SBAR Nursing Handoff

I. Situation

Patient Name: Mr. John Doe

Room Number: 203

Brief Description of Current Situation:
Mr. Doe, a 65-year-old male with a history of hypertension and diabetes, was admitted for elective knee replacement surgery. Surgery was performed earlier today.

Chief Complaint/Reason for Admission:
Knee replacement surgery.

Vital Signs (current):

- Blood Pressure: 130/80 mmHg
- Heart Rate: 82 bpm
- Respiratory Rate: 18 bpm
- Temperature: : 98.6°F
- Oxygen Saturation: 98%

II. Background

Admitting Diagnosis:
Osteoarthritis of the knee

Allergies:
None known

Current Medications (including IV medications and rates):
Amlodipine 5 mg daily

Metformin 1000 mg BID

Recent Lab Results:

- CBC: Within normal limits
- BMP: Within normal limits
- Coagulation Profile: Within normal limits

Recent Imaging Results:

- X-rays: Pre-op knee X-rays
- CT scans: None
- MRIs: None

Relevant Procedures/Interventions:
Knee replacement surgery was completed successfully

No post-op complications reported

Current Code Status: Full code

Family Support/Concerns: Wife at the bedside, no specific concerns expressed

Advanced Directives:
None

III. Assessment

Current Patient Status:

- Level of Consciousness (LOC): Alert and oriented x3
- Pain Level: Managed with PCA (Patient-Controlled Analgesia)
- Mobility: Limited mobility post-surgery
- Skin Integrity: Intact, no signs of infection
- Respiratory Status: Stable, clear lung sounds
- Cardiovascular Status: Stable
- Gastrointestinal Status: Bowel sounds present
- Neurological Status: No deficits noted

Any Changes Since Last Shift:
No significant changes reported

Concerns/Issues:
None at this time

Plan of Care

- Nursing Interventions:

Monitor pain, assist with mobility

- Pending Consultations:

Physical therapy is scheduled for tomorrow

- Scheduled Procedures:

None

Response to Interventions:
Pain is well-managed, with no signs of adverse reactions

Anticipated Changes:
Continued post-op recovery

Orthopedic surgeon follow-up in the morning

IV. Recommendation

Specific Actions Needed:
Continue PCA for pain management

Administer routine post-op medications

Plan for the Next Few Hours:
Monitor vital signs every 4 hours
Encourage deep breathing exercises
Provide patient and family education on post-op care

Escalation Plan:
Criteria for contacting the provider: Increasing pain not relieved by PCA, signs of infection, or any acute changes in condition

Emergencies: Activate rapid response for any sudden deterioration

Patient and Family Education Needs:
PCA usage and management

Expected post-op recovery milestones

V. Additional Information

Patient Preferences:
No specific preferences mentioned

Pending Tasks:
None

Any Unresolved Issues:
None

Verification

Read-back from the receiver:
The receiver confirms understanding of the patient's current status and care plan.

Any questions or clarifications:
None

Follow-up

Scheduled Follow-up Handoff: 0700 hours for the morning shift

Documented Communication:
Information documented in the EHR, handoff report sheet, and communicated verbally during shift change.