

IN-HOME QUALITY IMPROVEMENT

BEST PRACTICE: PHYSICIAN RELATIONSHIPS

NURSE TRACK



Best Practice Intervention Packages were designed for use by any In-Home Provider Agency to support reducing avoidable hospitalizations and emergency room visits. Any In-Home care nurse/clinician can use these educational materials.

Best Practice Intervention Packages were designed to educate and create awareness of strategies and interventions to reduce avoidable hospitalizations and unnecessary emergency room visits.

Nurse Track

This best practice intervention package is designed to educate and support nurses in methods to improve communication and physician relationships that will support reducing avoidable acute care hospitalizations.

Objectives

After completing the activities included in the Nurse Track of this Best Practice Intervention Package, *Physician Relationships*, the learner will be able to:

1. Define SBAR
2. Describe how improving communication will support reducing avoidable acute care hospitalizations
3. Describe two examples where SBAR might promote optimal communication from clinician to physician and clinician to clinician

Complete the following activities:

- View the SBAR WebEx “**SBAR Made Easy**”
- Review SBAR tool
- Review SBAR Communication examples
- Complete SBAR Scenario Exercise

Listen to the audio recording located at www.homehealthquality.org. You will need to log in and go to My Links, Fall Prevention. Go to the Podcast section and left click on July Podcast. This is a podcast on Nurse/Physician Communication (47 minutes). (You cannot access this audio if your agency has not signed on as a member of the Home Health Quality Improvement Campaign. For instructions for signing up on the HHQI website, go to the welcome page of the Missouri In-Home Quality Campaign – <http://www.dhss.mo.gov/seniors/hcbs/qualitycampaign.php>)

- Complete the Nursing Post Test.

Disclaimer: Some of the information contained within this Best Practice Intervention Package may be more directed and intended for an acute care setting, or a higher level of care or skilled level of care setting such as those involved in Medicare. The practices, interventions and information contained are valuable resources to assist you in your knowledge and learning.

Disclaimer: All forms included are optional forms; each can be used as Tools, Templates or Guides for your agency and as you choose. Your individual agency can design or draft these forms to be specific to your own agency's needs and setting.

SBAR

Have ALL information **AVAILABLE** when reporting:
chart, allergies, medication list, pharmacy number, pertinent lab results

S

SITUATION

I am calling about _____ (patient's name)
The problem I am calling about is _____

B

BACKGROUND

State the **primary diagnosis & reason patient is being seen** for home care _____

State the pertinent **medical history** _____

Most recent **findings** _____

Mental status _____ Neuro changes _____ Temp _____

BP _____ Pulse rate/quality/rhythm _____ Resp. rate/quality _____

Lung sounds _____ Pulse Ozimetry _____ % Oxygen _____ L/min via _____

GI/GU changes (nausea/vomiting/diarrhea/impaction/hydration) _____

Weight _____ (actual) Loss or Gain Skin color _____ Blood Glucose _____

Wound status (location, size, wound bed and margins, drainage type and amt, treatment and frequency) _____

Pain level/location/status _____

Musculoskeletal changes (weakness) _____

DNR status _____

Telemonitoring Report _____

Other _____

A

ASSESSMENT

I think that the patient is _____

OR

I am not sure of what the problem is, but the patient's status is deteriorating.

R

RECOMMENDATION

I suggest or request:

PRN visit or referral: Nurse PT ST OT NH Aide MSW Dietician

Visits frequency change

Schedule for a physician office visit

Physician, Nurse Practitioner or Physician Assistant home visit

Pulse Oximetry Telemonitoring Lab work _____

Urinalysis, C&S X-rays EKG

Medication changes _____

Wound care changes _____

Nutrition or fluid restriction changes _____

Other _____

Specific patient parameters _____

Call physician with _____

Staff Name _____ Date & Time _____

Physician's Name _____

SBAR Interdisciplinary Communication

Skilled Nursing

The following example demonstrates using SBAR to communicate issues, problems or opportunities for improvement to coworkers or supervisors.

SITUATION-State what is happening at the present time that has warranted the SBAR communication.

Example: Hi (nursing supervisor) this is (your name) calling to report that my patient, Mrs. L., has an elevated blood pressure this morning and admits to feeling very anxious.

BACKGROUND-Explain circumstances leading up to this situation. Put the situation into context for the reader/listener.

Example: Mrs. L's blood pressure is 188/92 (R) up from 126/80, 186/90 (L). Her pulse has increased from 64 bpm (regular rate and rhythm) to 98 bpm (regular rate and rhythm). No other abnormal symptomatology evident during my assessment. The patient has verbalized that she is somewhat nervous and jumpy but denies any unusual activity or stress. She also has a history of panic attacks.

ASSESSMENT-What do you think the problem is?

Example: She has elevated blood pressure and pulse and what appears to be a panic attack.

RECOMMENDATION-What would you do to correct the problem?

Example: I would like you to notify the physician of these findings and ask if we can have a social worker referral for an evaluation to r/o psychosocial issues that may be causing Mrs. L's suspected panic attacks. I would also like you to visit the patient in the a.m. to assess her vital signs. I will plan to call the physician tomorrow with our findings to see if he would like to schedule Mrs. L for an office visit.

SBAR Interdisciplinary Communication

Skilled Nursing

The following example demonstrates using SBAR to communicate issues, problems or opportunities for improvement to physicians.

