Communicating Concerns and Documenting Discussions (SBAR Tool)

THIS MUST BE DOCUMENTED IN THE NURSING RECORD

INFORMATION TO COLLECT AND HANDOVER		
S	**Situation**	1. Identify yourself and the ward you are calling from 2. Identify your patient by name and the reason for your call (e.g. vomiting, feels unwell, breathlessness, pain, dizziness, fall) 3. Onset of symptoms (30 minutes, 1 day)
B	**Background**	4. Give the reason for admission 5. Explain significant past medical history 6. Give an overview of the patients' current admission, including: admitting diagnosis, date of admission, prior procedures, current medication, allergies, pertinent laboratory results and other relevant diagnostic results.
A	**Assessment**	7. Objective observations (**be specific, do not use terms high or low**) e.g. Temperature - 38.5, Pulse - 110, BP – 160/95, Respirations -24, O2 sats - 98%, Alert, Urinalysis positive to ketones 8. Report any evidence of bleeding and location (skull, arm) 9. Advise whether the patient is in pain and colour of skin (flushed, pale, blue?), colour of sputum (white and frothy, green?) 10. Any abnormal sounds e.g. wheezing, coughing? 11. Any abnormal smells e.g. ketones, alcohol? 12. Is the patient taking in fluids? 13. What is the patient's urine output
R	**Recommendation**	14. Recommended action from doctor/specialist contacted: e.g. Increase observations/ commence on medication/ call ambulance 15. What are the actions of the nursing team and actions of the medical team? 16. When should this be reviewed?