**SBAR for Suspected Skin/Soft Tissue Infection (SSTI)**

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| **Resident Name** | | | | | **DOB** | | | **Unit/Wing, Room** | | | **Completed by:** | | |
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| **S** | ***Situation:***  I am reaching out to you regarding the resident above having a suspected SSTI. | | | | | | | | | | | | |
| **B** | ***Background:***  PMH (especially existing peripheral vascular disease, diabetes, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Recurrent skin infections?  Chronic ulcers/wounds  Indwelling Devices?  Percutaneous venous access  Advance directives? | | | □ YES □ NO  □ YES □ NO If yes, worsening? □ YES □ NO  □ YES □ NO If yes: □ Pacemaker □ ICD □ LVAD □ Prosthetic Joint □ Other: \_\_\_\_\_\_\_\_\_\_\_\_  □ YES □ NO If yes: □ CVC □ Port □ Dialysis Catheter □ Other: \_\_\_\_\_\_\_\_\_\_\_\_  □ YES □ NO If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| **A** | ***Assessment:***  Vital Signs: BP: \_\_\_\_\_\_/\_\_\_\_\_\_ mmHg HR: \_\_\_\_\_\_ beats/min RR: \_\_\_\_\_\_ breaths/min Temp: \_\_\_\_\_°F/\_\_\_\_\_°C   |  |  |  | | --- | --- | --- | | Criteria to initiate antibiotics are met if **at least 1** following situations are selected:  □ New or increasing purulent drainage at a wound, skin, or soft  tissue site  □ At least 2 of the following signs and symptoms  □ Temp of >100°F (38°C), repeated temps of >99°F (37°C),  or temps >2°F (1.5°C) above baseline  □ New or increased redness of the affected site  □ New or increased swelling of the affected site  □ New or increased warmth of the affected site  □ New or increased tenderness of the affected site | Additional description of affected site:  Location: □ Left side □ Right side □ Bilateral | | | Body site:  □ Upper extremities  □ Chest/abdomen  □ Buttock  □ Lower extremities | □ Face/head/neck  □ Back  □ Groin  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Depth: □ Intact skin □ Superficial □ Deep  Drainage:  □ None □ Serous □ Serosanguinous □ Purulent  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **R** | ***Recommendation(s):***  The above resident:  □ **Does meet criteria to initiate antimicrobial therapy for a SSTI at this time:** See Physician/Prescriber Response section below  □ **Does NOT meet criteria to initiate antimicrobial therapy for a SSTI at this time:** Resident may require more frequent monitoring  and/or physician/prescriber assessment | | | | | | | | | | | | |
| Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Faxed or □ Called to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family/POA Notified (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **Physician/Prescriber Response** | | | | | | | | | | | | | |
| □ I have reviewed the resident SBAR above | | | | | | | | | | | | | |
| **Please obtain the following (check all that apply):** | | | | | | | | | | | | | |
| □ BMP | | □ BUN/SCr | □ CBC w/ differential | | | □ Biopsy/pathology review | | | □ Incision and drainage | | | □ Culture  Note: Superficial skin swab cultures may have limited benefit in treating SSTIs due to the increased presence of superficial skin bacterial/fungal colonization | |
| □ Continue monitoring vital signs and temps; every \_\_\_\_\_\_\_\_\_\_ hours for \_\_\_\_\_\_\_\_\_\_ days  □ Encourage continued fluid intake; \_\_\_\_\_\_\_\_\_\_ oz of fluid every \_\_\_\_\_\_\_\_\_\_ hours until symptoms resolve  □ Monitor/record fluid intake and output | | | | | | | | | | | |
| **Please initiate the following selected antibiotic regimen from the corresponding diagnosis:** | | | | | | | | | | | | | |
| ***Non-purulent SSTIs (Mild)***  □ Penicillin V Potassium 500mg PO QID x 7 days  □ Amoxicillin 500mg PO TID x 7 days  □ Cephalexin 500mg PO QID x 7 days  □ Clindamycin 450mg PO TID x 7 days  ***Purulent SSTI (Mild)***  Incision and drainage only  ***Purulent SSTI (Moderate)***  Incision and drainage **PLUS**  □ Doxycycline 100mg PO BID x 7 days  □ TMP/SMX 2 DS tabs PO BID x 7 days  □ Linezolid 600mg PO BID x 7 days  ***Diabetic-related Foot Infection (Mild)***  Surgical debridement, if appropriate, **PLUS**  □ Cephalexin 500mg PO QID x 10 days  □ Doxycycline 100mg PO BID x 10 days  □ TMP/SMX 2 DS tabs PO BID x 10 days  □ Amoxicillin/Clavulanate 875/125mg PO BID x 10 days  □ Linezolid 600mg PO BID x 10 days  □ Levofloxacin 750mg PO Daily x 10 days | | | | | | | ***Human Bite***  □ Amoxicillin/Clavulanate 875/125mg PO BID x 5 days  □ Doxycycline 100mg PO BID x 5 days  □ Moxifloxacin 400mg PO Daily x 5 days  ***Thrush (Oropharyngeal candidiasis)***  □ Nystatin 500,000 units (5mL) swish and spit PO QID x 10 days  □ Clotrimazole troche 10mg dissolved slowly PO 5 times daily x 10 days  □ Fluconazole 200mg PO Daily x 7 days  ***Yeast Infection (Vaginal candidiasis)***  □ Fluconazole 150mg PO one-time | | | | | | |
| □ Pharmacist to renally dose adjust antimicrobial(s). Ensure BUN/SCr is ordered.  □ Notify me once culture identification and susceptibilities have resulted. Will adjust  antibiotics as needed.  □ Notify me if symptoms worsen or do not resolve within \_\_\_\_\_\_\_\_\_\_ hours after  initiating antibiotics  □ Resident to be considered for hospital admission due to severity of disease and/or the  need for IV antibiotics  □ For fever/pain, initiate:  Drug:\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_ Duration:\_\_\_\_\_\_\_\_\_  □ For wound care, apply \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Consult wound care team for wound management | | | | | | |
| Order(s) provided via: □ Fax □ Phone □ In-person □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
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| **Physician/Prescriber Signature:** | | | | | | | | | | | | | **Date/Time:** |
|  | | | | | | | | | | | | | |
| **Please return fax to: (\_\_\_\_)\_\_\_\_--\_\_\_\_\_\_** | | | | | | | | | | | | | |
| *Document to be filed under Physician/Prescriber Order or Progress Note* | | | | | | | | | | | | | |