SBAR – *Report about a Critical Situation*

Every SBAR report is different. Focus on the problem, be concise. Not everything in the outline below needs to be reported – just what is needed for the situation.

NOTE: Before calling the physician **ASESS** the patient, **REVIEW** the chart for appropriate physician to call and **READ** the most recent physician and nursing notes.

S

Situation *– What is the situation you are calling about?*

This is _____ *(name)* and I am the _____ *(profession)* for patient _____ *(name and location)*.
This is the patient that _____ _____
(current patient identifier e.g. new admission, recent procedure or event).
Are you familiar with this patient? *(Confirm correct ID).*
I am concerned* about the patient because _____ _____(concise description, use key phrases to emphasize concern) .

B

Background - *Pertinent Information & Relevant History*

Relevant history _____ *(admitting diagnosis/ pertinent history from past hours)* Relevant current care/Treatment:

- Admit date _____
- Recent procedures/ diagnostics/ OR's _____
- Vital signs: T: _____ P: _____R: _____ BP: _____ Pain: _____ LOC: _____
- The EOPC score is _____ The previous score was _____
- Recent lab results (have available: date, time, previous results for comparison)
- Oxygen _____ L/min or _____ % for _____ (length of time)
- Allergies _____
- Code Status _____

A

Assessment – *What do you think the problem is?*

This is what I think the problem is: _____. **OR**
The patient seems to be unstable and may deteriorate. **OR**
The patient is deteriorating and if we don't do something they may arrest.

R

Recommendation – *What do you want to happen?*

I suggest (or request) that you _____ (*be specific and request time frames).*

- Come and see the patient now
- Ask a consultant to come and see the patient now
- Order diagnostic tests or labs ex. CXR ABG ECG CBC

Before you end the call, confirm plan of care by asking:

1. When are you going to be here to see the patient?
2. What parameters do you want me to continue monitoring?
3. What change should I be expecting that would indicate an improvement?
4. If you are **not** coming in, when should I call you again? Or If patient does not improve, when would you like to be called?

Guidelines to Communicating with Physicians using the SBAR Process

1. Prior to calling the physician, follow these steps:
   - See and assess the patient personally before calling.
   - Discuss the situation with a colleague, supervisor, educator or preceptor (if available).
   - Determine the appropriate physician to call.
   - Know the admitting diagnosis and date of admission.
   - Read the most recent progress/multidisciplinary notes.
   - Have available the following:
     a. Patient's chart
     b. List of current medications, allergies, IV's and labs
     c. Most recent vital signs
     d. Lab results, including date and time done, and recent results for comparison
     e. Code status

2. When providing background information, try to organize information into "systems" and consider whether the following information is relevant:
   - ***Neurological system***

Alert & oriented to person, place & time	Confused and cooperative or non-cooperative
Agitated or combative	Lethargic but conversant
Responding to painful stimuli only	Not responding to painful stimuli
Facial droop	Weakness – left/right

   - ***Respiratory system***

Breath sounds audible throughout	Breath sounds diminished in some areas
Breath sounds equal or not equal	Absent breath sounds in some areas
Extra breath sounds -wheezes, crackles	Cough productive or non-productive
Symmetrical chest expansion	Chest tube – fluctuation, air leak, drainage

   - ***Circulatory system***

Skin color	Heart sounds
Peripheral pulses	Edema
Capillary refill	

   - ***Gastrointestinal/genitourinary system***

Diet	Nausea and vomiting
Bowel sounds	Abdominal pain/tenderness
Diarrhea	Urine output

   - ***Musculoskeletal system***

History of falls	Visible deformity
Leg length discrepancy	CWMS to affected limb
Weakness – left/right	

Please remember that this document is a guide only! The examples are provided solely to assist you in achieving successful communication. Use this as a cheat sheet to document the information you want to provide to the physician, and then throw it away. Don't forget to document the content of your discussion in the progress notes!