Long-Term Care Survey Alert

Care Management : Turn to SBAR for Handoffs to the Emergency Department

Summing up what's going on can expedite care.

You may send a resident with signs of a life-threatening condition to the ED in a blaze of ambulance sirens. But to keep the care ball rolling when he arrives, make sure to pass along vital information to the ED triage nurse by phone.

Consider using an "SBAR" format, which stands for Situation, Background, Assessment, and Recommendations, advises triage expert **Carol Rutenberg, RNC-BC, MNSc,** principal of Telephone Triage Consulting Inc. in Hot Springs, Ark. She provides an example of an SBAR report below.

Situation: "Patient states he is too fatigued to get out of bed and is experiencing shortness of breath. This is a change from baseline for this patient. BP 155/90, P 112, R 28; the patient is afebrile but diaphoretic and pale. Breath sounds and heart sounds are unchanged. Patient has a pulse consistent with atrial fibrillation. Urine output is good. Appetite is poor."

Background: "This patient has a history of congestive heart failure, diabetes, and hyperlipidemia with one MI in the past." He is usually alert and oriented and ambulates with a walker.

Assessment: "I'm concerned that this is a significant change for this patient and I believe his hemodynamic status is potentially compromised."

Watch out for wording: If an LPN is making the report, you have to be careful about using the word "assessment" in a state that doesn't allow the LPN to assess, Rutenberg cautions. In such states, however, "the LPN can collect and provide data about the patient's condition, such as vital signs, etc." The RN can and should however provide their assessment of what's going on, if only to provide a brief statement like the one above, she advises.

Recommendation: In this case, it would be that "the patient be seen by the ED staff for evaluation," says Rutenberg.