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| **SBAR Protocol for Diagnosing Lower Respiratory infections in Long Term Care** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Resident's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **S - Situation** |  |  |  |  |  |  |  |  |  |  |
| I am contacting you about a suspected Lower Respiratory infection for the above resident. |  |  |  |  |  |
|  | Vital signs: BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Resp rate \_\_\_\_\_ Temp.\_\_\_\_\_ O2 sat \_\_\_\_\_\_\_\_\_ |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **B - Background** |  |  |  |  |  |  |  |  |  |
| Resident has COPD  Yes  No Resident is on supplemental O2  |  Yes  No |  |  |  |
|   |  |  | O2 requirements have increased: Specify amt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  |  |  | Resident uses nebulizer/inhaler  Yes  No |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Resident is diabetic:  No  Yes |  |  |  |  |  |  |  |  |
| Advance directive for limiting treatment (especially antibiotics):  No  Yes |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **A- Assessment (check all boxes that apply)** |  |  |  |  |  |  |  |  |  |
| **Resident WITH fever of 102◦F (38.9◦C) or higher and one of the following** | **Resident with a fever of 100◦F (37.9◦C) and less than 102◦F (38.9◦C)** |  |
|  |  |  |
|  No |  Yes |  | No | Yes |  |  |
| □ | □ | Respiratory rate of > 25 breaths per minute | □ | □ | Cough and at least one of the following: |  |
| □ | □ | New or worsened cough |  |  |  □ Delirium (sudden onset of confusion,  disorientation, dramatic change in mental status) |  |
| □ | □ | New or increased sputum production |  |  |  | □ Pulse >100 |  |
| □ | □ | O2 sats <94% on RA or reduction in O2 sats of >3% from baseline |  |  |  | □ Rigors (shaking chills) |  |
| □ | □ | New dramatic change in mental status |  |  |  | □ RR >25 breaths/minute |  |  |
| □ | □ | **Afebrile resident WITH COPD and age >65** New or increased cough with purulent  sputum production | □ | □ | **Afebrile resident WITHOUT COPD and age >65**New or increased cough with purulent sputum production **AND** at least one of the following |  |
|  |  |  |  | □ RR > 25 |  |
|  |  |  |  | □ Delirium (sudden onset of confusion, disorientation, dramatic change in mental status) |  |
| \*For residents who regularly run a lower temperature, use a temperature of 2 F (1 C) above the baseline as a definition of fever. |
| **R - Provider Recommendation**  No action necessary |  |  |  |  |  |  |  |
|   Order sputum culture |  |  Encourage fluids |  |  |
|   Assess vital signs, including temp every \_\_\_\_ hours for \_\_\_\_ hours |  |  |  |  |  |
|   Notify Physician if symptoms worsen or if unresolved in \_\_\_\_ hours |  |  |  |  |  |
|   Medication (include dose and duration/stop date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ordered on Meditech |  |  |  |
| **Diagnosis/sign/symptom for treatment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| ***Nursing***: Information reviewed with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  Telephone order received by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  Family/POA notified: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **Physician signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Patient Label |  |  | **Boundary Community Hospital & Nursing Home****6640 Kaniksu Street****Bonners Ferry, ID 83805****(208)267-3141** |  |  |  | **SBAR Protocol for Diagnosing Lower Resp. Infection in LTC**\*PO.WRITTEN\*11/06/2017/lmh/BOU-255 |  |  |  |  |