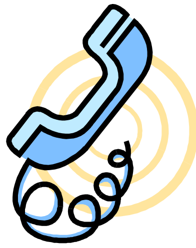
SBAR for Palliative Reporting



***BEFORE* Giving Report:**

1. Assess the patient
2. Review the chart for the appropriate physician or care provider to call
3. Know the primary diagnosis.
4. Read the most recent Progress Notes and the assessment from the nurse of the prior shift or visit.

Have *available* when speaking with the physician or care provider: **Chart, Allergies, Meds, labs / results**

S — SITUATION

State your **name and agency**

I am calling about: **(Patient Name & Facility)**

The **problem** I am calling about is:

B — BACKGROUND

State the pertinent **medical history/ any recent trauma**

A Brief Synopsis of the **treatment to date and effectiveness**

A — ASSESSMENT

ESAS (enter scores)	**_____PAIN** **_____ANXIETY** **_____APPETITE**	**_____DEPRESSION** **_____DROWSINESS** **_____WELL BEING**	**______NAUSEA** **______TIREDNESS** **______SOB/ DYSPNEA**
PPS	**______%**	**Change in Status?**	
Physical			
Psychological			
Social			
Spiritual			
Practical			
End of Life Care Management			
Grief/ Loss Issues			

Any changes from prior assessments:

R — RECOMMENDATION

Do you think we should: (State what you would like to see done)

- ❑ Order an analgesic? (NB: match the severity of the pain with the analgesic order)
- ❑ Order another medication for symptom management? (Refer to Clinical Guidelines)
- ❑ **Come to see the patient at this time ?**
- ❑ Make a **referral** to another member of the team? Physio? OT? Spiritual Care? PPSM Team?
- ❑ Order **diagnostic tests?**
- ❑ Other ____

Are any tests needed ?

- ❑ Do you need any tests? ❑ XRAY ❑ Bloodwork? ❑ Other?

If a change in treatment is ordered, then ask:

- ❑ If the patient does not improve, **when would you want us to call again?**
- ❑ **Will your on call team be available for us should we need a physician off hours?**

Document the change in condition & the MD notification