Emergent and After Hours Calls in Skilled Care Facilities

“‘I know you think you understand what you thought I said, but I’m not sure you realize that what you heard is not what I meant.’—Alan Greenspan

Making and taking calls in and for skilled nursing facilities (SNFs) is often unsettling for all nursing facility staff placing the call, health care providers receiving it, and residents/family awaiting resolutions to requests. These phone calls are a part of the job and important to both the safety and well-being of residents and frequently result in changes in care plans. Yet, the skills needed to be successful in communication are seldom taught in school or outlined in new employee orientation. The current editorial focuses on methods to improve processes and outcomes for urgent calls (i.e., those that need to be handled within 1 to 2 hours) and same-day calls that occur in SNF and long-term care facilities (Katz, 1990). These techniques are equally relevant for residents who are short term or those who reside in the facility.

BEFORE MAKING CALLS

For those individuals making the calls, the first question to be answered is, “Does the call need to be made?” For true emergencies, such as a fall with injuries, the decision is seldom difficult. Examples of urgent calls would be acute illnesses with changes in vital signs, level of consciousness, or onset of new symptoms. The most frequent same-day call is abnormal laboratory studies or the reporting of routine international normalized ratios with the need for warfarin adjustment. Patient or family requests to “call my primary” can fall into urgent or same-day call categories. In advance to placing the call, the caller needs to prepare by assessing the resident, checking vital signs, having the resident’s record available, and anticipating questions that could be asked.

PLACING A CALL

Health care professionals in general, but those in SNFs in particular, are plagued with too much to do and not enough time. Calls need to begin with an acknowledgment (e.g., “Hello”), not with an apology for calling. Next, it is important for the receiver to know who is calling, who it is about (including the patient’s date of birth), and where the call is originating. Information to be conveyed needs to be current, clear, concise, correct, and generally presented in chronological order. Avoiding abbreviations and acronyms also enhances clear communication. For example, “PE” may mean pulmonary emboli to one individual and pleural effusion to another. Both are serious conditions, but they require radically different interventions and attention.

FORMATTING THE CALL

The SBAR (Situation, Background, Assessment, and Recommendation) format serves the purpose of logically organizing information needed for communication with health care providers (Renz, Boltz, Wagner, Capezuti, & Lawrence, 2013). The SBAR format has been used in hospitals for conveying information about seriously ill patients in an effort to avoid further status deterioration.
Subsequently, it has been adapted to different settings. A comprehensive SBAR tool tailored for nursing homes can be found online (access http://interact2.net/tools_v3.aspx; Interactions to Reduce Acute Care Transfers [INTERACT], 2013). This detailed tool can be helpful in preparing for the phone communication, documenting the event, and enhancing quality improvement processes. It also helps nurses anticipate questions that may arise during the phone call. If a provider is not reached by the nurse identifying the need for the phone call, the completed SBAR is a record and provides data for a nurse colleague who may receive the call-back. For a provider, there will never be an adequate replacement for in-person assessment of the patient. But by focusing on the resident and using facts and data, a well-prepared nurse has the ability to describe the situation so that the provider can understand what is happening and reach an accurate medical decision.

The SBAR format is somewhat analogous to the SOAP (Subjective, Objective, Assessment, Plan) format, which is the standard and familiar clinical organization pattern for most providers (Larimore & Jordan, 1995). The Situation/Subjective should succinctly describe the resident’s situation and reason for the call. If the patient were to describe what was wrong, what would he or she say?

The Background/Objective section should be limited to relevant current and past medical issues, including medications that have recently been started or discontinued, high-risk drugs (e.g., warfarin, insulin), and allergies. Recent vital signs are essential.

The Assessment/Assessment is the “ah-ha” or “diagnosis” of the situation based on the data garnered from the former two sections. It needs to convey not only what the nurse thinks the problem is but also the magnitude and immediacy of the situation.

Finally, the Recommendation/Plan reflects what must be done to meet the current needs of the resident as well as follow up to monitor and evaluate the outcomes. Because many providers are not aware of the routines in SNFs, laboratory and pharmacy schedules as well as the ability to perform certain treatment (e.g., intravenous therapy) need to be clarified for the plan to be a success.

Documentation of the call entails more than just writing a phone order. Therefore, the INTERACT II (2013) SBAR serves double duty, as not only the tool for organization of the call, but also as a record of the call and the resolution.

Phone calls are seldom received or made at ideal times (i.e., with access to a quiet environment, good phone connection, and all the necessary information available). Asking questions is imperative to clarify and gain information from both parties on the call. Although there are always logical reasons for illogical orders, plans that are cumbersome, do not make sense, or cannot be performed in a timely fashion need to be clarified. The responsibility is not all on the caller. Providers need to be better at listening and not interrupting. Using the SBAR/SOAP format for organizing, completing, and documenting phone communications will enable the best plans to be formulated to meet the complex needs of the vulnerable SNF population (Table).

### REFERENCES


### TABLE

**KEYS FOR SUCCESSFUL CALLS**

<table>
<thead>
<tr>
<th>1.</th>
<th>Does a call need to be made?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Have available resources in current care plan/treatment regimen been used to meet the current situation?</td>
</tr>
<tr>
<td>2.</td>
<td>Have the necessary assessments been completed and documented in the SBAR/SOAP format?</td>
</tr>
<tr>
<td></td>
<td>• Important for preparation and completion of call, but also assists nursing colleagues if the call-back occurs at a later time.</td>
</tr>
<tr>
<td></td>
<td>• Accompanying data sources (e.g., the resident’s chart and medication administration record) need to be readily accessible for unexpected questions.</td>
</tr>
<tr>
<td>3.</td>
<td>During the call, focus on:</td>
</tr>
<tr>
<td></td>
<td>• the facts.</td>
</tr>
<tr>
<td></td>
<td>• meeting the needs of the resident.</td>
</tr>
<tr>
<td></td>
<td>• clarifying questions to avoid additional calls.</td>
</tr>
<tr>
<td>4.</td>
<td>After the call, the completed SBAR/SOAP is filed as documentation of the interaction.</td>
</tr>
</tbody>
</table>

Note. SBAR/SOAP = Situation, Background, Assessment, and Recommendation/Subjective, Objective, Assessment, Plan.

*Brenda Bergman-Evans, PhD, APRN-NP, APRN-CNS*  
**Vice President, Advanced Practice and Acute Care**  
CHI: Alegent Creighton Health

The author has disclosed no potential conflicts of interest, financial or otherwise.

doi:10.3928/00989134-20150218-01