SBAR for Suspected Skin/Soft Tissue Infection (SSTI)

Resident Name	DOB	Unit/Wing, Room	Completed by:

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? ☐ YES ☐ NO

Chronic ulcers/wounds ☐ YES ☐ NO If yes, worsening? ☐ YES ☐ NO

Indwelling Devices? ☐ YES ☐ NO If yes: ☐ Pacemaker ☐ ICD ☐ LVAD ☐ Prosthetic Joint ☐ Other: ____________

Percutaneous venous access ☐ YES ☐ NO If yes: ☐ CVC ☐ Port ☐ Dialysis Catheter ☐ Other: ____________

Advance directives? ☐ 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:	Additional description of affected site:
☐ 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	Location: ☐ Left side ☐ Right side ☐ Bilateral Body site: ☐ Upper extremities ☐ Face/head/neck ☐ Chest/abdomen ☐ Back ☐ Buttock ☐ Groin ☐ Lower extremities ☐ 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: ______________________

Physician/Prescriber Signature:	**Date/Time:**

Please return fax to: (____)____--______

Document to be filed under Physician/Prescriber Order or Progress Note