

4-min Shift Report

Guide to Giving Effective Report

SBARQ=Situation, Background, Assessment, recommendation & Questions

A stylized logo consisting of the letters 'S' and 'B' in a cursive font, with an ampersand between them. The letters are rendered in a multi-colored, glowing effect with shades of blue, purple, and pink.

Situation and Patient Pertinent Med/Surg History

A stylized logo of the letter 'A' in a cursive font, rendered in a multi-colored, glowing effect with shades of blue, purple, and pink.

- Vital Signs
- Abnormal Assessment Findings
- Lines & Drains: Plan for Removal
- Risks, VTE, Fall, Self-Harm, Self-Harm, Bed Pump
- Pain: Treatment & Plan
- Mobility & Elimination
- New Orders
- Discharge Plan
- Diet
- Lab Values
- Airways & Wounds

A stylized logo of the letter 'R' in a cursive font, rendered in a multi-colored, glowing effect with shades of blue, purple, and pink.

Plan for The Shift

- Preferences/Routines
- Safety Check of Room: Call-light, Bed Alarm, Cleanliness

A stylized logo of the letter 'Q' in a cursive font, rendered in a multi-colored, glowing effect with shades of blue, purple, and pink.

Questions



Introduce- Meet the Patient

Keep Your SBARQ Cheat Sheet Handy!

This essential tool is designed to fit easily in your pocket, badge holder, or clipboard. Make it a part of your daily practice to enhance communication and patient care.

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SBARQ Cheat Sheet for Nurses

Streamline Your Communication with the SBARQ Method

Purpose: The SBARQ (Situation, Background, Assessment, Recommendation, Questions) Cheat Sheet is a handy, pocket-sized tool designed to enhance communication and ensure clarity when reporting patient information. Carry this cheat sheet with you for quick reference during handoffs, emergencies, or anytime you need to convey critical information succinctly and effectively.

Components:

1. Situation

- a. What is happening now?
- b. Briefly describe the current situation or issue.
- c. Example: "Patient is experiencing chest pain."

2. Background

- a. What is the relevant background?
- b. Provide context and pertinent history.
- c. Example: "The patient has a history of heart disease and recent surgery."

3. Assessment

- a. What do you think is going on?
- b. Share your clinical assessment and findings.
- c. Example: "Vital signs indicate hypotension and tachycardia."

4. Recommendations

- a. What do you need?
- b. Clearly state your recommendation or what you need done.
- c. Example: "I recommend starting IV fluids and performing an EKG."

5. Questions

- a. What questions or clarifications are needed?
- b. Ensure all concerns are addressed and confirm understanding.
- c. Example: "Are there any specific medications we should consider?"

How to Use:

- During Shift Handoffs: Ensure seamless transitions by providing comprehensive yet concise updates on patient status.
- In Emergencies: Quickly convey critical information to the healthcare team for immediate action.
- Daily Reporting: Maintain clear and organized communication with doctors and colleagues.

Benefits:

- Improved Patient Safety: Clear communication reduces the risk of errors.
- Enhanced Efficiency: Quick and structured reporting saves time.
- Consistency: Standardized format ensures no critical information is missed.

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Stay Organized, Stay Effective, Stay Caring!