

SBAR Antipsychotic Medication Reduction



SBAR: Communication and Progress Note for Antipsychotics

Before calling the attending physician, nurse practitioner, or physician assistant:

- Evaluate the resident and document in the SBAR form. Review chart: recent progress notes, labs, orders.
- Have relevant information available when reporting (e.g., identify needs-driven expressions, behaviors, falls, medications, disease, adverse drug reactions, interdisciplinary team recommendations, etc.).

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| S SITUATION | The symptom I'm calling about is: <input type="checkbox"/> Violent/self-destructive behavior <input type="checkbox"/> Unpleasant hallucinations <input type="checkbox"/> Suicidal ideations/attempts <input type="checkbox"/> Physically abusive <input type="checkbox"/> Other: _____ _____ | The symptom/why the call was initiated: _____ What are the contributing factors that make it worse? _____ What are the contributing factors that make it better? _____ What are other things that have occurred with this change? _____ This symptom has gotten <input type="checkbox"/> worse <input type="checkbox"/> better <input type="checkbox"/> stayed the same since it started. |
| B BACKGROUND | Primary diagnosis and/or reason for antipsychotic medication use: _____ Pertinent history: _____ Vital signs: BP ___/___ HR ___ RR ___ Temp _____ Pulse oximetry: ___% on O2 at ___L/min via _____ (NC, mask) Change in function or mobility: _____ Medication changes or new orders in the last two weeks: _____ Side effects or adverse drug reactions: _____ Mental status changes: (e.g., confusion/agitation/lethargy) _____ Recent infections: _____ GI/GU changes: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Impaction <input type="checkbox"/> Distension <input type="checkbox"/> Decreased urinary output <input type="checkbox"/> Other _____ Numeric pain level/location of pain: _____ Change in intake/hydration: _____ Labs: _____ Allergies: _____ Any pertinent information: _____ | |
| A ASSESSMENT | What do you think is going on with the resident? (e.g., cardiac, infection, respiratory, urinary, dehydration, mental status change, medication side effects or adverse reaction?) _____ The resident appears: _____ The interdisciplinary team (IDT) met and recommended: _____ Alternatives tried include: <input type="checkbox"/> Align resident past preferences with care plan <input type="checkbox"/> Provide companionship and supervision <input type="checkbox"/> Changing or eliminating bothersome approaches <input type="checkbox"/> Frequent reorientation to surroundings <input type="checkbox"/> Offering person-centered activities (social HX) <input type="checkbox"/> Schedule checks for pain, food, or comfort <input type="checkbox"/> Anticipate resident voiding needs <input type="checkbox"/> Modify environment <input type="checkbox"/> Other: _____ | |
| R REQUEST | I suggest or request (check all that apply): <input type="checkbox"/> Comprehensive facility IDT evaluation <input type="checkbox"/> Provider visit (MD/NP/PA) <input type="checkbox"/> Monitor vital signs and observe <input type="checkbox"/> Lab work, X-rays, EKG, other tests <input type="checkbox"/> Physical therapy evaluation <input type="checkbox"/> Speech therapy evaluation <input type="checkbox"/> Occupational therapy evaluation <input type="checkbox"/> Pharmacy medication review <input type="checkbox"/> Social consultant review <input type="checkbox"/> Activity consultant review <input type="checkbox"/> Psychiatric evaluation <input type="checkbox"/> Other _____ | |
| Nurse's name and signature: _____ RN/LVN MD/NP/PA notified. Name: _____ (MD/NP/PA) Date ___/___/___ Time _____ a.m./p.m. Resident name: _____ Room number: _____ | | |

Source: The SBAR technique was developed by Michael Leonard, MD, Doug Bonacum, and Suzanne Graham at Kaiser Permanente of Colorado.

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