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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 | |  | | |  | |  |  | | |