Raise the SBAR

Elevate your facility's workplace communication

SBAR (which stands for Situation, Background, Assessment, Recommendation) is a communication technique designed to convey a complete message in a concise manner. With SBAR as the expectation, communication becomes streamlined and systematic — allowing less room for human error.

WHAT are the advantages of SBAR?

- Decrease of potentially avoidable and costly adverse events, such as emergency department (ED) visits, falls, and unnecessary medications
- Important details efficiently communicated between providers
- Health care team members receive all relevant information in an organized way
- Collaboration promotes value of all team member voices, enhancing job satisfaction
- Improved quality of life for residents

WHY is SBAR considered the best practice?

- Reduces serious adverse events and unanticipated deaths when consistently used
- Increases perception of effective communication and collaboration
- Standardization promotes effective, accurate, clear communication

WHO should use SBAR?

SBAR was originally designed for nurse to physician communication. It can be used to reduce barriers across all disciplines and levels of staff.

WHEN should SBAR be used?

- Between nurse and physician
- Interdisciplinary communication
- During nurse to nurse handoff
- In nursing assistant to charge nurse report
- Anytime a change in condition is suspected

HOW do I use SBAR?

Use the SBAR acronym as your guide.

SITUATION

What is happening with the resident? Why do you need to communicate about them?

- Identify yourself, the resident, and your relationship to resident
- Briefly state problem (i.e. what problem is, when it started, how severe it is)
- Code status
- Vital signs (now and baseline)
- Your biggest concern at this time

BACKGROUND

Put the situation into context for who you are talking to.

- Admission date
- Active diagnosis
- Mental status (now and baseline)
- List of current medications, allergies
- Lab results with most recent comparisons values
- Other relevant clinical information (skin condition, oxygen orders, blood sugar readings, had fall three days ago, etc.)
- Relevant psychosocial information (husband just died, MD spoke with son related to living will, etc.)

ASSESSMENT

This is your opportunity to tell the person you are talking with what you think the problem is based on your current assessment and considering the residents history.

RECOMMENDATION

What action do you recommend? What do you hope to gain from the communication?

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