

Is my resident unwell?

If you feel the situation is a life-threatening emergency, ring 999.

1. This is a tool to ensure that communication is clear and purposeful. It can be adapted to any situation. This is a guide to help you give relevant information. In all cases the health professional contacted is responsible for determining what action is required and for the diagnosis of the problem.
2. The checklist can be used to help with describing symptoms. It is not exhaustive and if you notice other symptoms not listed or have other information please include this as well.
3. Not every question will be relevant to every person.
4. Write it down before you make contact! This helps you put the information together in a logical way, provides a written record and a record for other members of staff to follow if necessary.
5. The information on the completed form is confidential. Remember to keep it where it can only be accessed by the people who require the information.

➔ Step 1: Recognise and record the changes

Resident name:		Date of birth:	
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Am I worried enough to want a review?			
		YES	NO
	Are they becoming restless or agitated?		
	Are they flushed, sweating hot or cold, or clammy?		
	Are they more or less mobile than usual, or unsteady?		
	Is there new, or worrying, pain?		
	Are there changes in skin colour or condition?		
	Are they short of breath or breathing harder than usual?		

Am I worried enough to want a review?			
		YES	NO
	Are they more confused or drowsy?		
	Do they have cold hands or feet?		
	Are they feeling sick, or being sick?		
	Are they off their food or drinking less fluid?		
	Any changes in urine colour or smell?		
	Any changes in bowel habits?		

What does the resident say about how they feel? If the resident is able to express how they feel please tell us what they say.

Name:	Date:	Time:	Signature:

➔ Step 2: Take a set of observations

Resident name:

Date of birth:

NEWS2. Please record

Temperature	Pulse	Respiration	Blood pressure	Air or oxygen	SpO2:1	SpO2:2	Consciousness (see key below)



Current NEWS2 score

Consciousness ACVPU Key:

A = ALERT - awake and responding, eyes open

C = CONFUSION - new onset of confusion (do not score if chronic)

V = VERBAL - moves eyes / limbs or makes sounds to voice

P = PAIN - responds only to painful stimuli

U = UNRESPONSIVE - unconscious

Baseline Resident NEWS2 score:

Does your resident have an end of life plan, anticipatory care plan or Emergency Health Care Plan?

yes / no

Does our resident have a DNACPR / (Do Not attempt Resuscitation) / ReSPECT form?

yes / no

Resident Clinical Frailty Score / Status is:

How concerned are you? (tick appropriate box)

0	1	2	3	4	5
No concern					Extremely concerned

Any extra information you think might be important?
i.e. fluid chart, medication changes etc.

Name:

Date:

Time:

Signature:

➔ Step 3: Pass on your concerns

Resident name:

Date of birth:

SBARD Escalation and Communication Tool and action tracker

		Notes (including date and time of escalation)
S	SITUATION Briefly describe the current situation and give a clear, concise overview of relevant issues. • (Provide address, direct line contact number.) • I am... from... (say if you are a registered professional). • I am calling about resident... (Name, DOB.) • The residents present NEWS score is... Reference/ baseline NEWS score is... • I am calling because I am concerned that...(think about the signs you ticked on page 2 or the part of the NEWS score which is concerning you.)	
B	BACKGROUND Briefly state the relevant history and what got you to this point. • Resident XX has the following medical conditions... • The resident does/does not have a DNACPR or ReSPECT form / agreed care plan with a limit on treatment/hospital admission. • If the person is approaching End of Life and they on a palliative care register, Do they wish to be treated at home. • They have had... (GP/other health professional involved recently, eg review, investigation, medication.) • Resident XX's condition has changed in the last XX hours. • The last set of observations was...(date and time.) • Their normal condition is...	
A	ASSESSMENT Summarise the facts and give your best assessment on what is happening. • I think the problem is... • And I have... (e.g. given pain relief, medication, sat the patient up etc.) OR • I am not sure what the problem is, but the resident is deteriorating OR • I don't know what's wrong, but I am really worried.	
		Actions I have been asked to take (initial & time when actions completed)
R	RECOMMENDATION What actions are you asking for? What do you want to happen next? • I need you to... • Come and see the resident in the next XX hours AND • Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services).	
D	DECISION What have you agreed? • We have agreed you will visit/call in the next XX hours, and in the meantime, I will do XX. If there is no improvement within XX, I will take XX action.	

Name:

Date:

Time:

Signature: