall with injury
☐ Fever
☐ Gastrointestinal concern
☐ Influenza symptoms
☐ Lab values (critical)
☐ Medication error
☐ Pain management
☐ Palliative orders
☐ Query fracture
☐ Shortness of breath
☐ Skin problem
☐ Urinary concern
☐ Other *(inform dispatch)*

Notes:_____

BACKGROUND

Relevant Medical History / Usual Functional Status

Allergies

MOST: M___ or C___

ASSESSMENT

BP	SpO_2	RR	Temp
HR	eGFR	☐ Room Air ☐ Oxygen @ ____ L/min	
If Available/Relevant			
INR		BG	

Assessment ***** Ensure all vitals & a respiratory assessment are recorded PRIOR to calling *****

RECOMMEND

Nursing Recommendations

RESPONSE

On-Call Physician Response ☐ Orders Transcribed in Chart ****MANDATORY** - DO NOT use this section to transcribe orders / send to Pharmacy**

IF RESIDENT CONFIRMED COVID-19 POSITIVE: Physician (MRP, LTCI After-Hours, or Medical Coordinator) **to attend an Emergency Outbreak Management Teleconference** *(90-120 min after Communicable Health Nurse notifies care home)* **@ 250.519.7700 x 26834**

FOLLOW-UP

Nurse / Designate: **1. FAX completed SBAR & Additional Documentation to MRP:** ☐ FAXED

2. Place completed SBAR in the Physician Notes section of resident chart: ☐ COMPLETED