I-SBAR-R-D

KeithRN.com

Identification

- Identification of yourself: include: name, license initials (RN, LPN)
- Identification of your patient: Patient name, facility name, unit, room number

Situation

- Name/age
- Brief summary of primary problem
- Day of admission/post-op if relevant

Background

- Primary problem/medical diagnosis
- Most important past medical history
- Most important background data

Assessment

- Current vital signs
- Most important nursing assessment findings
- Most important lab values
- Most important abnormal clinical data
- How have you advanced the plan of care?
- Patient response
- Interpretation of current clinical status (stable/unstable/worsening)

Recommendation

- Suggestions to advance plan of care

Repeat-Read back

- Repeat-Read back to confirm-plan of care

Document

- Document the conversation/New orders