SITUATION-State what is happening at the present time that has warranted the SBAR communication.

Example: This is NURSE B from XYZ home health agency calling to report that my patient, Mrs. L., has an elevated blood pressure this morning. She also verbalizes that she feels anxious.

BACKGROUND-Explain circumstances leading up to this situation. Put the situation into context for the reader/listener.

Example: XYZ home health agency has been seeing Mrs. L for three weeks for care of a pressure ulcer. This is the first time her blood pressure has been elevated. Today her blood pressure is 188/92 (R); up from 126/80; 186/90 (L). Her pulse has increased from 64 bpm (regular rate and rhythm) to 98 bpm (regular rate and rhythm). No other abnormal symptomatology evident during my assessment. The patient has verbalized that she is nervous and jumpy but denies any unusual activity or stress. She also verbalizes that she has a history of panic attacks..

ASSESSMENT-What do you think the problem is?

Example: She has elevated blood pressure and pulse.

RECOMMENDATION-What would you do to correct the problem?

Example: I can draw electrolytes and enzymes this morning and call you with the results. I am also requesting to have an order for a social worker to visit to r/o psychosocial issue. I will revisit Mrs. L tomorrow and contact you with our findings.

SBAR Scenario

Read the following scenario and then complete the SBAR individually or in a small group. Discuss your SBAR with your partner or your small group.

Nursing

Mr. S is a 78-year-old patient with CHF and HTN who lives with elderly wife. Today's vital signs were: T -98.6, BP-188/90, RR-24. He is more SOB today as evidenced by an increased respiration rate and now SOB ambulating 8 feet (baseline ability –ambulate 20 feet). Lungs sounds were previously clear, but today he has crackles in the posterior bilateral lower bases (1/3rd lung fields). He usually has +1 edema, but today it is now +2 and slightly pitting. Mr. S's wife forgot to weigh him for the last 3 days. He has now gained 6 lbs. over 4 days.

His current med regime includes: Digoxin, 0.125mg, every day; Lasix, 20 mg, every day; Slow-K, 20 meq, every day; and Prinivil, 5 mg, every day. He has no standing/prn orders. You talked with his wife about his compliance with his medication regimen. She states her daughter pre-fills the medications once a week. Upon examining the pillbox, it appears that the medications were given as ordered. His diet recall was not much different than his normal 2 Gm Na diet, except for a ham dinner 2 days ago. His wife is anxious over his change in status. The nurse calls the physician with the update using SBAR format.

S

B

A

R

S

Dr. G, I am _____ from XYZ Home Care. I am calling about Mr. S, whose blood pressure, respirations and weight are elevated.

B

Mr. S, a 78-year-old patient, with diagnosis of CHF & HTN. BP has increased to 188/90, resp. to 24. SOB when ambulating 8 feet, previously SOB at 20 feet. Wgt increased 6#/4 days. Crackles in the posterior bilateral lower bases (*1/3rd lung field). Complaint with medications. For the most part he is compliant with his 2 Gm Na diet, with the exception of eating ham for dinner two days ago.

A

Mr. S is experiencing fluid retention which may or may not have been exacerbated by the ham dinner.

R

I would like to give Mr. S a dose of IV Lasix now and then continue with his daily Lasix p.o. dose in the a.m. I will have his wife measure his urine output for the next 24 hours to assess his diuresis. I would like an order to visit in the a.m. to assess his respiratory status, and urine output. May I draw a stat K+ level? I will call you with the visit results in the a.m. The on-call nurse will call his wife in 2 hours to assess Mr. S's SOB and urine output. Mrs. S will be instructed on the s/s to watch for and to call if patient's SOB worsens.

Read the sample scenario and complete the SBAR. Then, look at the example and discuss it.

Nurse Name: _____
Date: _____

NURSING POST TEST Physician Relationships

Directions: Choose the ONE BEST response to the following questions. Circle the answer that identifies the ONE BEST response.

1. The SBAR acronym stands for which of the following:
 - A. Symptoms, Billing information, Assessment, Refinement
 - B. Symptoms, Blood work, Advice, Risk level
 - C. Situation, Background, Assessment, Recommendation
 - D. Safety, Bowel sounds, Appetite, Respirations
2. The purpose of using the SBAR communication method for In-Home Agencies is all of the following **except:**
 - A. Improving communication between clinicians and physicians
 - B. Improving interdisciplinary communications
 - C. Providing significant patient information in a clear, concise and to-the-point manner
 - D. Utilizing a military system in reporting
3. The use of a structured communication method, such as SBAR, can assist with reducing acute care hospitalizations by improving communication within the interdisciplinary team (all disciplines) and physicians. Communicating in a structured manner (oral or written) will assist the physician in assimilating patient information and facilitate the selection of patient-centered interventions.
 - A. True
 - B. False
4. The following information is essential to have available before calling the physician **except:**
 - A. Name, medical record number, age, and advance directive status
 - B. Social security number
 - C. Diagnosis, including significant secondary diagnosis
 - D. Vital signs and physical assessment; detailed phone assessment; and/or telemonitoring assessment
 - E. Significant lab results
5. The SBAR communication method would be appropriate for nursing in the following situations **except:**
 - A. Giving a nursing report to the manager
 - B. Providing an update on the patient to the therapist, social worker or aide
 - C. Telling a friend about one of your patients
 - D. Calling the doctor's office with a patient problem
 - E. Faxing a report to the doctor's office with a patient problem