SBAR Communication Worksheet

Form Number: SBAR-001

This is not part of the medical record

Patient Name:	Patient Date of Birth: / /

Date: / /	Time: AM PM	Location:	Room Number:

Pre-call preparation: Gather the following information: Patient's name; age; chart. Rehearse in your mind what you plan to say. Run it by another nurse if unsure. If calling about pain, when and what was last pain medication? If calling about fever, what was the most recent temperature? If calling about an abnormal lab, what was the result of the last test? What is the goal of your call? Remember to start by introducing yourself by name and location. Use area below as a checklist to gather your thoughts and prepare.

☐ **Situation**

Briefly describe the current situation.
Give a clear, succinct overview of pertinent issues.

☐ **Background**

Briefly state the pertinent history.
What got us to this point?

☐ **Assessment**

Summarize the facts and give your best assessment.
What is going on? Use your best judgement.

☐ **Recommendation**

What actions are you asking for?
What do you want to happen next?

☐ **Follow-up Action (Next Steps):** Document the call and "read back" orders to ensure accuracy. Is there a change in the plan of care? Yes No

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Form Number: SBAR-002

Topic:

Date: / /

Time: AM PM

Location:

☐ **Situation**

S

☐ **Background**

B

☐ **Assessment**

A

☐ **Recommendation**

R

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Form Number: SBAR-003

SBAR Process / Quality Improvement Action Form

The purpose of this form is to document and outline an action plan to make an improvement to a process or work flow. It is designed to encourage ... transparency and improve the quality and delivery of patient care.

Your Name:

Date Submitted: / /

Proposed Improvement Project Title:

Situation (Use the back of this sheet if you need more room to provide explanation.)

Please provide a brief explanation of what the situation is: What is the process that you believe can be improved.

Where does this process and/or situation occur or what area is impacted? (Check all that apply)

- ☐ Preoperative Area (e.g., Holding Area, Inpatient Unit, Admit Area)
- ☐ Other Clinical Department (e.g., Pharmacy, Radiology) (Specify Below)
- ☐ Administrative Department (Specify Below)
- ☐ Other (Specify Below)
- ☐ Operating Room
- ☐ Procedure Room (e.g., Endoscopy Suite, Procedure Room)
- ☐ Labor and Delivery Suite
- ☐ PACU

Background (Use the back of this sheet if you need more room to provide explanation.)

What drew your attention to this? Is this an issue that happens frequently? Does it affect other people? Why make a change?

Assessment

This recommended change will positively impact the following: (Check all that apply)

- ☐ Improve Efficiency
- ☐ Reduce Paperwork
- ☐ Prevent Harm to Patients
- ☐ Increase Workplace Safety
- ☐ Cut Costs
- ☐ Eliminate Waste
- ☐ Increase the Quality of Patient Care
- ☐ Speed the Delivery of Care
- ☐ Improve Employee Morale
- ☐ Increase Patient Satisfaction
- ☐ Clarify a Policy or Procedure
- ☐ Standardize Care

This recommended change will make an impact and improvement(s) in the following: (Check all that apply)

- ☐ Communication between staff
- ☐ Staff Changes / Hand-offs
- ☐ Work Space Cleanliness
- ☐ Other (Please Specify):
- ☐ Reduce Rushing / Haste
- ☐ Teamwork
- ☐ Scheduling
- ☐ Equipment Storage
- ☐ Supplies and Stocking
- ☐ Room Changeover

Recommendation

Please use the back of this form or attach additional pages to answer the following:

- ☐ 1. What can be done to improve this situation / or process?
- ☐ 2. What changes need to happen to ensure that this is fixed or improved?
- ☐ 3. How can you help make this change a reality?
- ☐ 4. What is the simplest, fastest but most thorough way to make this happen?

Status

Stick status label here

- Red (Submitted)
- Yellow (Under Review)
- Green (Resolved)

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Form Number: SBAR-004

SBAR Nurse Shift Report Guide for Labor Patients

Situation

- ☐ Patient name ☐ Date / Time of Admission
- ☐ Age ☐ Physician
- ☐ Room ☐ Midwife
- ☐ Multiple birth ☐ yes ☐ no
- ☐ Previous C-section ☐ yes ☐ no
- ☐ Ruptured membranes ☐ yes ☐ no
- ☐ High risk for:
  - ☐ shoulder dystocia ☐ pre-eclampsia ☐ maternal post-partum hemorrhage
  - ☐ urine rupture ☐ fetal distress
- ☐ Gestational age: _____
- ☐ Allergies: _____
- ☐ Comorbid conditions (i.e. diabetes, cancer, heart condition, etc.)

