Success in Nursing Program

Learning Activity Plan

Unit 10: Communication with professionals and patients in the clinical setting

Learning outcome:

Participants will be able to:

* List two concepts applicable to communication with patients in the clinical setting
* Use the SBAR tools during role play

Learning activity:

* Social interaction
* Micro-lecture
* Role-play in small groups

Time for learning activity:

* Social interaction – 15 minutes
* Micro-lecture - 10 minutes
* Role-play – 30 minutes

Time for debriefing: 5 minutes

Resources needed:

* Paper copies of SBAR for Shift Report & SBAR Communication with Physicians tools
* Role-play case scenarios for groups

Your patient today, Mr. Washington, is a 30 year old African American man who was born and raised in the U.S. You need to provide him with pre-operative teaching for abdominal surgery. He speaks more directly and loudly than most people do in your culture.

Your patient, Mrs. Smith, had knee replacement surgery today at 0700. On your shift, Mrs. Smith has had stable vital signs, the dressing has been dry & intact, and she has been taking fluids without any nausea. She has a PCA pump with narcotics infusing as ordered, but she is still complaining of pain at a level 10 (1-10 scale). It is now 1500 and you need to provide shift report to the evening nurse.

Your patient, Mr. Jones is in the hospital to determine the cause of his abdominal pain. Mr. Jones is 51 years old and has diabetes. Mr. Jones says that eating increases his pain, therefore he has not eaten anything today. You are concerned because Mr. Jones received his normal dose of insulin this morning. It is now 1300 and Mr. Jones’ accucheck blood sugar is 40. Mr. Jones’ skin is diaphoretic, his blood pressure is low and he is slightly confused. Please call Mr. Jones’s physician, Dr. Young, and report what is occurring with the patient.

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**SBAR Communication with Physician**

**S**ituation:

* Identify yourself & the site/unit you are calling from
* Identify the patient by name and the reason for your report
* Describe your concern

Firstly, describe the specific situation about which you are calling, including the patient's name, consultant, patient location, code status, and vital signs. An example of a script would be:

*"This is Lou, a registered nurse on Nightingale Ward. The reason I'm calling is that Mrs Taylor in room 225 has become suddenly short of breath, her oxygen saturation has dropped to 88 per cent on room air, her respiration rate is 24 per minute, her heart rate is 110 and her blood pressure is 85/50. We have placed her on 6 liters of oxygen and her saturation is 93 per cent, her work of breathing is increased, she is anxious, her breath sounds are clear throughout and her respiratory rate remains greater than 20. She has a full code status."*

**B**ackground:

* Give the patient's reason for admission
* Explain significant medical history
* You then inform the consultant of the patient's background: admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results and other relevant diagnostic results. For this, you need to have collected information from the patient's chart, flow sheets and progress notes. For example:

*"Mrs. Smith is a 69-year-old woman who was admitted ten days ago, following a MVC, with a T 5 burst fracture and a T 6 ASIA B SCI. She had T 3-T 7 instrumentation and fusion nine days ago, her only complication was a right hemothorax for which a chest tube was put in place. The tube was removed five days ago and her CXR has shown significant improvement. She has been walking with PT and has been progressing well. Her hemoglobin is 100 gm/L; otherwise her blood work is within normal limits. She has been on Enoxaparin for DVT prophylaxis and Oxycodone for pain management."*

**A**ssessment:

* Vital signs
* Contraction pattern
* Clinical impressions, concerns

You need to think critically when informing the doctor of your assessment of the situation. This means that you have considered what might be the underlying reason for your patient's condition. Not only have you reviewed your findings from your assessment, you have also consolidated these with other objective indicators, such as laboratory results.

If you do not have an assessment, you may say:   
  
*"I think she may have had a pulmonary embolus.'"*   
"*I'm not sure what the problem is, but I am worried."* (Continued on next page)

**R**ecommendation:

* Explain what you need - be specific about request and time frame
* Make suggestions
* Clarify expectations

Finally, what is your recommendation? That is, what would you like to happen by the end of the conversation with the physician? Any order that is given on the phone needs to be repeated back to ensure accuracy.   
  
*"Would you like me to get a stat CXR? ABGs? Start an IV?"   
"Should I begin organizing a spiral CT?"   
"When are you going to be able to get here?"*

**SBAR for Shift Report**

**S**ituation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room number: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**B**ackground \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consults: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A**ssessment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current vital signs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart rhythm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lung sounds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oxygen rate: \_\_\_\_\_\_\_\_\_\_\_

Skin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IV site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ IV site change date: \_\_\_\_\_\_\_\_\_\_\_\_

Dressings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last BM: \_\_\_\_\_\_\_\_\_\_\_\_\_ Foley: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drains: \_\_\_\_\_\_\_\_\_\_\_ Fall risk: \_\_\_\_\_\_\_\_\_\_\_

**R**ecommendations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current labs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pending labs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Awaiting procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nursing concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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