

## SBAR

(Situation-Background-Assessment-Recommendation)

### Communication Among Caregivers

Home Health  
Keys For Success  
August 24, 2006

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1

## Objectives

- Understand the SBAR approach.
- Learn how to implement SBAR.
- Understand effective communication tools and techniques to use among caregivers.
- Evaluate the use of SBAR in your agency.

2

## Impact of SBAR

- Establishes behaviors for effective teamwork and communication.
- Ensures clear, accurate information is exchanged.

3

## Impact of SBAR (continued)

- Creates a shared mental model for providing safe patient care.
- Provides a standardized structure for factual communication among caregivers.

4

## Why Adopt SBAR?

- Easy to remember (and use).
- Creates a concrete mechanism for framing critical conversations.
- Requires the clinician's immediate attention and action.

5

## Why Adopt SBAR? (continued)

- Allows easy and focused communication between caregivers.
- Sets clear expectations for fostering a culture of patient safety.

6

## SBAR

Situation: What is happening at present time?

Background: What are the circumstances?

Assessment: What do I think the problem is?

Recommendation: What should we do to correct the problem?

7

## SBAR (continued)

Prior to calling the physician, follow these steps:

- Assess the patient.
- Discuss the situation with nurse/supervisor.
- Review documentation.
- Know diagnosis, date of admit, DOB.
- Read recent patient notes from clinician.

8

## **SBAR** (continued)

Have the following available when speaking with the physician:

- List of current medications, allergies, IV fluids, and labs
- Most recent vital signs, bloods sugars, and pulse reading
- Recent lab results—date/time
- DNR status

9

## **SBAR** (continued)

Know the physician's communication preference:

- Call physician's office
- Call physician's call service
- Direct page or on call cell phone
- Fax

Establish a protocol.

10

## SBAR: Situation

Describe the situation:

- Identify yourself.
- Identify your home health agency.
- Identify the patient and briefly state the problem:
  - When the problem started
  - How severe the situation is

11

## SBAR: Background

Give the physician pertinent background information related to the situation:

- Admitting diagnosis for home care
- Date of admission to home health
- DOB and recent hospitalizations
- List of current medications, allergies, IV fluids, and treatment

12

## SBAR: Background (continued)

- Lab results—include date/time
- Most recent vital signs
- Other clinical information
- DNR status

13

## SBAR: Assessment

Relay the clinician's assessment of the situation:

- Tell the physician your assessment of the problem
  - cardiac, infection, neurological, respiratory

14

## SBAR: Assessment (continued)

- I'm not sure what the problem is, but the patient is deteriorating.
- The patient is unstable and may get worse.

15

## SBAR: Recommendation

What action would you like the physician to take?

- Change level of care
- Change frequency
- Change duration

16

## **SBAR: Recommendation (continued)**

- Request extra PRN visits
- Change or make additions/deletions to medication
- Educate physician on possible solutions

17

## **SBAR: Recommendation (continued)**

- Implement an agency disease management protocol.
- Notify the physician that the patient has been admitted.
- Let the physician know that the patient needs to be seen now.

18

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## SBAR: Report to Physician

**SBAR report to physician about a critical situation**

<b>S</b>	<p><b>Situation</b> I am calling about patient name and location: The patient's code status is <u>code status</u>. The problem I am calling about is _____ I am afraid the patient is going to arrest.</p> <p>I have just assessed the patient personally: Vital signs are: Blood pressure _____/_____/_____. Pulse _____ Respiration _____ and temperature _____</p> <p>I am concerned about the: Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual Pulse because it is over 140 or less than 50 Respiration because it is less than 8 or over 40 Temperature because it is less than 95 or over 104.</p>
<b>B</b>	<p><b>Background</b> The patient's mental status is: Alert and oriented to person place and time. Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation.</p> <p>The skin is: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm</p> <p>The patient is not or is on oxygen. The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____ % The oximeter does not detect a good pulse and is giving erratic readings.</p>
<b>A</b>	<p><b>Assessment</b> This is what I think the problem is: <u>say what you think is the problem</u>. 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.</p>
<b>R</b>	<p><b>Recommendation</b> I suggest or request that you <u>say what you would like to see done</u>. Transfer the patient to critical care Come to see the patient at this time. Talk to the patient or family about code status. Ask the on-call family practice resident to see the patient now. Ask for a consultant to see the patient now.</p> <p>Are any tests needed? Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others?</p> <p>If a change in treatment is ordered then 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?</p>

19

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## SBAR: Patient Sticker

<p>SITUATION: Admission/Discharge/Nursing Problems/Date(s) of surgery: _____</p>		<p><b>PATIENT STICKER</b></p>
<p>BACKGROUND: Allergies/Code Status: _____</p> <p>Significant Medical History/Isolation Status: _____</p>		<p>Physicians: _____</p>
<p>Date: _____ Shift: _____</p> <p>ASSESSMENT: <u>Circle results - include only abnormal findings and notes</u></p> <p>Procedures past 24 hrs scheduled _____</p> <p>Results/outcomes: _____</p> <p>Vital Signs: Abnormal Post-procedure _____</p> <p>Rhythm (tele) _____ Pain score/last med given _____</p> <p>Assessments: Abnormal _____</p> <p>Dressing condition/changes _____ NG/Drain output _____</p> <p>IV/fluids/rips/size/te change due: _____</p> <p>Protocols: Skin Fall Restraint Other: _____</p>	<p>RNLPN: _____</p> <p>RECOMMENDATION: What does next shift need to be aware of?</p> <p>Pending labs x-rays _____</p> <p>We need to: Request a change in / Consult for Diet Activity Medications PT/ST/OT Social worker Wound care nurse _____</p> <p>Need copy of Advance Directive Y N Ask Dr. about DNR status Y N</p> <p>You need to / I have paged Dr. _____ about _____</p> <p>Problems most concerned/uncomfortable with: _____</p> <p>New Nursing Problems: _____</p> <p>Discharge planning: _____</p>	
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20

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## SBAR: Summary

- Agency develops a working relationship with the physician
- Physician develops confidence in the competency level of the clinician
- Saves time and improves communication between caregivers

21

## SBAR: Summary (continued)

- Creates a mental model to establish a standardized, factual exchange of information
- Improves safety of the patient
- Reduces acute care hospitalization (ACH) outcomes for the agency

22

## Important Web Sites

- CMS Web Sites

[www.medicare.gov](http://www.medicare.gov)

[www.cms.hhs.gov/quality/nhqi](http://www.cms.hhs.gov/quality/nhqi)

[www.medqic.org](http://www.medqic.org)

- HSAG Web Sites

[www.hsag.com](http://www.hsag.com)

<http://hhqi.hsag.com>

<http://nhqi.hsag.com>

<http://acute.hsag.com>

23

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24

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25