Background

- ☐ Gravida _____ para _____
- ☐ GBS status
- ☐ Allergies: _____
- ☐ rH
- ☐ Labor History
  - ☐ membranes / fluid
  - ☐ onset
  - ☐ contractions
  - ☐ dilated _____ effaced _____
  - ☐ station
- ☐ Medications
  - ☐ P-Gel ☐ oxytocics ☐ tocolytics (magnesium) ☐ antibiotics
- ☐ Pain (scale / interventions)
- ☐ Epidural
- ☐ Lab work (when ordered / results back)
- ☐ IV
  - ☐ what ☐ bag # ☐ rate ☐ site
- ☐ EFM

Assessment

- ☐ Patient is progressing within normal limits; no complications apparent
- ☐ I am concerned about: _____

Recommendation / Request

- ☐ I suggest or request that you _____
  - ☐ watch for _____
  - ☐ get test results
  - ☐ new orders
- ☐ On call / availability
  - ☐ physician ☐ midwife ☐ pediatrician ☐ anesthesiologist

Use this checklist to gather your thoughts and structure your hand-off report. Use the note space below to make additional notes pertaining to the report as needed.

Note: The elements within this checklist are not intended to be comprehensive but rather a starting guide to assist in organizing a plan of communication.

Patient:

Location:

Date: / /

Time: AM PM

Notes:

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Form Number: SBAR-005

SBAR Shift Report Hand-off Guide

1. Situation

☐ Patient ☐ Room #
☐ Admitting Physician ☐ Admitting Diagnosis / Secondary Diagnosis
☐ Most Current / Pertinent Issues

2. Background

Discuss only elements that have recently changed or are pertinent to this patient

☐ Admit Date _____ Anticipated Date of Discharge _____
☐ Physician / Ancillary Consults
☐ Psych. ☐ Surgical ☐ PT/OT ☐ Speech ☐ Wound Care ☐ Other
☐ Date / Time last seen by Physician _____
☐ Allergy _____
☐ Code Status / DNR _____
☐ Patient / Family Concerns
☐ Medications (pertinent issues / effectiveness) ☐ Immunization status
☐ Recent Interventions / Effectiveness _____
☐ Abnormal Labs _____
☐ Vital Signs ☐ Temp ☐ Pulse ☐ Respirations ☐ O_2 Sat.
☐ Pain status ☐ Location ☐ Score ☐ Modalities Used ☐ Effectiveness
☐ IV ☐ Type ☐ Amount ☐ Site ☐ Issues
☐ Drains / Tubes
☐ Wounds / Dressings
☐ Type ☐ Location ☐ Color ☐ Edema ☐ Temp ☐ Change in Size
☐ Decubiti ☐ Stage ☐ Location ☐ Treatment

Systems: Discuss only systems pertinent to this patient

☐ Neurological / Mental Status
☐ Level of consciousness ☐ Speech Pattern ☐ Dementia ☐ Confusion ☐ Depression
☐ Lungs / Respiratory
☐ Lung sounds (rales, rhonchi, wheezes)
☐ Cough (productive (description), dry)
☐ Shortness of breath, difficulty breathing, orthopnea
☐ Respiratory rate
☐ Oximetry
☐ O_2 @ _____ liters / per _____
☐ Cardiovascular ☐ Heart Rate ☐ Regularity ☐ SOB ☐ Edema
☐ GI ☐ Appetite changes ☐ Diet type ☐ Thickened Liquids ☐ TPN ☐ Weight
☐ Abdominal Tenderness ☐ Distention ☐ Vomiting ☐ Nausea ☐ I @ ___ ml / ___
☐ Last Bowel Movement ☐ Constipation ☐ Diarrhea ☐ Colostomy
☐ GU ☐ Catheter ☐ Urine Color ☐ Dysuria ☐ Frequency ☐ Last UTI ☐ O @ ___ ml / ___
☐ Musculoskeletal ☐ Pain ☐ Mobility Issues ☐ Positioning ☐ Fall risk status
☐ Assistive Devices ☐ Wheel Chair ☐ Cane ☐ Walker ☐ Other
☐ Skin ☐ Temperature ☐ Condition ☐ Edema ☐ Hematoma
☐ Discharge Plan / Issues ☐ Case Management ☐ Patient / Family Education
☐ Other _____

