SBAR REPORT

The **SBAR (Situation-Background-Assessment-Recommendation)** technique provides a framework for communication between members of the health care team about a patient's condition.

CLINICAL TIP:

Always assess patient and review last 24 hours of progress notes before contacting provider. Have pen and paper available.

Template

S

Situation:

"This is_____, nurse on floor/unit_____
I am calling about (patient name and location).
The problem I am calling about is_____
Most recent vital signs are: BP_____, HR_____, RR_____, Temp_____."

Example:

This is Mary RN, from the Med-Surg floor. I'm calling about Mr. Jones in room 101.
He is complaining of shortness of breath and chest pain.
His BP is 100/58, HR 124, RR 30, Temp 37 degrees celsius.

B

Background:

Provide background information related to the situation
(for example: diagnosis, medications, allergies, labs, code status, pain level, interventions, and any other pertinent clinical information).

Example:

Mr. Jones had a myocardial infarction two weeks ago and was admitted yesterday for observation due to new complaints of chest pain.
He is restless and experiencing rapid, shallow breathing.

A

Assessment:

"I think the problem is_____."
OR
"I am not sure what the problem is, but the patient is deteriorating."

Example:

Given his history, I am concerned he may be experiencing a new cardiac event.

R

Recommendation:

- State your request, if you have one, AND ask what the provider wants you to do.
- Read back and verify all verbal or telephone orders.
- Request a read-back when reporting critical lab values.

Example:

I've initiated 2L O2 as per standing order. I am requesting an order for an EKG and for you to assess him immediately please. Is this agreeable to you? Do you have any further orders?
Let me read these orders back to you.

NOTES