SBAR(D) Communication Tool

Southern Health
NHS Foundation Trust

S

Situation:
I am (name), on ward (X)
I am calling about (patient X)
I am calling because I am concerned that…
(e.g. BP is low/high, pulse is XX, temperature is XX, NEWS 2 score (if applicable is XX)

B

Background:
Patient (X) was admitted on (XX date) with…
(e.g. chest infection)
Patients (X)'s condition has changed in the last (XX mins)
Patient (X)'s normal condition is…
(e.g. alert/drowsy/confused, pain free)
Patient X's Mental Health status is…(if applicable)

A

Assessment:
A – Airway: Is the patient talking or are there added airway noises e.g. stridor/ wheeze/gurgling?
B – Breathing: Respiratory rate is (XX), oxygen saturations are (XX%). The patient is e.g. breathing normally/short of breath
C – Circulation: Blood pressure is (XX), pulse is (XX). The patient appears e.g. flushed/pale/clammy/waxy
D – Disability: ACVPU (alert, new confusion, voice, pain, unresponsive) is (XX), blood glucose is (XX), pupils are (XX)
E – Exposure: Temperature is (XX), any other abnormalities e.g. bleeding/bruising/wounds/rashes

R

Recommendation:
I need you to…
Come and review the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time? (e.g. increase frequency of observations, commence oxygen delivery)

D

Decision:
What decision has been agreed?
Document the conversation that has taken place in the patient's notes and amend the care plan to reflect this

Version 4
Adapted from NHSI 2018