PURPOSE:

The purpose of SBAR (Situation, Background, Assessment, and Recommendation) is to provide a communication tool that enables the staff nurses to effectively communicate by sharing information among team members and prioritizes quality patient care.

SCOPE:

This applies to all Nursing Service Division Staff of Dr. Pablo O. Torre Memorial Hospital (DPOTMH) and the Student Nurses under the supervision of the Riverside College Clinical Instructors.

PERSON RESPONSIBLE:

Staff Nurse

GENERAL GUIDELINES:

1. For the purpose of this SOP, the following terms are defined:
   - 1.1. **Situation** – in this segment, the staff nurse will describe the situation or problem in basic, short terms. Take into account the crucial details pertaining to the patient's condition, including the role in the patient's treatment, as well as the patient's identity, area, and room number. Describe the scenario, along with the extent of the situation, how it transpired, and the complexity of the condition.
   - 1.2. **Background** – in this segment, the staff nurse will provide pertinent background information on the patient, including their admission time and date, diagnosis, necessary details, test results, and code status. If a patient has several laboratory reports, the nurse or other health provider may

provide information about the preceding test's date and time, as well as any differences in the results.

1.3. **Assessment-** provide a professional evaluation or judgment based on the patient's situation and background in this segment. This is where the nurse explains what they found out about the patient. This can encompass everything they see, hear, smell, and feel, among other things.

a) Vital signs (blood pressure, temperature, pain level, etc.)
b) Results of diagnostic tests
c) Significant physical observations
d) Physical and mental state changes
e) Concerns and complaints from patients

1.4. **Recommendation-** in this segment, staff nurses shall state directions to their colleagues in healthcare and convey what they require from them in an accurate and direct manner on how to proceed with the patient's treatment.

a) Medications
b) Diagnostic tests to run or specimens to obtain
c) Other possible procedures to be done
d) Additional interventions
e) Order to transfer or refer as applicable

2. Nursing documentation is the responsibility of the Registered Nurses or in the case of student Nurses, it should be checked by a Clinical instructor or Staff nurse assigned.
3. All documentation should be written legibly as it is a basis for future research.
4. Abbreviations are strongly discouraged and only universally accepted abbreviations can be used.
5. All admitted patients should have a SBAR form.
6. DPOTMH advocates continuity of care for its patients from one shift to the next.

7. Safe patient turnover requires proper endorsement every shift which includes the SBAR form.
8. When to use the SBAR:
   - 8.1. SBAR shall be used to guide and inform any patient information exchange with other healthcare practitioners in every interdepartmental transfer.
   - 8.2. Shall be used when a medical team is dealing with a patient's problem.
   - 8.3. Doctors, nurses, and other healthcare professionals are invited to participate in the discussion.
   - 8.4. When a quick response team needs access to information about a situation during an emergency or a crisis.
   - 8.5. In between shifts or during a shift change, when passing communication to other healthcare providers.
   - 8.6. In crisis and health briefings.

9. Who should use the SBAR:
   - 9.1. The SBAR is recommended by the Agency for Healthcare Research and Quality (AHRQ) for the following:
     a) Communicating with the administrators and physicians
     b) Nurses conversing with one another/endorsing
     c) Nurses interact with physicians
     d) Nursing attendants and nurses
     e) Residents and attending physicians exchange information

PROCEDURE:

Demonstration of SBAR:

1. The staff nurse must check the SBAR for the accuracy and completeness of patients information.

2. The staff nurse must assemble thoughts before using the SBAR form to make sure to provide the most valuable information. The staff nurse shall determine whatever background data is significant to the patient's status.
3. The staff nurse shall make a brief and straightforward use of the SBAR form to enable patients and other healthcare providers to avoid receiving irrelevant data that could mislead or worry them. Others can ask for inquiries and more information after giving a recommendation.
4. The staff nurse shall collaborate to create a plan of action. After the nurse makes a proposal or solution, it often necessitates the opinion or expertise of a fellow staff nurse or head nurse to make an informed conclusion.

