Suspected SST **SBAR**

Complete this form before contacting the resident's physician.

Date/Time _____

Nursing Home Name _____

Resident Name _____ Date of Birth _____

Physician/NP/PA _____ Phone _____

Fax _____

Nurse _____ Facility Phone _____

Submitted by ☐ Phone ☐ Fax ☐ In Person ☐ Other _____

S Situation

I am contacting you about a suspected SST infection for the above resident.

Vital Signs BP _____ /_____ HR _____ Resp. rate _____ Temp. _____

B Background

☐ No ☐ Yes The resident has diabetes

☐ No ☐ Yes Other active diagnoses (especially, chronic venous insufficiency, edema or peripheral vascular disease)

Specify _____

_____

☐ No ☐ Yes History of skin infections

Specify _____

_____

☐ No ☐ Yes Advance directives for limiting treatment related to antibiotics and/or hospitalizations

Specify _____

_____

☐ No ☐ Yes Medication Allergies

Specify _____

_____

☐ No ☐ Yes The resident is on Warfarin (Coumadin®)

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care ● www.ahrq.gov

PREVENT HAIs Healthcare-Associated Infections

www.ahrq.gov/NH-ASPGuide • June 2014
AHRQ Pub. No. 14-0010-2-EF

Nursing Home Name _____ Facility Fax _____

Resident Name _____

A Assessment Input (check all boxes that apply)

Minimum Criteria for Initiating an Antibiotic

The criteria are met to initiate antibiotics if one of situations below are met

No Yes

☐ ☐ 1. New or increasing pus at a wound, skin, or soft-tissue site

OR

☐ ☐ 2. At least two of the following:

- ☐ Fever of 100°F (38°C) or repeated temperatures of 99°F (37°C)*
- ☐ redness
- ☐ pain
- ☐ warmth
- ☐ swelling that is new or increasing

Nurses: Please check box to indicate whether or not criteria are met

☐ **Nursing home protocol criteria are met.** The resident may have a skin and soft tissue infection and need a prescription for an antibiotic agent.†

☐ **Nursing home protocol criteria are NOT met.** The resident does NOT need an immediate prescription for an antibiotic, but may need additional observation.††

R Request for Physician/NP/PA Orders

Orders were provided by clinician through ☐ Phone ☐ Fax ☐ In Person ☐ Other _____

☐ Assess vital signs, including temp, every _____ hours for _____ hours

☐ Notify Physician/NP/PA if symptoms worsen or if unresolved in _____ hours

☐ For discomfort or prior to cleaning/dressing changes, consider using acetaminophen or other pain reliever as needed

☐ Initiate the following antibiotic

Antibiotic 1 _____ Dose _____ Route _____ Duration _____

Antibiotic 2 _____ Dose _____ Route _____ Duration _____

☐ No ☐ Yes Pharmacist to adjust for renal function

Other _____

Physician/NP/PA signature _____ Date/Time _____

Telephone order received by _____ Date/Time _____

Family/POA notified (name) _____ Date/Time _____

* For residents that regularly run a lower temperature, use a temperature of 2°F (1°C) above the baseline as a definition of a fever.
† This is according to our understanding of best practices and our facility protocols.
†† This is according to our understanding of best practices and our facility protocols. The information is insufficient to indicate an active skin or soft tissue infection.