Guidelines for Communicating with Physicians Using the SBAR Process

1. Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
   1. Direct page (if known)
   2. Physician’s Call Service
   3. During weekdays, the physician’s office directly
   4. On weekends and after hours during the week, physician’s home phone
   5. Cell phone

   Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

2. Prior to calling the physician, follow these steps:
   • Have I seen and assessed the patient myself before calling?
   • Has the situation been discussed with resource nurse or preceptor?
   • Review the chart for appropriate physician to call.
   • Know the admitting diagnosis and date of admission.
   • Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
   • Have available the following when speaking with the physician:
     • Patient’s chart
     • List of current medications, allergies, IV fluids, and labs
     • Most recent vital signs
     • Reporting lab results: provide the date and time test was done and results of previous tests for comparison
     • Code status

3. When calling the physician, follow the SBAR process:
   (S) Situation: What is the situation you are calling about?
   • Identify self, unit, patient, room number.
   • Briefly state the problem, what is it, when it happened or started, and how severe.

   (B) Background: Pertinent background information related to the situation could include the following:
   • The admitting diagnosis and date of admission
   • List of current medications, allergies, IV fluids, and labs
   • Most recent vital signs
   • Lab results: provide the date and time test was done and results of previous tests for comparison
   • Other clinical information
   • Code status

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(A) **Assessment:** What is the nurse’s assessment of the situation?

(R) **Recommendation:** What is the nurse’s recommendation or what does he/she want?

Examples:
- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

4. Document the change in the patient’s condition and physician notification.
SBAR report to physician about a critical situation

**Situation**
I am calling about <patient name and location>.
The patient's code status is <code status>.
The problem I am calling about is ________________________.
I am afraid the patient is going to arrest.

I have just assessed the patient personally:

Vital signs are: Blood pressure _____/_____, Pulse _____, Respiration_____ and temperature _____

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 5 or over 40.
- Temperature because it is less than 96 or over 104.

**Background**
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.

The skin is:
- Warm and dry
- Pale
- Mottled
- Diaphoretic
- Extremities are cold
- Extremities are warm

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.

**Assessment**
This is what I think the problem is: <say what you think is the problem>
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.

**Recommendation**
I suggest or request that you <say what you would like to see done>.
- 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.

Are any tests needed:
- Do you need any tests like CXR, ABG, EKG, CBC, or BMP?
- Others?

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?

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SBAR Report Competency Check Off

BEFORE Calling the Physician:
- Assess the patient.
- Review the chart for the appropriate physician to call.
- Read the most recent physician and nursing notes.

☐ Admitting Diagnosis: ______________________
☐ Code Status: __________  ☐ Allergies: __________
☐ IV Fluids: ______________________
☐ Significant Labs: ______________________
☐ Significant Test Results: ______________________

Every SBAR report is different. Focus on the problem. Be concise. Not everything in the outline below needs to be reported – just what is needed for the situation.

**Situation**
- Name ____________________  ☐ Unit __________
- Patient Name ____________________  ☐ Room # ________
- I am concerned about ______________________

**Background**
- The patient is in the hospital because ______________________
- Vital signs are ______________________
- The pulse ox is _____ and patient is on _____ oxygen.
- The patient is complaining of ______________________
- The patients physical assessment demonstrates ______________________
  - This is a change from ______________________
- Their pain level is ______________________
- The patients mental status / emotional state is ______________________

**Assessment**
- My assessment of the situation is ______________________
- Tell the physician if the problem is severe and may be life threatening.

**Recommendation**
- I think the following needs to be done:
  - ☐ Medication __________
  - ☐ Tests __________
  - ☐ Physician needs to come now and assess the patient.
- ☐ Do you want me to call you back for any reasons? __________

Name: ____________________  ☐ Department/Unit: ____________________
Date: ________________  Time: ________________  Physician: ____________________
Did the employee demonstrate competency in SBAR: Yes  ☐ No
Signature of Reviewer: ____________________
SBAR
Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

Before Calling MD/NP/PA:
☐ Evaluate the resident and complete the SBAR form (use “N/A” for not applicable)
☐ Check VS: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
☐ Review chart: recent progress notes, labs, orders
☐ Review relevant INTERACT II Care Path or Acute Change in Status File Card
☐ Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S
SITUATION
The symptom/sign/change I’m calling about is ___________________________________________

This started ___________________________________________
This has gotten (circle one) worse/better/stayed the same since it started
Things that make the condition worse are ___________________________________________
Things that make the condition better are ___________________________________________
Other things that have occurred with this change are ____________________________________

B
BACKGROUND
Primary diagnosis and/or reason resident is at the nursing home ___________________________
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) ___________________

Vital signs BP _____ / _____ HR _______ RR _______ Temp _______
Pulse Oximetry _____% On RA _______ on O2 at _______ L/min via _______ (NC, mask)
Change in function or mobility _________________________________________________________
Medication changes or new orders in the last two weeks _________________________________
Mental status changes (e.g. confusion/agitation/lethargy) _________________________________
GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other) _________________________________
Pain level/location _________________________________
Change in intake/hydration ___________________________________________________________
Change in skin or wound status _______________________________________________________
Labs ____________________________________________________________
Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented) _______________
Allergies _________________ Any other data _______________________________________________