What to do before using SBAR:

1. The staff nurse shall examine the patient. The staff nurse shall make a brief, concentrated evaluation and assess the patient.
2. The staff nurse shall check for any orders in place to deal with the problem currently being experienced.
3. The staff nurse shall contact the appropriate doctor or the resident on duty in charge.
4. The staff nurse shall provide a summary of the patient's hospital stay.
5. The receiving staff nurse shall inform the endorsing nurse about any concerns.
6. The staff nurse shall examine all the relevant physician progress notes and the end-of-shift summary by the nurses who submitted the report.
7. The staff nurse speaking with the physician or resident on duty shall keep the chart open to easily access information and the SBAR form.

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	Page Number:	5 of 5
	Department/Section:	Nursing Service Division
	Document Title:	**USE OF SBAR (SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION)**

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	HANNAH KHAY S. TREYES, RN, MN Chief Nurse		10/04/2022
Reviewed:	**DENNIS C. ESCALONA, MN, FPCHA, FPSQua** Quality Assurance Supervisor		10/04/2022
Recommending Approval:	**MARIA LIZA C. PERAREN, RN, MAN** Nursing Division Officer		10-15-2022
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President – Chief Medical Officer		10-26-22
Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		11/11/22

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KEY TASKS	PERSON RESPONSIBLE
1. Checks the SBAR for the accuracy and completeness of patients information.	Staff Nurse
2. Makes a brief and straightforward use of the SBAR form to enable patients and other healthcare providers to avoid receiving irrelevant data that could mislead or worry them.	
3. Makes a brief, concentrated evaluation and assess the patient.	
4. Checks for any orders in place to deal with the problem currently being experienced.	
5. Contacts the appropriate doctor or the resident on duty in charge.	
6. Informs the endorsing nurse about any concerns.	
7. Examines all the relevant physician progress notes and the end-of-shift summary by the nurses who submitted the report.	
8. Keeps the chart open to easily access information and the SBAR form.	

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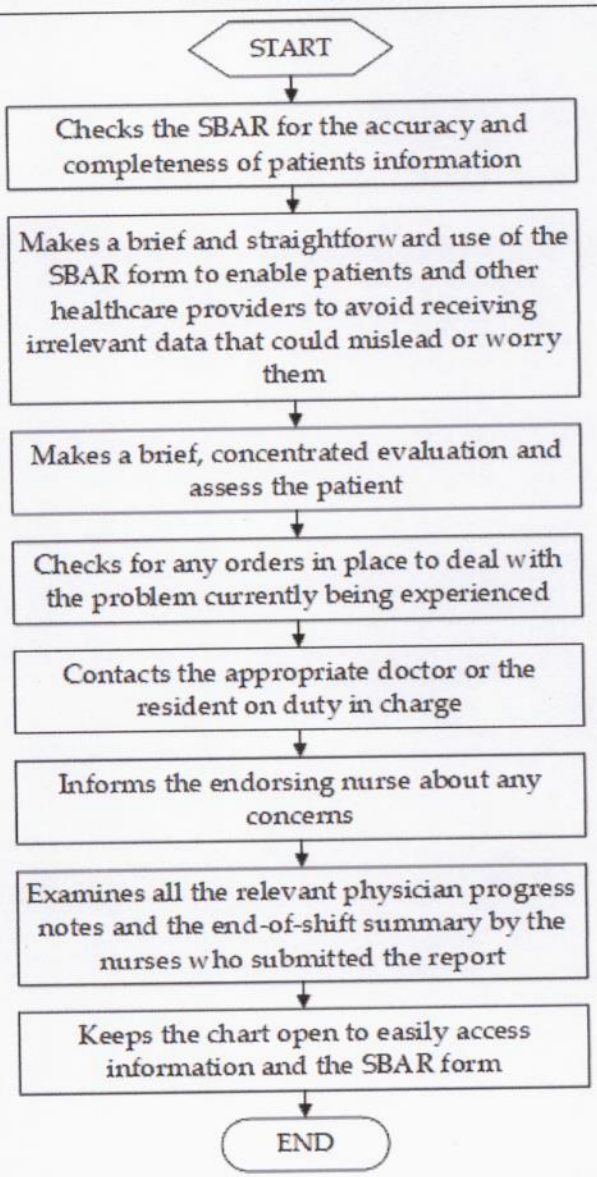
FLOWCHART



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