**INTRODUCTION TO SBAR COMMUNICATION**

**SBAR communication** provides a systematic approach to communication during care transitions and in situations in which communicating information about the patient’s condition to other members of the multidisciplinary team is necessary. SBAR has the following components: **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation. Using this tool helps reduce the risk of patient care errors that commonly occur during transitions in care. Before initiating the conversation about the patient’s condition, gather all of the relevant information so that you can accurately put it into context for the receiver.

**Putting SBAR Into Practice**

Here is an example of how you can use SBAR communication to guide communication. This is a handoff situation where there was a change in patient status overnight.

**Situation**

Hi, my name is Shamika Smith and I am patient Ryan’s night shift nurse. I am concerned that Ryan is getting sick as he is unusually cranky and has a slightly elevated respiratory rate.

Key elements:The Nurse introduces herself and patient, describes what is happening at the present time, and uses words like “I am concerned” to draw attention to the situation.

**Background**

Ryan is a 4 year old with Myotonic dystrophy. He is trach and ventilator dependent. He has required more than usual frequency of suctioning overnight. His secretions remain white to clear and he does not have a fever. His HR 95, RR 26, Sat’s are 95 on room air. His breath sounds clear with suction. Patient does have a history of chronic tracheitis with season changes.

**Key elements:** The nurse provides pertinent information from the patient’s history, along with his current vital signs and relevant assessment findings.

**Assessment**

I am concerned that Ryan may be getting sick, possible tracheitis. I have found that if we catch things early and intervene, then we can prevent Ryan from declining too much and requiring more serious treatment.

**Key elements:** The nurse states her analysis of the situation, including known and as-yet-unknown information.

**Recommendation**

Currently Ryan is stable, but he will require close monitoring for worsening status. Continue to provide adequate hydration and good humidity to avoid any plug. If Ryan shows changes in mental status or worsening symptoms, such as a fever or change in secetions (such as yellow color or new odor), call his provider.

**Key elements:** The nurse identifies that the situation is currently stable but could quickly change due to patient’s history. She clearly defines this is not urgent but advises patient be assessed more frequently and when to contact provider.