Interior Health

PALLIATIVE and END of LIFE CARE Multidisciplinary SBAR Communication Tool

Patient Name *(last)* _____

(first) _____

DOB *(dd/mm/yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

IH USE ONLY

If contacting a Clinical Nurse Specialist (CNS):

A CNS will respond to email requests within 24 hours Monday to Friday. Please email the request: PalliativeCNS@interiorhealth.ca.
If the nature of your request is more pressing:

1. Monday to Friday 0800 – 1600: contact the CNS directly: Elisabeth Antifeau 1-250-354-2883 or Vicki Kennedy 1-250-212-7807.
2. For After Hours, statutory holidays and weekends: call the IH Palliative Nursing Consult Service at 1-844-851-4192 and verbally use the SBAR (Situation, Background, Assessment and Recommendations) format below.

Directions: Complete the Palliative SBAR with brief bullets, providing enough information to communicate the context, clinical needs and main concerns for the individual and / or family. See back of page 1 to guide the type of information required.

Situation

Background

Assessment

Recommendations

Date (dd / mm / yyyy)	Time (24 hour)	Clinician Name / Signature	Designation / College ID #
/ /			

Outcomes: Actions and Follow-up (be specific, e.g., who does what by when; MRP; MRC)

Comments:

Date (dd / mm / yyyy)	Time (24 hour)	Clinician Name / Signature	Designation / College ID #
/ /			

Permanent part of the health record

Clear Form Print Form

Guidelines for Communicating Palliative Needs

Purpose: A tool to communicate focused concerns about an individual / family with palliative symptom management concerns, transitional needs, or distress that requires inter-professional attention. The standardized Palliative SBAR can be used to present in Whole Community Palliative Rounds (WCPR), Clinical Huddles, to communicate succinctly with Physicians or Nurse Practitioners to obtain relevant orders for care, or for warm and cold handovers of individuals with palliative needs who are being transferred across the settings to ensure better continuity of care. This Palliative SBAR is a worksheet. Inclusion in the chart is optional.

Population: Any individual and family members living with advancing life limiting illness (malignant or non-malignant) who present with current palliative needs, symptom burden and / or distress. Individuals may be located in any sector of care.

Most Responsible Practitioner (MRP): Family Physician, Nurse Practitioner or Medical Specialist

Most Responsible Clinician (MRC): Nurse, Social Worker, or any Allied Health member

Instructions: Complete the SBAR with brief bullets, providing enough salient information to correctly communicate the context and summary of existing palliative needs that require rapid clinical attention. Examples of the types of information that may be communicated are identified in each category of the SBAR below:

Situation	• Name, Age, Location (home, LTC, hospital, Community Hospice Bed) • Diagnosis, Current PPS (Palliative Performance Scale) (include rate of decline if known) • Positive or negative delirium screen CAM-PRISME (Confusion Assessment Method with PRISME) as relevant; • Current Problem, presenting symptom(s), including ESASr (Edmonton Symptom Assessment System, revised) Scores for each symptom of concern (e.g., Pain 8 / 10; Dyspnea 6 / 10; Fatigue 4 / 10; Anxiety 8 / 10)
Background	• Succinct description of medical history (other conditions, current treatments or related factors); • Known Goals of Care, MOST, Chosen location of death (if known); • Known / relevant health team members / services; this includes both relevant internal & external care partners (e.g. hospice, BC Emergency Health Services (Paramedics), First Nation Health Authority (FNHA) nurses, contracted facility staff) • Current medications, any known allergies
Assessment	**Further assessment of presenting symptom using the Symptom Assessment O to V Tool**: • **O** – Onset • **P** – Provoking / Precipitating factors • **Q** – Quality • **R** – Region / Radiating • **S** – Severity (ESASr score for each symptom) • **T** – Treatment / timing • **U** – Understanding (what does the person think is happening) • **V** – Values / Goals for symptom management (includes trade-offs) **Further clinical decision supports are described in the IH Palliative Symptom Assessment Clinical Care Standard.**

Recommendations	**Requests:**
	• "I am asking for… new / revised / different orders to address these… XYZ symptoms"
	• Example: "He has had 6 break-through doses in the past 24 hours, can we please evaluate and titrate the regular dosing to give him better pain relieve?"
	Recommendations:
	• "I wondered if we could try…."
	• Examples:
	  • "Would low-dose Haldol be a possible solution to relieve his nausea?"
	  • "May we try an anti-depressant such as Citalopram to address her depression?"

Permanent part of the health record