3. Assessment

☐ What do you think is going on with the patient?
☐ Do you have concerns about this patient? If yes, are they mild, moderate or severe?
☐ Discharge planning issues or concerns that need to be addressed

4. Recommendation

☐ Care / Issues requiring follow-up
☐ Orders requiring completion / follow-up
☐ Pending treatment / tests
☐ Issues / Items left undone that require follow-up

Use this checklist to gather your thoughts and structure your hand-off report. Use the note space below to make additional notes pertaining to the report as needed.

Note: The elements within this checklist are not intended to be comprehensive but rather a starting guide to assist in organizing a plan of communication.

Notes:

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Form Number: SBAR-006

Critical Situation Report Checklist

SBAR

Patient:

Time: AM PM

Location:

Date: / /

Situation

- ☐ Introduce yourself
- ☐ The patient I am calling about is _____ *patient's name*
- ☐ The situation I am concerned about is _____
- ☐ The patient's code status is _____

Background

- ☐ Here is the supporting background information.
- ☐ The patient's vital signs are:
  - ☐ Blood pressure: ____ / ____
  - ☐ Pulse: _____
  - ☐ Respiration: _____
  - ☐ Temperature: _____
  - ☐ Pain (Scale 1 2 3 4 5 6 7 8 9 10)
- ☐ The patient's mental status is...
  - ☐ alert and oriented to person, place and time
  - ☐ confused and... ☐ cooperative ☐ non-cooperative
  - ☐ agitated and / or combative
  - ☐ lethargic but conversant and able to swallow
  - ☐ stuporous / not talking clearly and possibly unable to swallow
  - ☐ comatose / eyes closed / not responding to stimulation
- ☐ The patient's skin is...
  - ☐ warm and dry ☐ diaphoretic ☐ mottled
  - ☐ pale ☐ extremities are cold ☐ extremities are warm
- ☐ The patient... ☐ is not on oxygen ☐ is on oxygen
  - ☐ The patient has been on _____ (l./min.) or (%) oxygen for _____ minutes (hours)
  - ☐ The oximeter reads _____ %
  - ☐ The oximeter does not detect a good pulse and is giving erratic readings
- ☐ The patient is allergic to: _____

Assessment

- ☐ In assessing the situation, I think the problem is _____ *state problem*
  - ☐ The problem seems to be ☐ cardiac ☐ infection ☐ neurologic ☐ respiratory
  - ☐ I am not sure what the problem is, but the patient is deteriorating
  - ☐ The patient seems to be unstable and may get worse. We need to do something.

Recommendation / Request

- ☐ I recommend or request that you _____
  - ☐ transfer the patient to critical care
  - ☐ come to see the patient right away
  - ☐ talk to the patient or family about the code status
  - ☐ add / change orders to _____
- ☐ Do you want to have any tests done?
  - ☐ CXR ☐ ABG ☐ EKG ☐ CBC ☐ BMP ☐ Others
- ☐ If a change in treatment is ordered, ask...
  - ☐ how often do you want vital signs?
  - ☐ how long do you expect this problem will last?
  - ☐ if the patient does not get better, when would you want us to call again?

Notes

SAMPLE

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Form Number: SBAR-008

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SBAR Communication Worksheet

Patient Name:		**Patient Date of Birth:** / /	
Date: / /	**Time:** AM PM	**Location:**	**Room Number:**

Pre-call preparation: Gather the following information: Patient's name; age; chart. Rehearse in your mind what you plan to say. Run it by another nurse if unsure. If calling about pain, when and what was last pain medication? If calling about fever, what was the most recent temperature? If calling about an abnormal lab, what was the result of the last test? What is the goal of your call? Remember to start by introducing yourself by name and location. Use area below as a checklist to gather your thoughts and prepare.

☐ **Situation**
Briefly describe the current situation.
Give a clear, succinct overview of pertinent issues.

☐ **Background**
Briefly state the pertinent history.
What got us to this point?

☐ **Assessment**
Summarize the facts and give your best assessment.
What is going on? Use your best judgement.

☐ **Recommendation**
What actions are you asking for?
What do you want to happen next?

