SBAR Training Case Studies

Case Study 1: Asepsis & Post-Operative Infection

Patient Information

Name: Maria Gonzalez
Age: 67
Sex: Female
Ethnicity: Hispanic
Language Preference: Spanish (limited English proficiency)
Admission Reason: Total abdominal hysterectomy for uterine fibroids
Post-op Day: 3
Medical History:
- Type 2 Diabetes (HbA1c: 8.2%)
- Hypertension
- Obesity (BMI: 34)
- GERD

Surgical Details:
- Procedure: Total abdominal hysterectomy
- Duration: 3.5 hours
- Surgeon: Dr. Patel
- Anesthesia: General
- Foley catheter removed POD 2

Current Status:
- Vitals: T 100.8°F, HR 98, BP 142/88, RR 18, SpO_2 96% RA
- Incision: Midline abdominal, 12 cm, dressing intact but saturated with yellow drainage
- Pain: 7/10 at incision site
- Labs: WBC 14.2, Glucose 198
- Meds: Metformin, Lisinopril, Acetaminophen PRN
- Nutrition: NPO until bowel sounds return (now audible)
- Mobility: Limited; ambulating with assistance
- Psychosocial: Anxious about recovery, prefers daughter present during care

Environmental Factors:
- Roommate with MRSA history
- Dressing change yesterday done by float nurse unfamiliar with aseptic protocol
- Supplies: Limited sterile gauze available on unit

SBAR Answer

S – Situation:
This is Trent, the RN caring for Maria Gonzalez, a 67-year-old post-op hysterectomy patient on day 3 post-op. She is showing signs of a possible surgical site infection.

B – Background:
Maria has a history of Type 2 Diabetes and hypertension. She underwent a total abdominal hysterectomy three days ago. Her incision is midline, and she's been on standard post-op care. Yesterday's dressing change was performed by a float nurse. She has limited English proficiency and prefers her daughter present during care.

A – Assessment:
Today, her temperature is 100.8°F, WBC is 14.2, and her incision site is painful with yellow drainage saturating the dressing. Her glucose is elevated at 198. I'm concerned about a developing infection, possibly due to compromised aseptic technique during dressing changes.

R – Recommendation:
I recommend notifying the surgical team, obtaining a wound culture, and starting antibiotics. We may also need to reinforce aseptic protocols on the unit and consider isolation precautions if needed.

Case Study 2: CVAD Dressing & CLABSI Risk

Patient Information

Name: James Carter
Age: 45
Sex: Male
Ethnicity: African American
Admission Reason: Crohn's flare requiring TPN
Medical History:
- Crohn's Disease
- Depression
- History of opioid misuse (in remission)
- Multiple prior central line placements

Current Status:
- CVAD: Right subclavian triple lumen, placed 5 days ago
- Dressing: Tegaderm lifting at edges, mild erythema at insertion site
- Vitals: T 101.2°F, HR 110, BP 130/76, RR 20, SpO_2 98% RA
- Symptoms: Chills, fatigue, nausea
- Labs: WBC 15.6, Lactate 2.1, Blood cultures pending
- Meds: TPN, Prednisone, Ondansetron
- Nutrition: NPO
- Psychosocial: Lives alone, worried about missing work
- Communication: Alert, cooperative, asks detailed questions

Environmental Factors:
- Dressing change overdue (last documented 72 hours ago)

- Nurse preceptor observed improper glove use during last dressing change
- IV pump alarm frequently ignored due to staffing shortage

SBAR Answer

S – Situation:
This is Trent, the RN caring for James Carter, a 45-year-old patient with Crohn's disease receiving TPN via a CVAD. He is showing signs of a possible central line-associated bloodstream infection.

B – Background:
James has had a right subclavian CVAD for 5 days. He's on TPN and prednisone. His last documented dressing change was 72 hours ago. He has a history of opioid misuse and lives alone. He's been reporting chills and fatigue since this morning.

A – Assessment:
His temperature is 101.2°F, HR is 110, and WBC is 15.6. The CVAD dressing is lifting at the edges, and the insertion site is red. Blood cultures have been drawn, and lactate is 2.1. I observed that the dressing change was overdue and may not have been done with proper technique.

R – Recommendation:
I recommend initiating antibiotics, replacing the CVAD if indicated, and escalating to the provider for further orders. We should also reinforce CVAD dressing protocols and ensure timely dressing changes.

Case Study 3: Ethics & Legal Implications – Advance Directive Conflict

Patient Information

Name: Thomas Nguyen
Age: 82
Sex: Male
Ethnicity: Vietnamese
Language Preference: English (fluent)
Admission Reason: COPD exacerbation
Medical History:
- CHF
- COPD
- Advanced Dementia
- Chronic Kidney Disease Stage 3
- Multiple hospitalizations in past 6 months
Advance Directive:
- Signed DNR and DNI
- POLST form on file

- Healthcare proxy: Daughter, Linh Nguyen
Current Status:
- Vitals: T 98.6°F, HR 88, BP 110/70, RR 28, SpO_2 88% on 4L NC
- Symptoms: Labored breathing, confusion, non-verbal
- Labs: ABG shows respiratory acidosis
- Meds: Albuterol, Furosemide, Morphine PRN
- Nutrition: Poor intake, on thickened liquids
- Psychosocial: Family at bedside, visibly distressed
Family Dynamics:
- Daughter Linh supports DNR
- Son David demands "everything be done"
- Conflict escalating; nurse feels pressured
- Ethics consult not yet initiated
Environmental Factors:
- ICU bed requested but not yet available
- Primary physician off duty; covering resident unfamiliar with case

SBAR Answer

S – Situation:
This is Trent, the RN caring for Thomas Nguyen, an 82-year-old patient with advanced dementia and COPD. He is currently in respiratory distress, and there is a conflict between his advance directive and family wishes.

B – Background:
Thomas has a signed DNR and DNI on file, with a POLST form and his daughter Linh as the healthcare proxy. He is non-verbal and confused. His son David is demanding full resuscitation, which contradicts the documented wishes.

A – Assessment:
Thomas is in respiratory distress with SpO_2 at 88% on 4L NC and RR of 28. He is not responding to verbal cues. The family is visibly distressed, and the son is escalating the situation. The covering resident is unfamiliar with the case, and the primary physician is off duty.

R – Recommendation:
I recommend initiating an ethics consult immediately, notifying the attending physician, and reinforcing the legal validity of the advance directive with the family. We may also need social work support to help mediate the family conflict.