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SBAR Tool

Situation
Background
Assessment
Recommendation

A framework for communication between members of the health care team about a patient's condition.

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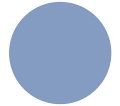

SBAR: Situation-Background-Assessment-Recommendation

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism useful for framing any conversation, especially critical ones, requiring a clinician's immediate attention and action. It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a culture of patient safety.

This tool includes:

- SBAR Guidelines ("Guidelines for Communicating with Physicians Using the SBAR Process"): Explains in detail how to implement the SBAR technique
- SBAR Worksheet: A worksheet/script that a provider can use to organize information in preparation for communicating with a physician about a critically ill patient (includes both an example and a blank SBAR Worksheet template)

Both the worksheet and the guidelines use the physician team member as the example; however, they can be adapted for use with all other health professionals.

Michael Leonard, MD, Physician Leader for Patient Safety, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado (Evergreen, Colorado, USA) developed this communication tool, which was adapted from the US Navy. The SBAR technique has been implemented widely at health systems such as Kaiser Permanente.

NOTE: Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

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Guidelines for Communicating with Physicians Using the SBAR Process

1) Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
   - Direct page (if known)
   - Physician's Call Service
   - During weekdays, the physician's office directly
   - On weekends and after hours during the week, physician's home phone
   - Cell phone

   Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care. Start by defining the first and the last step in the process — so that everyone has a shared understanding of where the process you're working on begins and ends.

2) Prior to calling the physician, follow these steps:
   - Have I seen and assessed the patient myself before calling?
   - Has the situation been discussed with resource nurse or preceptor?
   - Review the chart for appropriate physician to call.
   - Know the admitting diagnosis and date of admission.
   - Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
   - Have available the following when speaking with the physician:
     - Patient's chart
     - List of current medications, allergies, IV fluids, and labs
     - Most recent vital signs
     - Reporting lab results: provide the date and time test was done and results of previous tests for comparison
     - Code status

3) When calling the physician, follow the SBAR process:

   (S) Situation: What is the situation you are calling about?
   - Identify self, unit, patient, room number.
   - Briefly state the problem, what is it, when it happened or started, and how severe.

   (B) Background: Pertinent background information related to the situation could include the following:
   - The admitting diagnosis and date of admission
   - List of current medications, allergies, IV fluids, and labs

- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Other clinical information
- Code status

(A) Assessment: What is the nurse's assessment of the situation?

(R) Recommendation: What is the nurse's recommendation or what does he/she want? Examples:

- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

4) Document the change in the patient's condition and physician notification.

	Example 1: SBAR Report to Physician about a Critical Situation
S	**Situation** Dr. Jones, this is Sharon Smith calling from the CCU. I have Mr. Holloway in Room 217, a 55-year-old man who looks pale and sweaty, feels confused and weak, and is complaining of chest pressure.
B	**Background** • He has a history of HTN. • He was admitted for a GI bleed, received 2 units. • His last crit two hours ago was 31. • His vital signs are BP 90/50, pulse 120.
A	**Assessment** I think he's got an active bleed and we can't rule out an MI, but we don't have a troponin or a recent H&H.
R	**Recommendation** I'd like to get an EKG and labs, and I need for you to evaluate him right away.

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	Example 2: SBAR Report to a Primary Care Physician
S	**Situation** Patient arrived for appointment on wrong day.
B	**Background** • Patient arrived for 11:00AM appointment today. • Appointment is scheduled for 11:00AM tomorrow. • Patient comes from 40 miles away and needed to have friend drive them to appointment. • Doctor has 1+ appointment available on schedule. • Doctor's hall partner has some open times. • We don't know if the mistake was with the patient or the call center.
A	**Assessment** We should see the patient today.
R	**Recommendation** I recommend that we use the 1+ time or have your hall partner see this patient.

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Template: SBAR

S	**Situation:** What is the situation you are calling about? • Identify self, unit, patient, room number. • Briefly state the problem, what is it, when it happened or started, and how severe.	
B	**Background:** Pertinent background information related to the situation could include the following: • The admitting diagnosis and date of admission • List of current medications, allergies, IV fluids, and labs • Most recent vital signs • Lab results: provide the date and time test was done and results of previous tests for comparison • Other clinical information • Code status	
A	**Assessment:** What is the nurse's assessment of the situation?	
R	**Recommendation:** What is the nurse's recommendation or what does he/she want? Examples: • Notification that patient has been admitted • Patient needs to be seen now • Order change	

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