

Sooke After-Hours SBAR

Complete this form prior to calling dispatch at **1.888.686.3019**

URGENT Resident issues only for After-Hours Coverage

Contact MRP during regular hours (Mon-Fri 0800 – 1800) for other issues

PREPARE <input type="checkbox"/> Completed SBAR <input type="checkbox"/> Chart & MOST <input type="checkbox"/> MAR		Resident Name (Last, First)	
Responding Physician (Last, First)		Resident DOB (DD/MM/YYYY)	Resident PHN (10)
Nurse: <input type="checkbox"/> LPN <input type="checkbox"/> RN/RPN	Date:	MRP (Last, First)	
Care Home:	Time:	Primary Contact (Name, Phone)	
Phone:	Local:		

COMMUNICABLE DISEASE SCREENING:

<input type="checkbox"/> None <input type="checkbox"/> suspected	<input type="checkbox"/> COVID-19: <input type="checkbox"/> Influenza-like Illness: <input type="checkbox"/> Norovirus-like Illness: <input type="checkbox"/> C-difficile:	<input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed	<input type="checkbox"/> Shingles: <input type="checkbox"/> ARO: <input type="checkbox"/> Other:	<input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed	Specimen Sent: <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Additional Precautions: <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne
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SITUATION	Reason for Call	<input type="checkbox"/> Chest pain <input type="checkbox"/> Delirium <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Confusion <input type="checkbox"/> Diabetes <input type="checkbox"/> Agitation <input type="checkbox"/> Cough <input type="checkbox"/> Fall with injury <input type="checkbox"/> Cardiac <input type="checkbox"/> COVID symptoms <input type="checkbox"/> Fever <input type="checkbox"/> Change in LOC <input type="checkbox"/> Death (unnatural) <input type="checkbox"/> Gastrointestinal concern <input type="checkbox"/> Palliative orders	<input type="checkbox"/> Influenza symptoms <input type="checkbox"/> Query fracture <input type="checkbox"/> Lab values (critical) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Medication error <input type="checkbox"/> Skin problem <input type="checkbox"/> Pain management <input type="checkbox"/> Urinary concern <input type="checkbox"/> Other: _____

BACKGROUND	Relevant Medical History / Usual Functional Status
	Allergies: _____ MOST: M ___ or C ___

ASSESSMENT	BP SpO ₂ RR Temp	Assessment
	HR BG <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen @ _____ L/min	
	Pain	
	<i>If Available/Relevant</i>	
	INR eGFR	

RECOMMEND	Nursing Recommendations

ON-CALL PHYSICIAN RESPONSE NOTES

	Please select 1 of 3 options: <input type="checkbox"/> No orders received <input type="checkbox"/> Nurse transcribed verbal orders in resident's health record <input type="checkbox"/> Physician on-call transcribed orders the resident's health record <i>Most Responsible Nurse (MRN) documents summary of physician response in progress notes</i>
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FOLLOW-UP	Nurse / Designate: FAX COMPLETED SBAR & additional documentation to:	<i>* fax numbers located on next/second page</i>
	1. After-Hours On-Call Physician*: <input type="checkbox"/> SBAR + <input type="checkbox"/> Additional Documentation (e.g. handwritten paper orders)	
	2. Most Responsible Provider* (MRP): <input type="checkbox"/> SBAR + <input type="checkbox"/> Additional Documentation (e.g. written notes if on-call physician visited site)	
	→ PLACE SBAR in <u>Physician Notes</u> section of chart OR <u>unit MRP communication binder</u>: <input type="checkbox"/> Date: _____ Time: _____	

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SOOKE On-call Physician Fax Numbers* (for follow-up fax only)

PHYSICIAN	FAX	PHYSICIAN	FAX
Forsberg, Tracy	250.642.6032	Rabien, Anton	250.642.6032
Herrling, Kristi	250.642.6032	Saunders, Robin	250.642.6032
Kluge, Hagen	250.642.6032	Vally, Tomas	250.642.6032

Instructions: After-Hours Communication SBAR Form

USE: For **URGENT** after-hours resident issues only. The Sooke After-Hours Call Line is available from **Monday to Thursday 1700 – 0700, Friday 1700 - Monday 0700, and statutory holidays**. Please contact the resident's MRP during regular hours for all other concerns.

PURPOSE: To facilitate efficient, consistent communication of key information in an urgent situation to the physician on-call, and to provide clear communication of the situation for the resident's Most Responsible Provider (Physician or Nurse Practitioner) (MRP*).

STEPS:

1. Clearly write the resident's Name, DOB, PHN, and MRP. Redact/black out all other information if using a resident label.
2. Complete the entire SBAR form as appropriate PRIOR to calling the dispatch line.
3. Complete the questions in the '**COMMUNICABLE DISEASE**' section prior to all calls.
4. Call the after-hours call line at **1.888.686.3055** and report the reason(s) for the call to dispatch. You will either be patched directly through to the on-call physician, or they will call you back shortly.
5. In 'Physician Response Notes', select how orders from the physician were documented (if orders were given) and document the interaction and physician directions in the nursing progress notes.
6. Fax the SBAR form to the resident's MRP to inform them of the urgent call, response, and plan. Indicate whether MRP follow-up is required or recommended. If handwritten orders or notes are written by the on-call physician during an on-site visit, include these documents in the fax to the MRP and on-call physician. Include nursing progress notes as necessary.
7. Fax the SBAR form to the on-call physician for their records (see fax numbers above).
8. Place SBAR in the 'Physician Notes' section of the resident's chart or the care home's MRP communication binder.

ABBREVIATIONS					
BG	Blood Glucose	LOC	Level of Consciousness	MRN	Most Responsible Nurse
BP	Blood Pressure	MC	Medical Coordinator	MOST	Medical Orders for Scope of Treatment
DOB	Date of Birth	MAR	Medication Administration Record	PHN	Personal Health Number
eGFR	Estimated Glomerular Filtration Rate	MRP*	Most Responsible Provider (Physician or Nurse Practitioner)	LTCI	Long-term Care Initiative
INR	International Normalized Ratio			RR	Respiration Rate

Questions or Comments about the After-Hours SBAR?

Please contact the LTCI team at VictoriaSouthIsland.LTCI@victoriadivision.ca or 778.265.3137