Interior Health

PALLIATIVE SBAR

Palliative Care & End of Life Services
Clinical Practice Bulletin

WHAT IS THE PALLIATIVE SBAR?

This standardized tool supports a concise conversation around an individual's palliative symptom management concerns to be shared within the interdisciplinary team.

The tool is a worksheet to support Whole Community Palliative Rounds (WCPR), clinical huddles, communicating with the MRP, and handovers of palliative individuals transferring to another care setting. It is also used for submissions to the After Hours Palliative Care Nurse Consult Line.

SBAR WORKSHEET

Situation: Individual identifiable factors, diagnosis, current PPS, +/- delirium screen, current problem, and presenting symptoms with ESASr score.

Background: Medical Hx, MOST, known Goals of Care, relevant health team members/services, current medications, any known allergies, chosen location of death.

Assessment: Utilize the Symptom Assessment O to V tool on the presenting symptom.

Recommendations: You can either make a *request* ('I am asking for...' to address these symptoms) or a *recommendation* ('I wondered if we could try...' to address these symptoms).

PRACTICE TIPS

CLICK HERE TO LOCATE THE PALLIATVE SBAR

WHO CAN USE THE PALLIATIVE SBAR?

Any clinician can utilize the Palliative SBAR to address person/family palliative care needs including the:

Most Responsible Practitioner *(MRP)*

- Family Physician, Nurse Practitioner, or Medical Specialist

Most Responsible Clinician *(MRC)*

- Nurse, Social Worker, or any Allied Health member

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)

RESOURCES

SBAR for Communicating Palliative and End-of-Life Care Needs