Bullet Point Nursing

Nursing fundamentals – SBAR

Disclaimer: These notes are designed to provide the key points of each topic and should not be used as a complete source for all necessary information. Every effort is made to ensure this content is up to date and accurate at the time of writing. No liability is assumed for the content or its relation to current standards and practices. This should not replace comprehensive nursing educational resources.

This is focused on the SBAR strictly as the nurse report to provider when needing an order or to give an update. This is not about the use of the SBAR format for any other type of reporting

SBAR is used to deliver clear and concise information from a nurse to a provider relating to an issue that needs their attention. This can be something as simple as needing an order for nausea medicine or as complex as new onset of stroke like symptoms.

SBAR:

- Situation
- Background
- Assessment
- Recommendation

Situation:

- Your name
- Facility
- Patient
- Age and Gender
- Admitting Diagnosis
- LOS / POD
- One sentence problem

“This is Josh at ABC Hospital, I am calling regarding Jane Smith, 67-year-old female that is one day post-op for a right total knee replacement (TKR). She is now complaining of discomfort to the right leg.”

Background:

- What is the background of the patient’s stay/condition relating to THIS concern?
    - Examples are:
        - Related issues since their admission
        - Related issues since their surgery

“She has not had any complications since surgery other than mild incisional pain which was controlled with acetaminophen.”

Assessment:

- Your related assessment to the issue at hand
- Can include any of the following or more:
    - Vitals

    - Lung sounds
    - OPQRST assessment
    - GCS or mental status exam
    - Surgical site assessment

“She has no change in vital signs or mental status. She does have 2 plus pitting edema to the affected extremity distal to the knee. This was not present on shift change exam this morning. Her pulse, motor, and sensation are intact throughout the extremity. Cap refill is less than 3 seconds. Her leg is slightly warmer to the touch compared to her other leg. She reports pain upon palpation of the leg. No redness, cyanosis or other issues noted.”

Recommendation:

- Suggestion to the provider:
    - Test to order
    - Provider assessment
    - Necessary intervention
- You do not need to have any either. You can leave it to them and simply ask what would you like me to do. You may also be calling just to notify the provider of a change that you feel they should know but that may not require any immediate action.

“Would you like to examine her or order an ultrasound?”

Key points:

1. Do not ramble
2. Be ready to answer any questions
3. Always start with the key points mentioned above so the provider has appropriate context for your information.
4. Be ready to write down any orders
    a. Depending on facility, the provider may be entering the order themselves via the EMR
5. Always read back any orders