A
ASSESSMENT (RN) OR APPEARANCE (LPN)
(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _________________________________ - OR
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The resident appears (e.g. SOB, in pain, more confused) ______________________

R
REQUEST
I suggest or request (check all that apply):
☐ Provider visit (MD/NP/PA)
☐ Lab work, x-rays, EKG, other tests
☐ IV or SC fluids
☐ Other (specify) _______________________________________
☐ Monitor vital signs and observe
☐ Change in current orders ___________________________________ 
☐ New orders ______________________________________________
☐ Transfer to the hospital___________________________________

Staff name ____________________________________________ RN/LPN
Reported to: Name __________________________ (MD/NP/PA) Date _____ / _____ / _____ Time ______ a.m./p.m.
If to MD/NP/PA, communicated by: ☐ Phone ☐ In person
Resident name ___________________________________________

(Complete a progress note on the back of this form)
Progress Note

Return call/new orders from MD/NP/PA

☐ Family or health care proxy notified

Date___/___/___

Time___/___AM/PM

Signature ____________________________ RN/LPN Date___/___/___

Time___/___AM/PM

Resident Name ____________________________
SBAR

A structured communication technique designed to convey a great deal of information in a succinct and brief manner. This is important as we all have different styles of communicating, varying by profession, culture, and gender.

**Situation**
A concise statement of the problem
*What is going on now*

**Background**
Pertinent and brief information related to the situation
*What has happened*

**Assessment**
Analysis and considerations of options
*What you found/think is going on*

**Recommendation**
Request/recommend action
*What you want done*
Secret Tip on how to talk to physicians and fellow employees to really help our patients: Use SBAR

All of us at one point have experienced frustration while talking to a physician or a fellow worker about a patient care issue. Have you gotten the sense the person receiving the message was not really listening to you at all and had their own idea of what they wanted, regardless of your plan?

This is not an uncommon occurrence. In fact it happens on a regular basis each day but it doesn’t have to any more. A simple communication method already exists and is being introduced throughout the Capital Service Area that helps physicians and staff to listen better, understand each other and work better together to help serve our patients.

What is the Communication Model?
The model is commonly known as SBAR or Situation, Background, Assessment and Recommendation and is designed to improve listening.

When do you use it?
SBAR can be utilized whenever you have a request of a physician or fellow worker.

How do you use it?
Say you are a health care worker and you want to get some help from a nurse or need a physician to provide guidance on a patient care issue. You know what you would like to recommend and you have all of the background information. Here is what you do:

State the SITUATION
Your situation should be described in one sentence. For example, “Dr. Smith, I have a patient of yours that is here on the wrong day for his appointment and would still like to be seen.”

Give BACKGROUND information
State the details of the situation you have obtained by researching the problem.
For example: The patient arrived today at 11 am. His appointment is really for 11 tomorrow. Patient comes from over 40 miles away. Patient cannot drive a friend brought him. Patient is willing to wait to be seen today. I have looked at your appointments and you have several slots available. I have looked at your hall partner’s schedule and he has a few slots open also.

Give your ASSESSMENT
Assess the situation and tell the physician what you think should be done.

For example: The patient is traveling from a long distance. I don’t know if it was our mistake or the patient. I think we should see him today.

Give your RECOMMENDATION
A recommendation is where you advise the physician what your method would be for solving the problem. It may or may not be accepted by the physician but is a starting point to discuss solutions.

For example: I think he should be seen at your afternoon appointment time.

Why does SBAR work?

- When you use this method, both you and the other person are on the same page to think through a problem.
- You are proactively giving the listener data that they would be requesting anyway if they were going to try to solve the problem.
- You save them time by researching options.
- You keep them from having guess by giving them a recommendation.
- Doctors already know how to use this method. They use a similar method known as SOAP when they speak doctor to doctor about patient care issues.

So what are you waiting for? You can use SBAR right now and watch yourself become more productive and less frustrated as you communicate with others.

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# S - B - A - R Communication Tool

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation</td>
<td>One sentence description of need</td>
<td>Patient arrived for appoint on wrong day</td>
</tr>
</tbody>
</table>
| Background   | Details that give information to make an assessment. (Can be from patient's view and from your clinical view as you inquire and research) | 1. Patient arrived for 11 am appointment today.  
2. Appointment is at 11 am tommorrow  
3. Pt. Comes from 40 miles away  
4. Pt. Needed to have friend drive them to appointment  
5. Doctor has 1+ appointment available on schedule  
6. Doctor's hall partner has some open times  
7. We don't know if the mistake was with the patient or the call center |
| Assessment   | Your position on the issue                                                 | We should see the patient today                                         |
| Recommendation | Your specific method for solving the problem                             | I recommend that we use the 1+ time or have your hall partner see this patient. |
# S - B - A - R Communication Tool

Scenario Development Sheet

<table>
<thead>
<tr>
<th>Item</th>
<th>Narrative without S - B - A - R</th>
<th>Using S - B - A - R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation</td>
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<td>Background</td>
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