SBAR Palliative Reporting

Before Giving Report

1. Assess the Patient/Resident
2. Review the chart for the appropriate physician or care provider to call
3. Know the patients/residents diagnosis
4. Read the most recent Progress Notes and the assessment from the nurse of the prior shift.
5. Have *available* when speaking with the physician or care provider:

Known Allergies, Medication, Lab Results, Consultation Reports

S	**SITUATION** State your **name** and **contact information:**_____ I am calling about: (**Patient Name & Organization**) _____ The **problem** I am calling about is: _____
B	**BACKGROUND** State the pertinent **medical history/any recent trauma** Give a brief synopsis of the **treatment to date and effectiveness**

A	**ASSESSMENT**		

ASSESSMENT

ESAS _____/10 **(enter scores)**	_____ Pain _____ Depression _____ Nausea _____ Anxiety _____ Drowsiness _____ Tiredness _____ Appetite _____ Wellbeing _____ SOB/Dyspnea _____ Other e.g. constipation
PPS	_____% Has there been a change in status? ☐ Yes ☐ No
Physical Issues	
Psychological Issues	
Social Issues	
Spiritual Issues	
Practical Issues	
End-of-Life Care Management Issues	
Grief/Loss Issues	

Any changes from prior assessments:

R	**RECOMMENDATION** **Do you think we should:** (State what you would like to see done) ☐ Order and analgesic? (NB: match the severity of the pain with the analgesic order) ☐ Come to see the patient/resident at this time? ☐ Consult the Palliative Care Consultant? ☐ Make a referral to another member of the team e.g. SW, Spiritual Care, Physio, OT ☐ Are any tests needed? ☐ Xray ☐ Blood work ☐ Urinalysis ☐ Other _____ **If a change in treatment is ordered, then ask:** ☐ If the patient/resident does not improve, **when would you want us to call again?** _____ **DOCUMENT the change in condition & the physician notification**