

SBAR ASSESSMENT

Overview

The SBAR assessment provides a structured communication tool that can be used to bridge the communication gap(s) that may exist between care providers, care partners and within teams.

The components include:

Situation = What is going on – identifying the problem.

Background = Identifying the context/history.

Assessment = Identify what the problem is.

Recommendation = Precise and specific recommendations of action.

Item	Definition	Example
Situation	One sentence description of need.	Resident (John Smith) almost had two falls today.
Background	Details that give information to make an assessment (can be from patient/resident view and from your clinical view as you inquire and research).	Incident 1: Mr. Smith almost fell while assisting him while he got dressed this morning, stated he felt dizzy. Incident 2: Mr. Smith stumbled while trying to sit down for his breakfast, stated he felt dizzy again.
Assessment	Your position on the issue.	I reviewed Mr. Smith’s chart and see he recently was given an antipsychotic PRN because of a behaviour incident that occurred three days ago. I believe Mr. Smith is at risk of a fall because of this recent medication.
Recommendation	Your specific method for solving the problem.	I recommend we put a safety rail on his bed tonight as well as in his washroom. Tomorrow we will discuss a further action plan with the Interdisciplinary Behaviour Support team during our weekly huddle.



HEALTH QUALITY BC

SBAR Communication Tool

Scenario Development Sheet

Item	Narrative without SBAR	Using SBAR
Situation		
Background		
Assessment		
Recommendation		

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SSC SBAR Communication Tool

Definitions 7/7/2004