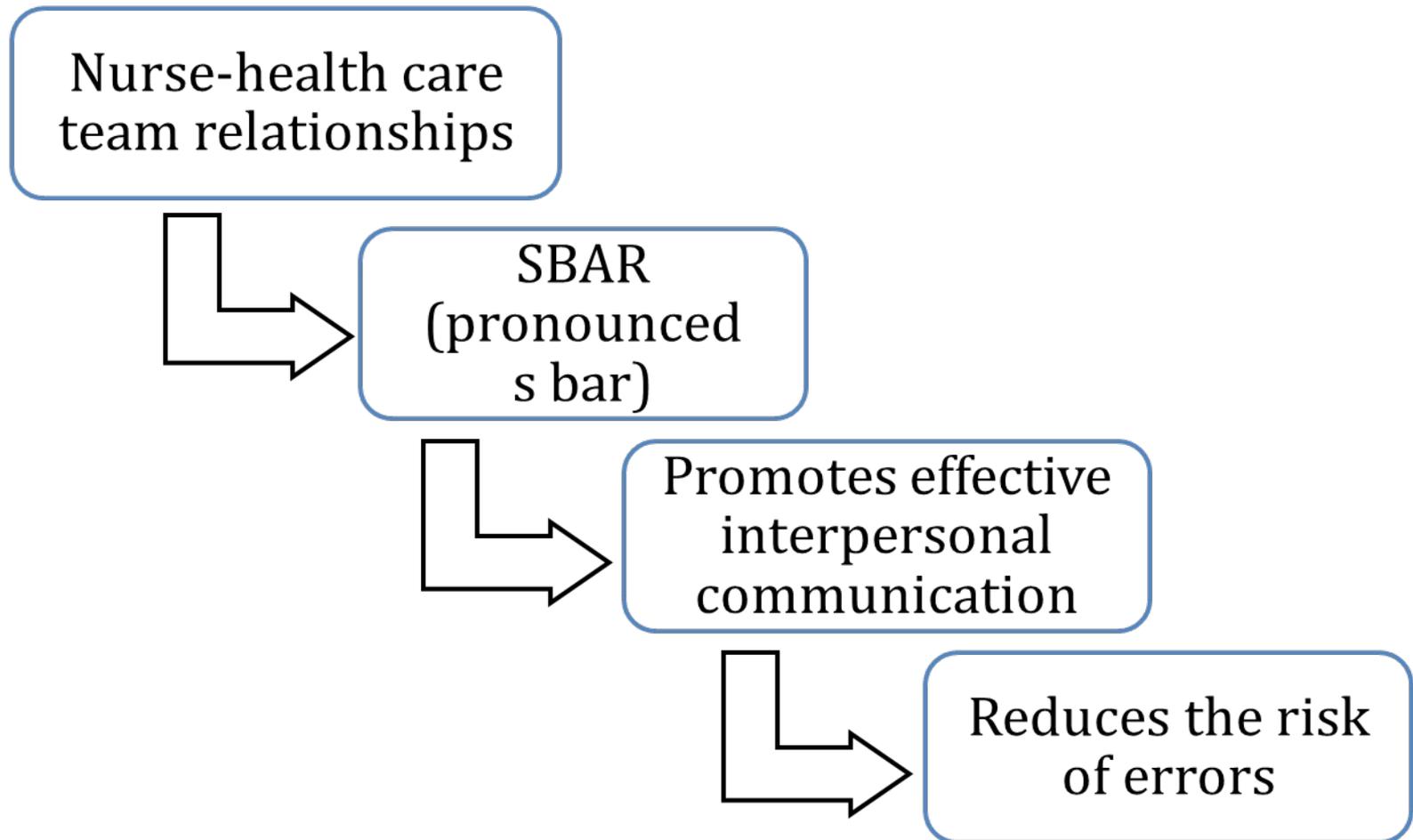


SBAR/Communication

Instructional Module 1

Debbie Dutton, MSN, RNC-OB

Professional Nursing Relationships



SBAR

- Tool
 - Improves communication
 - ***Standardizes the process***

SBAR

Situation

- Patient's details
- Identify reason for this communication
- Describe nurse's concern

SBAR

Background

- Relating to the patient, significant history
 - Include:
 - Medications
 - Investigations
 - Treatments