Follow-up Action (Next Steps): Document the call and "read back" orders to ensure accuracy.
Is there a change in the plan of care? Yes No

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Form Number: SBAR-009

Patient:

Date: / /

Time: AM PM

Location:

☐ Situation

S

☐ Background

B

☐ Assessment

A

☐ Recommendation

R

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Skilled Nursing Facilities

Form Number: SBAR-010

SBAR Shift Report Guide for Skilled Nursing

1. Situation

☐ Patient ☐ Room #
☐ Admitting MD / PCP / NP ☐ Admitting Diagnosis / Secondary Diagnosis
☐ Most Current / Pertinent Issues ☐ Patient / Family Concerns

2. Background

Discuss only elements that have recently changed or are pertinent to this patient

☐ Admit Date _____ Anticipated Date of Discharge _____
☐ Patient Status (STR or LTC)
☐ Physician / Ancillary Consults
☐ Psych. ☐ Surgical ☐ PT/OT ☐ Speech ☐ Wound Care ☐ Other
☐ Date / Time last seen by MD / NP _____
☐ Allergy _____
☐ Code Status / DNR _____
☐ Medications (pertinent issues / effectiveness) _____
☐ Recent Interventions / Effectiveness _____
☐ Abnormal Labs _____
☐ Vital Signs ☐ Temp ☐ Pulse ☐ Respirations ☐ O_2 Sat.
☐ Pain status ☐ Score ☐ Modalities Used ☐ Effectiveness ☐ Location
☐ IV ☐ Type ☐ Amount ☐ Site ☐ Issues
☐ Drains / Tubes
☐ Wounds / Dressings
☐ Type ☐ Location ☐ Color ☐ Edema ☐ Temp ☐ Change in Size ☐ Eschar ☐ Slough
☐ Decubiti ☐ Stage ☐ Location ☐ Treatment

Systems: Discuss only systems pertinent to this patient

☐ Neurological / Mental Status
☐ Level of consciousness ☐ Speech Pattern ☐ Dementia ☐ Confusion ☐ Depression
☐ Lungs / Respiratory
☐ Lung sounds (rales, rhonchi, wheezes)
☐ Cough (productive (description), dry)
☐ Shortness of breath, difficulty breathing, must sit up to breathe
☐ Respiratory rate
☐ Oximetry
☐ O_2 @ _____ liters / per _____
☐ Cardiovascular ☐ Heart Rate ☐ Regularity ☐ SOB ☐ Edema
☐ GI ☐ Appetite changes ☐ Diet type ☐ Thickened Liquids ☐ TPN ☐ Weight
☐ Abdominal Tenderness ☐ Distention ☐ Vomiting ☐ Nausea
☐ Last Bowel Movement ☐ Constipation ☐ Diarrhea ☐ Colostomy
☐ GU ☐ Catheter ☐ Urine Color ☐ Dysuria ☐ Frequency ☐ Last UTI
☐ Musculoskeletal ☐ Pain ☐ Mobility ☐ Positioning
☐ Functional Status ☐ Functional goals ☐ Fall risk status ☐ Paralysis ☐ Decreased mobility
☐ Assistive Devices ☐ Wheel Chair ☐ Cane ☐ Walker ☐ Other
☐ Skin ☐ Temperature ☐ Condition ☐ Edema ☐ Hematoma
☐ Other _____

3. Assessment

☐ What do you think is going on with the patient?
☐ Do you have concerns about this patient? If yes, are they mild, moderate or severe?
☐ Discharge planning issues or concerns that need to be addressed

4. Recommendation

☐ Care / Issues Requiring Follow-up
☐ Orders Requiring Completion / Follow-up
☐ Pending Treatment / Tests
☐ Issues / Items Left Undone that Require Follow-up

Use this checklist to gather your thoughts and structure your hand-off report. Use the note space below to make additional notes pertaining to the report as needed.

Note: The elements within this checklist are not intended to be comprehensive but rather a starting guide to assist nurses in organizing their communication.

