

SBAR

Quick guide to progress notes.

Situation / Background / Assessment / Recommendation

DAILY ROUTINE VITAL SIGNS | Hospitals, care homes and other care settings

1 WHAT EACH LETTER MEANS

For clinically stable patients receiving treatment: document findings from routine daily checks required by local policy, including NEWS2 scores of 1 or above where SBAR is required.

2 WORKED EXAMPLE

Fictional inpatient case. All findings, times and actions are invented for teaching; document only what actually occurred.

S SITUATION

What happened during the check?

Record the time, the context and the main finding. Include whether the patient was calm and resting.

"09:00: During routine daily vital-sign observations, the patient was calm and resting. Pulse was elevated at 112 bpm."

B BACKGROUND

What is relevant to this change?

Record relevant treatment and previous observations. Distinguish the previous NEWS2 score from the usual resting pulse.

"28-year-old male inpatient, in his first week of oral clozapine. Previous observations: pulse 98 bpm, NEWS2 1 due to pulse, with all other parameters scoring 0."

A ASSESSMENT

What did you check and find?

Repeat the pulse manually after rest; record time and rate. Check all vital signs, NEWS2 and symptoms. Ask about bowel function and record findings.

"09:10: After further rest, manual pulse 112 bpm, regular. BP 118/76, RR 16, SpO2 98% on air, T 36.8 C; alert, no new confusion. NEWS2 2 (Scale 1), due to pulse. No chest pain, breathlessness, dizziness or palpitations reported. Last bowel movement yesterday; no abdominal pain or constipation reported."

R RECOMMENDATION / PLAN

Who was informed? What is the plan?

Inform the nurse in charge promptly. Record their name, time, advice and review requested. Specify observation frequency and the next check.

"Nurse in charge was informed. If the raised pulse persists, contact the duty doctor. Repeat vital signs after four hours; next observations due at 13:10. Encourage the patient to drink fluids. Continue bowel monitoring and report new symptoms promptly."

? WHAT IS A PHYSICAL HEALTH BASELINE?

Your starting point for spotting change.

A physical health baseline is a documented starting picture of the patient's physical health. It includes resting vital signs, relevant physical-health checks, existing conditions and usual symptoms. It helps staff compare later findings and recognise changes.

Example: Before clozapine, resting pulse = 78 bpm. Today, resting pulse = 112 bpm. Record both values and report the change.

Remember: Baseline = starting picture. Previous reading = last measurement. NEWS2 = a score calculated from the observations; it is not the baseline itself.