SBAR practice examples

Use these original fictional scripts for role-play. Practice identifying the concern, selecting relevant facts, describing your assessment, and making a clear request.

Training examples only, not care instructions, diagnostic criteria, or a treatment protocol. In a real emergency, activate local emergency or rapid-response processes immediately. Do not delay help to finish SBAR or collect every detail. Use approved patient identification when communicating about real care.

1. New breathing concern

S · Situation: I am the new RN calling with my preceptor about a fictional adult inpatient who is newly short of breath. I need an urgent bedside review.

B · Background: The patient was admitted with pneumonia and was speaking comfortably at the last assessment. The shortness of breath began in the past ten minutes.

A · Assessment: Respiratory rate is now 30 compared with 18 earlier, with increased work of breathing. The patient is alert but speaks in short phrases. I am concerned about deterioration.

R · Recommendation / request: Please assess the patient now. My preceptor is here and we are following the unit's urgent escalation process. Can you confirm who is coming and when?

2. Medication order clarification

S · Situation: I am calling to clarify the route on a fictional patient's new medication order before administration.

B · Background: The new order lists a route that differs from the previous order. The scheduled dose has not been given.

A · Assessment: I verified the chart and found no documented explanation for the change. I cannot confirm that this is the intended route.

R · Recommendation / request: Please clarify the intended route and update the order through the approved process. I will follow our medication clarification policy and confirm the order before proceeding.

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SBAR practice & coaching

3. Escalating a workload concern

S · Situation: I need help reprioritizing our assignment with my preceptor. Two time-sensitive care needs now overlap.

B · Background: A new admission arrived while another assigned patient needed reassessment. I have not completed either task.

A · Assessment: I cannot safely meet both needs at the same time. My preceptor and I have identified what is pending and which patient needs attention first.

R · Recommendation / request: Can the charge nurse help arrange immediate coverage and confirm who will complete each task? I will repeat back the plan and follow up on the remaining work.

Preceptor observation checklist

☐ Concern and urgency stated early
☐ Relevant facts separated from assumptions
☐ Assessment and limits explained
☐ Clear request with a timeframe
☐ Response confirmed and follow-up owner agreed

Debrief: what was clear, and what would you change?

Practice again: one communication goal for next time

SBAR means Situation, Background, Assessment, and Recommendation or Request. Framework source: Agency for Healthcare Research and Quality. (n.d.). *Tool: SBAR.* https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html
Examples are original and are not AHRQ-endorsed or a competency validation.

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