

INTERACT^{II}
Instructions for the SBAR
Communication Tool and Progress Note



Purpose:

The purpose of the SBAR Communication Tool and Progress Note is to improve communication between nurses and primary care providers (physicians, nurse practitioners, physician assistants) by encouraging all health care team members to use the same language in communicating with one another. By creating standardized criteria and clear guidelines for communication around resident change in condition, more efficient and effective transmission of important information can occur. The SBAR form can also be used in place of a progress note.

Consistent use of this tool will help your nursing home:

- Communicate effectively with MDs, NPs, and PAs when a resident has had an acute change in condition
- Document communication with MDs, NPs, and PAs efficiently

When to use:

- Prior to contacting the provider when a resident has had a change in condition
- On residents who have had a change in condition or for shift to shift communication among nursing staff

Who to involve:

Before completing the SBAR, the nurse should check with other staff members who have regular contact with the resident to obtain an accurate history. Staff members who can provide useful information about the **SITUATION** include the CNA, rehab staff, social workers, and activities staff. A conversation with a family member or health care proxy may also be indicated to clarify advance directives

Helpful Hints:

- Before completing the tool, review the resident's chart (Diagnosis, Medications, Recent Progress Notes from MD/NP as well as most recent nurses notes)
- Bring form with you when talking to staff and family members about the resident as a reminder about data you are seeking.
- Refer to Care Paths or Acute Change in Status File Cards if indicated
- Complete every section of the SBAR prior to calling the MD/NP/PA
- Have chart available when making the call to the MD/NP/PA
- Use SBAR and Progress Note to guide your change of shift report