SBAR

Assessment

- Nurse's assessment of the patient or situation
 - Include:
 - Clinical impression
 - Concerns
 - Vital signs
 - Early warning score

SBAR

Recommendation

- Be specific
- Explain what is needed
- Make suggestions
- Clarify expectations
- Confirm actions to be taken

SBAR

- When SBAR is a **“must”**
 - During a patient hand-off
 - During RN-Healthcare provider communication
 - Any time there is important communication in the interdisciplinary team

S

Situation:

I am (name), (X) nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that...
(e.g. BP is low/high, pulse is XX temperature is XX,
Early Warning Score is XX)

B

Background:

Patient (X) was admitted on (XX date) with
(e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is...
(e.g. alert/drowsy/confused, pain free)

A

Assessment:

I think the problem is (XXX)
And I have...
(e.g. given O₂/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X)
is deteriorating
OR
I don't know what's wrong but I am really worried

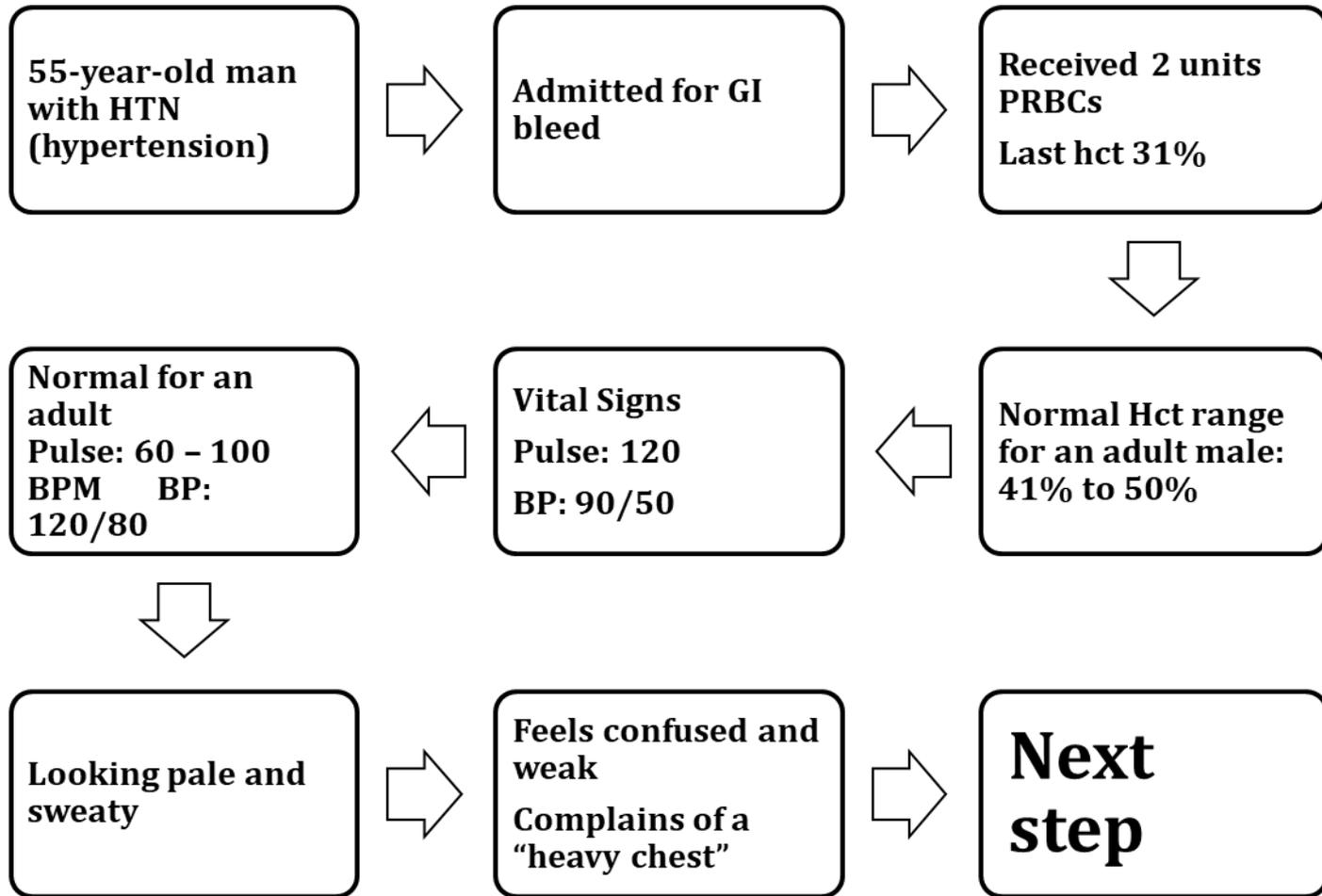
R

Recommendation:

