How to Use an SBAR for Antimicrobial Stewardship Activities

What is an SBAR?
SBAR is the acronym for Situation, Background, Assessment, and Recommendation. It is a communication technique originally developed by the US Navy and initially adopted into healthcare by Kaiser Permanente to facilitate prompt and accurate transfer of information.

Why use an SBAR?
SBAR outlines an easy-to-remember and structured format for communicating a standard set of information from one person/group to the next. Using this strategy, bedside nurses can communicate essential and relevant clinical information to clinicians as well as recommend protocol-driven actions. Using the provided information, a clinician can make management decision based on recommendations from the bedside nurse or provide an alternative management plan.

How to use an SBAR?
SBAR for antimicrobial stewardship activities are typically available as paper or electronic tools consisting of checkboxes or fill-in-the-blanks. Even though the format may be different, the procedure for using them remains similar.

Using a paper SBAR tool for suspected urinary tract infection (UTI) as an example, these steps should be followed:

1. Become familiar with the elements required on the SBAR tool. The sample tool included 3 main sections: resident identifier, the main SBAR information for communication, and the physician order
2. Evaluate residents and collect parameters indicated on the SBAR tool. For UTI,
   a. Make certain the situation statement is appropriate for the scenario.
   b. Obtain background information including whether resident has a urinary catheter, history of recent UTI, other active diagnosis, advance directives, etc.
   c. Evaluate residents for pertinent parameters. The assessment for suspected UTI starts with evaluation of vital signs. Further evaluation depends on presence or absence of urinary catheter. One should paid close attention that the number and type of criteria required for justifications of antibiotic therapy are different for each scenario.
3. Determine the appropriate clinician to contact once all relevant information has been collected. In addition to signs and symptoms, relevant information may include patient’s medical/surgical histories, medication allergies, current medications, recent vitals, and lab results (such as serum creatinine).

4. Prior to calling the clinician, organize the thought process and have in mind a clear concise message that needed to be conveyed to the clinician, including Recommendation as outlined on the SBAR tool.

5. During the call to the clinician, provide information in the Situation, Background, Assessment, and Recommendation sequence.

6. Once completed, request the clinician to provide a treatment and follow-up plan.

7. The assessment and management recommendations should be documented on paper or electronically and this record should be kept in a patient’s chart.