SBAR

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SBAR (Situation, Background, Assessment, Recommendation) is an instrument that complies with the Joint Commission's National Patient Safety Goal 2 (effective January 1, 2006)[1], requiring organizations to improve effectiveness of communication among caregivers. It provides a framework for communication about a patient's condition, especially when critical and requiring a clinician's immediate attention and action. It allows for an easy and focused way to set expectations about the content and structure of the information communicated between members of the team, which is essential for developing teamwork and fostering a culture of safety.

Example: Nurse Williams calls Dr. Smith and shares the following message:
Situation: "Good morning, Dr. Smith. My name is Nurse Williams from 5 EAST. I am calling to inform you that Mrs. Rogers, in room 511, has been complaining of lightheadedness and looks pale since she got to the floor one hour ago."
Background: "She underwent a laparoscopic hysterectomy to treat irregular bleeding. The procedure concluded after 4 hours without complications. The EBL was 200 mL. Her only medical problem is hypertension for which she takes HCTZ. Her BP is 90/60 mm Hg and her pulse is 120 bpm."
Assessment: "I am worried that she has an active bleed."
Recommendation: "Dr. Smith I think you should come evaluate Mrs. Rogers immediately."

Dr. Smith responds, "Please collect a CBC and chemistry panel and cross match her for 2 units of PRBC. Thank you so much for calling me. I will be there in 5 minutes."

Reference Materials

1. Catalano K. JCAHO'S National Patient Safety Goals 2006. J Perianesth Nurs. 2006 Feb;21(1):6-11. doi: 10.1016/j.jopan.2005.11.005.

Further Reading

http://www.ihi.org/Topics/SBARCommunicationTechnique/Pages/default.aspx