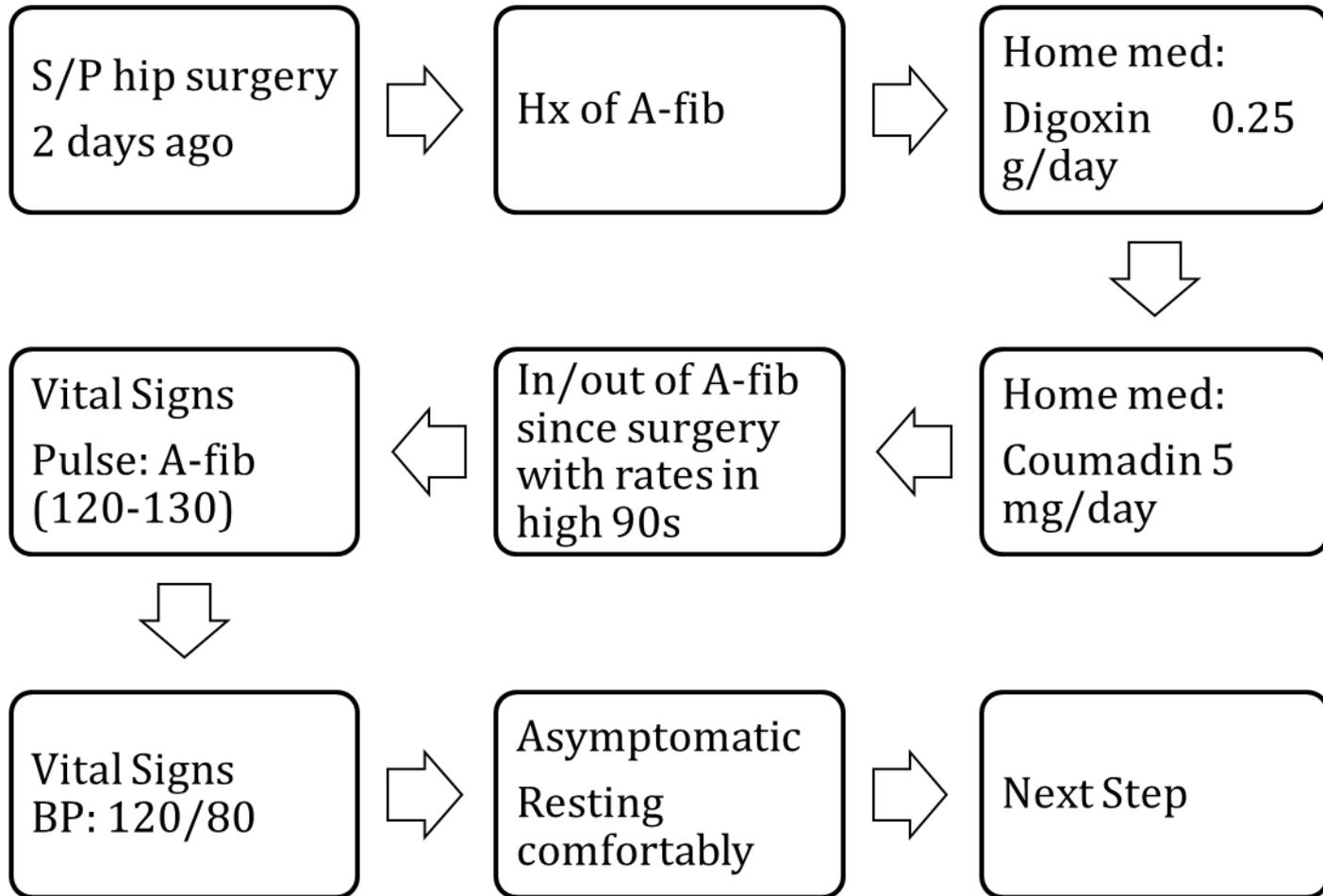
I need you to...
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time?
(e.g. stop the fluid/repeat the obs)

