



SBAR Observation Tool

Only the name of the person completing the observation tool will be identified. Please complete at least one observation each month.

If “No” is checked on the tool then observer is required to provide feedback using SBAR technique to individual being observed.

You are encouraged to use the comment box for discussion of topics or clarification. Please complete the tool before the end of the month and return it to your manager.

Date completed: _____

Time completed: _____

Observer: _____

Department: _____

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Patient Care SBAR

(Nursing shift changes; nursing patient changes; nursing contacting physician; dept. to dept. transfer; hospital to hospital, nursing home or home health care transfer).

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Other SBAR

(Internal or dept. communication, i.e. meeting minutes; policy needs revision; linen cart is empty; sink is leaking).

SBAR	SBAR Criteria	Yes	No	Comments
Situation	“Briefly described the problem”			
Background	“Described history”			
Assessment	“Described current conditions”			
Recommendation	“Offered suggestions or requests”			
	“Offered opportunity for Q&A”			

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Source: Parkview Hospital, Fort Wayne, IN.