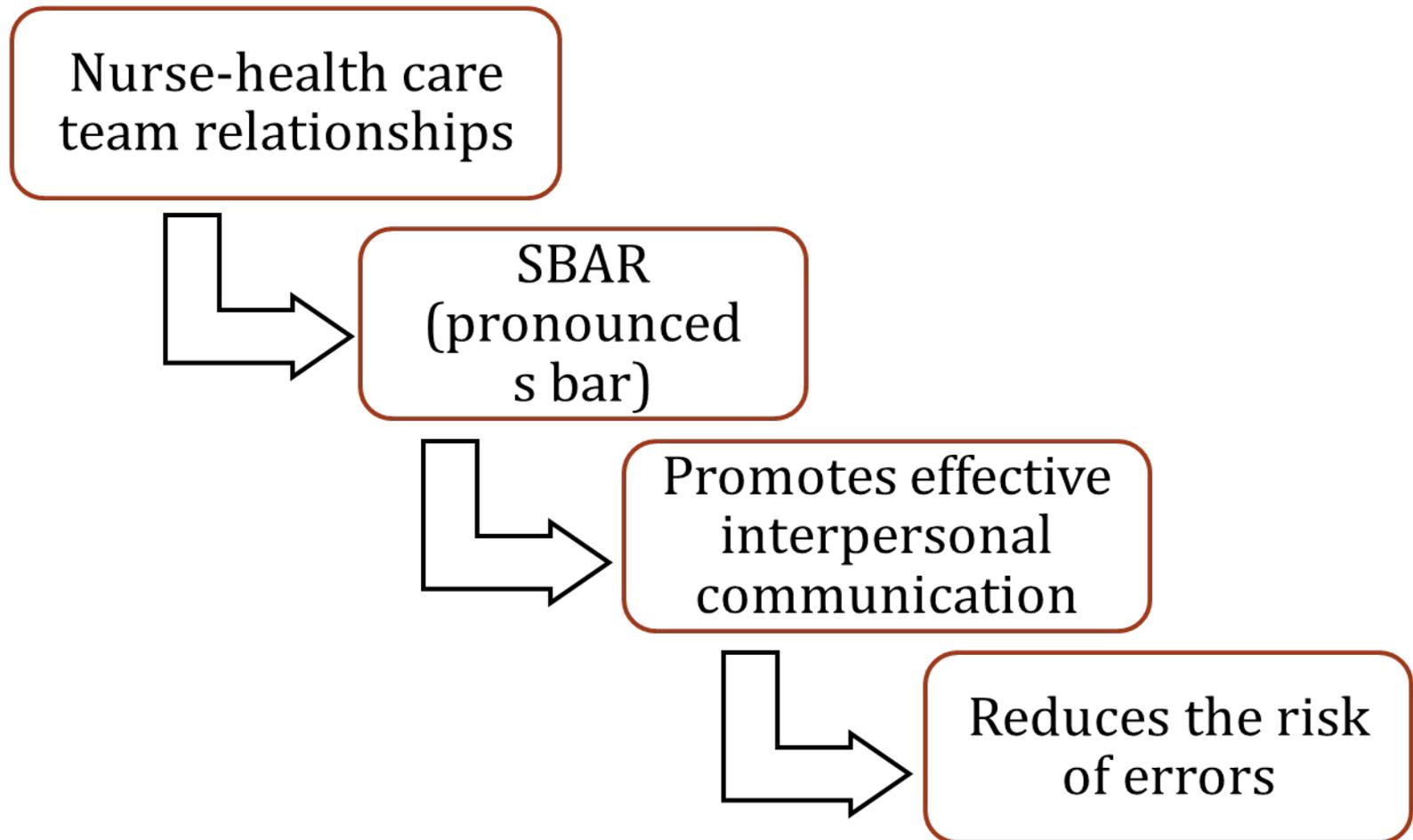


SBAR/Communication

Instructional Module 1

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Professional Nursing Relationships



SBAR

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

SBAR

Situation

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



Background

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



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

SCENARIOS

Scenario #1

- 55-year-old man with HTN (hypertension)
- Admitted for GI bleed
- Received 2 units PRBCs
- Last Hct 31%
 - Normal Hct range for an adult male:
 - 41% to 50%
- Vital Signs
 - Pulse: 120 bpm
 - BP: 90/50 mmHg
 - Normal for an adult
 - Pulse: 60–100 bpm
 - BP: 120/80 mmHg
- Looking pale and sweaty
- Feels confused and weak
- Complains of a “heavy chest”

SBAR Scenario #1

- Situation
- Assessment
- Background
- Recommendation(s)