Ask receiver to repeat key information to ensure understanding

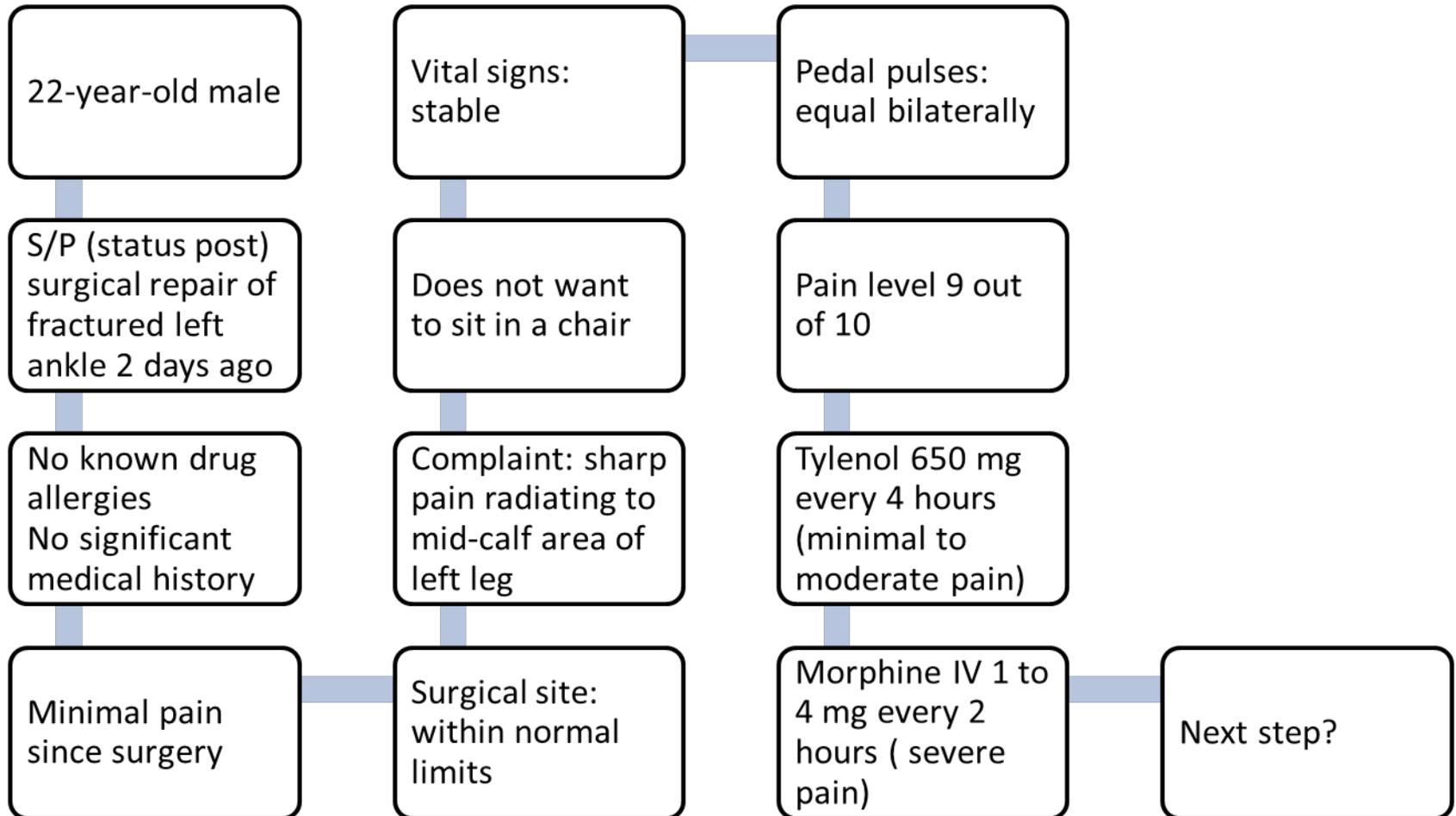
SBAR Scenario #1



SBAR Scenario #2



SBAR Scenario #3



SBAR Scenario #4

