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Safer Care

Leading Improvement in Patient Safety

Acute SBAR Communication Tool

S

Situation:
I am (name), (X) a nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that…
(e.g. BP is low/high, pulse is XX temperature is XX, Early Warning Score is XX)

B

Background:
Patient (X) was admitted on (XX date) with
(e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is…
(e.g. alert/drowsy/confused, pain free)

A

Assessment:
I think the problem is (XXX)
and I have…
(e.g. given O_2/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried

R

Recommendation:
I need you to…
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the meantime?
(e.g. stop the fluid/repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

If you require further copies quote SC042