Scenario #2

- Status post (S/P) hip surgery: 3 days ago
- History of atrial fibrillation (A-fib)
- Home meds:
 - Digoxin 0.25 g daily
 - Coumadin 5 mg daily
- In/out of A-fib since surgery with rates in high 90s
- Vital signs
 - Pulse: A-fib (atrial fibrillation) 120-130 bpm
 - BP: 100/58 mmHg
- Resting without complaint

SBAR: Scenario #2

- Situation
- Assessment
- Background
- Recommendation(s)

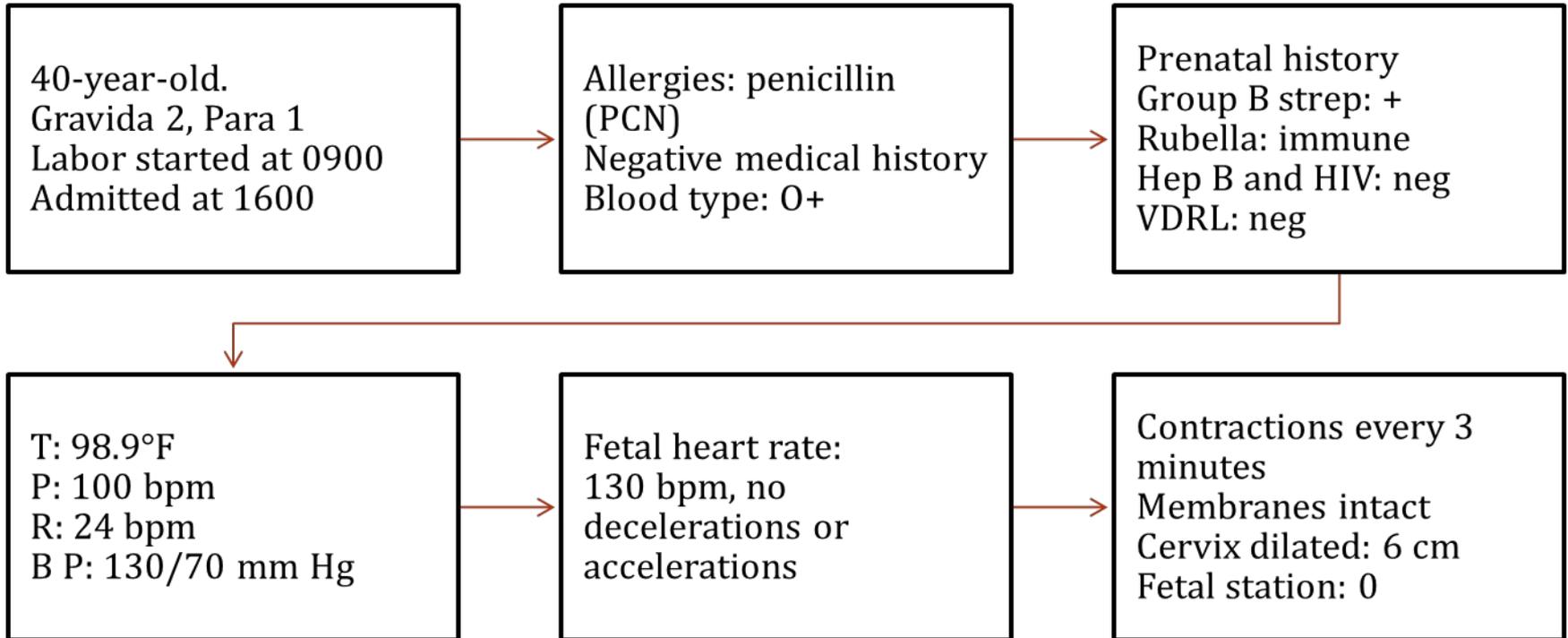
Scenario #3

- 22-year-old male
- S/P surgical repair of fractured left ankle 2 days ago
- No known drug allergies / no significant medical history
- Minimal pain since surgery
- Surgical site: within normal limits
- Complaint: sharp pain radiating to posterior mid-calf area of left leg
- Does not want to sit in a chair
- Vital signs: stable
- Pedal pulses: equal bilaterally
- Pain level 9 out of 10
- Medication orders:
 - Tylenol 650 mg every 4 hours (pain scale: 4-6)
 - Morphine IV 1 to 4 mg every 2 hours (pain scale: 7-10)

SBAR: Scenario #3

- Situation
- Assessment
- Background
- Recommendation(s)

Scenario #4



SBAR: Scenario #4

- Situation
- Assessment
- Background
- Recommendation(s)