Nursing faculty teaching resource

RECEIVER ROLE CARD

Play the covering clinician

You are Dr. Jordan Patel. Lee Harmon, RN, calls about Robert Hayes. Receiver: initially unavailable.

Before the call

Ask for immediate actions and the escalation decision. If activation is omitted or the learner would wait for permission, pause and clarify that emergency action cannot wait. The observer records the omission and prompt. Then give the call update card (page 2). Everyone uses the same update; it does not earn credit for the initial decision.

Opening

“This is the covering clinician. Tell me what is happening.” Let the learner finish the initial SBAR.

One realistic constraint

Say once: “I am tied up with another patient. Can this wait until I finish?” If the caller has already proposed the rapid response clinician as an alternative, say instead: “I cannot leave this patient. What response can we coordinate now?”

Accept either appropriate plan

Accept a clear request for immediate assessment. Choose your availability before the round and keep it the same for the retry. If unavailable, agree to response-team assessment with immediate covering-team contact. Accept equivalent wording; do not require your attendance or a diagnosis.

> ### Confirm the chosen plan
>
> If unavailable: “I cannot leave this patient yet. The rapid response clinician will assess on arrival. I am available by phone now; have that clinician contact me as soon as they arrive.” If attending: “I am coming to room 318 now. Continue with the rapid response pathway; do not wait for me.”

If a safe plan is not reached

End the conversation for debrief. Emergency help remains active; never withhold it to force the right words. Credit immediate coordination through the charge nurse and rapid response lead when a clinician is unavailable.

If asked for absent information, say “That information is not provided.” Do not invent orders, repeat measurements, arrival, or improvement. Keep this card separate from the calling learner.

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RELEASE AFTER THE INITIAL DECISION

Update for the SBAR call

RECEIVER: Keep this page until the learner states their initial decision. Then give it to the calling nurse to read and keep in view. This supplied update is the same for all learners, including anyone who needed a prompt.

Actions now underway

It is now 2:00 p.m. Rapid response was requested at 1:58 p.m., without waiting for the phone call. Bedside observation continued and the head of the bed was raised. After the oxygen equipment was checked, oxygen was increased to 4 L/min by nasal cannula under the standing emergency protocol. Continuous pulse oximetry is in place. The charge nurse now stays at the bedside while you call Dr. Jordan Patel; the rapid response team, including respiratory therapy and a clinician, is on its way. The 89% reading was on 2 L/min before this change. No post-adjustment reading is supplied in this exercise. Obtain and report current findings without delaying help; do not assume improvement.

Now make the call

Call Dr. Jordan Patel, the covering clinician, using SBAR. Communicate the change, your working concern, actions underway, and the response needed. Confirm the agreed plan.

Keep observations and actions separate

The chart readings describe the patient before the increase in oxygen. Do not report a new saturation or improvement. New treatment orders are outside this exercise; repeating the response plan is not medication-order read-back.

Response-team context

If the patient worsens or help is delayed, immediately alert the charge nurse and response lead.

If the patient becomes unresponsive and is not breathing normally (including only gasping), call the code team (local emergency response) and start BLS as trained; return to SBAR only when immediate care is covered.

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OBSERVER REFERENCE

Facts for the observer

Keep this reference and the worksheet together. Use the facts to check the report; do not give the caller the model answer.

Patient / location	Robert Hayes, 67 years; fictional MRN 593824; 3 East, room 318
Admission	Hospital day 2 with pneumonia; receiving prescribed antibiotics.
History / status	Hypertension; no chronic lung disease or home oxygen use. No known medication allergies. Full code.
Respiratory change	Earlier: speaking in full sentences. Latest: more short of breath at rest, accessory-muscle use and short phrases; awake and responding.

Observation	1:30 p.m.	1:58 p.m.
Respiratory rate	18/min	30/min
Oxygen saturation	96% on 2 L/min	89% on 2 L/min
Heart rate	88/min	118/min
Blood pressure	126/74 mmHg	104/64 mmHg
Temperature	100.8 °F (38.2 °C)	100.8 °F (38.2 °C)

Stage 1: initial decision

Before the update, no emergency call has occurred. Look for immediate help and rapid response, staying with the patient, upright positioning and oxygen/monitoring support under the standing emergency protocol. Do not require a specific oxygen flow at this stage. Record the learner’s words; the update does not earn retrospective credit.

Stage 2: supplied actions

At 2:00 p.m.: rapid response requested at 1:58 p.m.; head of bed raised; oxygen increased to 4 L/min after equipment check under the standing emergency protocol; continuous oximetry. Charge nurse remains at bedside. Team including clinician and respiratory therapy is on its way. No post-adjustment findings are supplied; obtain current readings without delaying help.

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OBSERVER GUIDANCE

What to credit

If the patient worsens

If the patient worsens or help is delayed, immediately alert the charge nurse and response lead.

If the patient becomes unresponsive and is not breathing normally (including only gasping), call the code team (local emergency response) and start BLS as trained; return to SBAR only when immediate care is covered.

Acceptable response plans

Credit immediate assessment by an appropriate clinician: the covering clinician, or the rapid response clinician with covering-team coordination. Confirm who, timing, and the response to worsening or delayed help through the charge nurse/response lead. Do not require covering-clinician attendance.

Credit an uncertain concern about respiratory failure or sepsis tied to findings. Do not require a definitive diagnosis. A call confirms communication, not patient improvement.

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OBSERVER WORKSHEET

Observe the decision and call

Patient: Robert Hayes | Guided brief | Initially unavailable receiver

Calling learner: _____ Observer: _____

O = observed as described; N = not yet demonstrated; N/A = no opportunity (explain). Note missing parts and prompts (Y/N). Use the reference. No total score.

Behavior	Attempt 1	Attempt 2
1. Initial decision: activates emergency help without waiting for the call.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
2. Initial decision: states immediate bedside support and continued observation.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
3. Identifies self, patient (name, MRN) and location; states the urgent problem before history.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
4. Reports trend, times, oxygen setting, breathing effort and mental status.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
5. States a supported clinical concern with appropriate uncertainty.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
6. Reports supplied actions without inventing a treatment response.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
7. Secures immediate assessment by an appropriate responder; addresses delay if raised.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
8. Confirms responder, timing and action for worsening or delayed help.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N

Attempt 1 evidence

Record words heard, missing parts and prompts. Refer to row numbers.

Attempt 2 evidence

What changed on the selected target? Note any remaining gaps.

Fictional scenario for formative communication practice. Not clinical guidance or a validated assessment. Confirm the facts and response pathway against your local policy before teaching.

Version 1.0 | November 4, 2026

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