Notes:

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Form Number: SBAR-011

SBAR Checklist

Critical Situation Call to a Physician or Nurse Practitioner

Situation

Introduction and overview of problem

☐ My name is _____ *insert your name and position / title*
☐ I am calling from _____ *insert facility name / unit* about _____ *insert patient name*
☐ The problem I am calling about is _____ (or) I am concerned about _____

Background

Information pertinent to the problem or your concern

☐ The admitting Doctor, PCP, or NP is _____
☐ Admitting diagnosis is _____
☐ Secondary diagnosis is _____
☐ Code status / DNR
☐ Allergies
☐ Vital Signs are: ☐ Temp: _____ ☐ Pulse _____ ☐ Respirations ____
☐ Pain status:
☐ Location ☐ Duration ☐ Changes in severity ☐ Intensity
☐ Pain scale number ☐ Effectiveness of pain meds ☐ Other treatment modalities
☐ Current meds pertinent to the problem
☐ Blood thinners ☐ Antibiotics ☐ Other
☐ There are changes in the following:

Use the checklist below to describe pertinent issues / recent changes that relate to the reason you are calling

☐ Neurologic: ☐ Speech pattern ☐ Numbness ☐ Paralysis ☐ Weakness
☐ LOC: ☐ Alert and oriented ☐ Confused ☐ Agitated ☐ Combative
☐ Unresponsive ☐ Delirium
☐ Respiratory function: ☐ Pulse ox reading ☐ Difficulty breathing
☐ O2 @ _____ ☐ Breath sounds ☐ Cough
☐ Cardiovascular: ☐ Pain ☐ Heart rate ☐ Heart sounds ☐ Regularity
☐ Chest pain ☐ Edema
☐ GI function: ☐ Tenderness ☐ Distension ☐ Vomiting ☐ Nausea
☐ GU function: ☐ Catheter ☐ I/O ☐ Pain upon urination

☐ Urine color: ☐ Red ☐ Pink ☐ Straw-colored ☐ Dark ☐ Concentrated
☐ Musculoskeletal system: ☐ Pain ☐ Tenderness ☐ Alignment
☐ Mobility ☐ Edema
☐ Skin: ☐ Temp ☐ Dry ☐ Moist ☐ Clammy ☐ Mottled ☐ Cyanotic ☐ Hives
☐ Wound status: ☐ Induration ☐ Drainage ☐ Color ☐ Wound approximation
☐ Abnormal test results: ☐ Labs ☐ INR ☐ Blood gases ☐ Imaging results
☐ Other: _____

Assessment

What you think is going on

☐ I think the problem may be _____ (i.e. infection, cardiac, neurologic, fracture, etc.)
☐ I'm not sure what is going on, but the patient's condition is deteriorating.
☐ The patient seems to be unstable and may get worse. We need to do something.

Recommendation / Request

What you think should happen / what you need

☐ I think this patient should be transferred to _____
☐ I think we need to discuss the code status with the patient / family.
☐ Do you want to order any tests or make changes in her current treatment plan?

Gather the chart and the patient information before you make a call. Use this checklist to gather your thoughts and structure your call.

Note: The elements within this checklist are not intended to be comprehensive but rather a starting guide to assist nurses in organizing their communication.

Use the note space below to make additional notes pertaining to the report as needed.

Notes:

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Form Number: SBAR-012

OR Team SBAR Briefing & Debriefing Checklist

Patient Name:	Patient Date of Birth: / /

Date: / /	Time: AM PM	Location:	Room Number:

Briefing (Pre-surgery)

Before Surgery

Elements Performed (check yes or no for each element)

Situation	Yes	No	Announce team briefing
	Yes	No	Introduce all personnel / team members
Background	Yes	No	Share critical information about patient and procedure
	Yes	No	Encourage team input and continued cross-talk / communication
	Yes	No	**Conduct Surgical Time Out (Surgical Pause)**
Assessment	Yes	No	Review plan/procedure and contingency plans as needed
Recommendation	Yes	No	Ask for questions or comments from team

Debriefing (Post-surgery)

After Surgery

Elements Performed (check yes or no for each element)

Situation	Yes	No	Announce team debriefing
Background	Yes	No	Discuss what went well and not-so-well during surgery
	Yes	No	Ask how / what the team can improve for next time
	Yes	No	Ask if the team had the right tools at the right time
Assessment	Yes	No	Ask all team members for any last questions or comments about case
Recommendation	Yes	No	Assign follow-up roles and responsibilities

☐ **Follow-up Action(s) Required:** Document the what needs to happen and who is responsible for follow-up.

Action Item: Assigned to:

Notes:

Action Item: Assigned to:

Notes:

Action Item: Assigned to:

Notes:

Action Item: Assigned to:

Notes:

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