

After-Hours Communication Form - SBAR

Complete this form prior to calling dispatch at [phone number]

URGENT Resident issues only for After-Hours Coverage.
Contact MRP during regular hours for all other issues.

HAVE READY <input type="checkbox"/> COVID-19 Screening ** <input type="checkbox"/> Chart & MOST <input type="checkbox"/> Completed SBAR <input type="checkbox"/> MAR		Resident Name (Last, First)	
Responding Physician (Last, First)		Resident DOB (DD/MM/YYYY)	Resident PHN (10)
Caller Name <input type="checkbox"/> LPN <input type="checkbox"/> RN		Resident MRP (Last, First)	
Facility:	Call Date:	Resident Primary Contact (Name & Phone)	
Phone:	Call Time:	Local:	

SITUATION	Reason for Call	<input type="checkbox"/> Confusion	<input type="checkbox"/> Fever	<input type="checkbox"/> Palliative orders	Notes: _____
	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Cough	<input type="checkbox"/> Gastrointestinal concerns	<input type="checkbox"/> Query fracture	
	<input type="checkbox"/> Agitation	<input type="checkbox"/> Death (unnatural)	<input type="checkbox"/> Influenza symptoms	<input type="checkbox"/> Shortness of breath	_____
	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Delirium	<input type="checkbox"/> Lab values (critical)	<input type="checkbox"/> Skin problem	_____
	<input type="checkbox"/> Change in LOC	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Medication error	<input type="checkbox"/> Urinary concern	_____
	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fall with injury	<input type="checkbox"/> Pain management	<input type="checkbox"/> Other (note & inform dispatch)	_____

FURTHER COVID-19 SCREENING ** Common COVID-19 symptoms highlighted in red **
Other S&S's of the resident: <input type="checkbox"/> Change in LOC; <input type="checkbox"/> Cough or <input type="checkbox"/> SOB; <input type="checkbox"/> Confusion; <input type="checkbox"/> Fatigue; <input type="checkbox"/> Fever; <input type="checkbox"/> Functional decline; <input type="checkbox"/> Gastrointestinal concerns
COVID-19 Positive: <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed
COVID-19 Swab Collected: <input type="checkbox"/> No <input type="checkbox"/> Yes
COVID-19 confirmed / suspected in other resident(s): <input type="checkbox"/> No <input type="checkbox"/> Yes
Any staff members showing symptoms of COVID-19? <input type="checkbox"/> No <input type="checkbox"/> Yes
Isolation precautions <input type="checkbox"/> No <input type="checkbox"/> Yes: Contact <input type="checkbox"/> / Droplet <input type="checkbox"/>
Infection Control aware of COVID status? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes
Are any facility residents utilizing AGMPs? <input type="checkbox"/> No <input type="checkbox"/> Yes (includes: O2 >5L NP, nebulizers, BiPAP, CPAP, suctioning)

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

ASSESSMENT	BP	SpO2	RR	Temp	Assessment ** Ensure all vital signs & a respiratory assessment are recorded PRIOR to calling **
	HR	eGFR	<input type="checkbox"/> Room Air	<input type="checkbox"/> Oxygen @ _____ L/min	
	If Available/Relevant				
	INR	BG	Pain		

RECOMMEND	Nursing Recommendations
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RESPONSE	On-Call Physician Response ** ORDERS MUST be transcribed in the chart – this section is to note response only **
	IF RESIDENT COVID-19 + : Physician is to attend an Emergency Outbreak Management Teleconference, 60 minutes from time of notification , by calling 250.519.7700 ext. 26834 . Refer to the IH COVID-19 Response Protocol: Long-term Care Facility for further steps.

FOLLOW-UP	Nurse or Designate to FAX completed SBAR & Additional Documentation to: FAXED: <input type="checkbox"/> Yes <input type="checkbox"/> No
	1. On-Call Physician (fax #s on second page): <input type="checkbox"/> SBAR 2. MRP: <input type="checkbox"/> SBAR & <input type="checkbox"/> Additional Documentation - <input type="checkbox"/> Follow-up required <input type="checkbox"/> For your info only
	Place completed SBAR in the Physician Notes section of resident chart: <input type="checkbox"/> Date: _____ Time: _____

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Instructions: After-Hours Communication Form - SBAR

USE: For **URGENT** after-hours Resident issues. Contact the Resident's Most Responsible Physician (MRP) during regular hours for all other concerns.

PURPOSE: To enable efficient, consistent communication of key information in an urgent situation to the physician on-call, and to provide clear communication to the Resident's MRP.

STEPS:

1. Clearly write the Resident's Name, Date of Birth (DOB), Personal Health Number (PHN), and Most Responsible Physician (MRP). If you use a Resident label, please redact/black out all information other than these identifiers.
2. Complete the entire SBAR (Situation, Background, Assessment, and Recommendations) form as appropriate PRIOR to calling the dispatch line.
3. **Items highlighted in red pertain to COVID-19 screening. Complete the questions in the 'FURTHER COVID-19 SCREENING' section prior to all calls, and other areas as relevant. Refer to the Island Health COVID-19 Response Protocol: Long-term Care Facility for further steps.**
4. Call the after-hours call line at **[phone number]** 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. Record the on-call Physician's response (including instructions and orders) on the SBAR form.
6. Fax the completed SBAR form to the Resident's MRP to inform and plan follow up, if necessary. If the On-Call Physician visits the Resident at the facility, include any progress notes or additional documentation to the MRP.
7. Fax the completed SBAR form to the on-call Physician for their records (see fax number below).
8. Place completed SBAR in the 'Physician Notes' section of the chart.

[AREA] After-Hours On-call Physician Fax Numbers – FOR FOLLOW UP FAX ONLY

Physician	Fax	Physician	Fax	Physician	Fax

ABBREVIATIONS					
AGMP	Aerosol Generating Medical Procedures	INR	International Normalized Ratio	PHN	Personal Health Number
BG	Blood Glucose	LOC	Level of Consciousness	LTCI	Long-term Care Initiative
BP	Blood Pressure	MAR	Medication Administration Record	RR	Respiration Rate
DOB	Date of Birth	MOST	Medical Orders for Scope of Treatment	SBAR	Situation Background Assessment Recommendation
eGFR	Estimated Glomerular Filtration Rate	MRP	Most Responsible Physician	Temp	Temperature

Questions or Comments about the After-Hours SBAR?

If you have any questions or feedback, please contact the LTCI team at **[email]** or **[phone number]**