# SBAR Scenario Authoring Pack

Receiver scripts, session method and debrief tools live on the guide page; this pack holds the cards and checklists you print and complete.

Version 1.1 - November 2026 - medical.linguacopilot.in/guides/sbar-simulation-scenario-builder

Contents: the policy card; three case cards (one per frame); the Escalation Call checklist; the Shift Handoff checklist; the two receiver tests; the two learner self-checks.

For: faculty running SBAR practice rounds in a classroom, skills lab or simulation session.

Not for: assessment of real handoffs or formal evaluation. The checklists are formative tools and have not been validated.

Complete the policy card and each case card as an educator master from reviewed material. Make a learner copy with clinical facts and applicable policy. Keep the expected concern/request, future orders and receiver script with the educator and receiver until debrief. The observer records all marks and prompts.

Written for US practice settings; adapt terms and policies for your setting. Version 1.1 replaces the August 2026 version 1.0 pack.

## POLICY CARD

One per institution, reused across frames. Complete from your hospital's or college's own policies.

Patient identifiers used locally: name plus which second identifier

Early-warning score in use, if any, and its response thresholds: score; urgent threshold; emergency threshold; who is informed at each

Who the nurse calls first for a deteriorating patient, and the escalation chain if there is no response or the response is refused: first contact; next step; emergency activation without waiting for provider permission

Verbal-order and read-back policy: who may give and receive; what is repeated; how the sender confirms or corrects the read-back; how it is recorded

Critical-result policy: receipt and reporting times; lab caller and recipient; value and units; read-back confirmation; actions and follow-up

Bedside handoff policy: patient choice about family presence; private discussion of sensitive findings; patient agreement to family information sharing; who discusses them and when; bedside safety checks

## EDUCATOR MASTER CARD - FRAME 1: A DETERIORATING PATIENT

Complete from reviewed material. Give the learner facts and policy only; keep expected answers and future orders separate.

Patient: name; age; second identifier; bed

Admission and day: diagnosis or procedure; day of stay

Relevant history and current medications: the two or three items that change the decision, including anything that masks or causes the problem

Allergies and code status

Last relevant result with its previous value

Baseline vital signs, earlier in the shift: time; values; score if used

Current vital signs: time; values; score if used; which threshold on your chart this crosses

The other findings that point the same way: two or three

Symptoms the patient reports

Distractor facts, true but not decision-changing: three to five (visitors, diet, therapy sessions, complaints)

Educator only - the concern the nurse should state: the working problem

The expected ask: assessment now and confirmation; appropriate alternative responder if the local pathway permits

The contingency, per the policy card: what the nurse does if the patient deteriorates or help is delayed

Receiver only - benign explanation, safe but insufficient holding measure from the reviewed case, and the second refusal

The receiver's orders after agreement: three to five time-specific actions, assessment plan and call-back requirements from the reviewed case/policy; who responds and when

## EDUCATOR MASTER CARD - FRAME 2: A BEDSIDE SHIFT HANDOFF

Complete from reviewed material. Give the outgoing nurse the facts and agreed discussion plan; keep role scripts separate.

Patient: name; age; second identifier; bed

Admission and day: diagnosis; day of stay; trajectory

Comorbidities and current medications that matter today, including anything with a timing the oncoming nurse must know

Allergies and code status; identity and allergy checks required by bedside policy

An event earlier in the admission that changes today's plan: what happened; why; what was done

Something being weaned or progressing

A risk being monitored: skin, falls, nutrition, or other

Lines and devices, with dates

Current vital signs

Pending today, each with an owner and a time: rounds; reviews; checks; changes

Contingencies, per your protocols: if the evening check is abnormal, what happens and who is told; if the vital signs change, when to call

Patient agreement about family presence and what may be shared: person, topic and limits

The family member's questions: discharge; a private word

Sensitive finding for a planned private discussion: selected finding; what the patient knows; what the nurse can explain; clinician who has agreed to discuss it and the appropriate time; action if delayed

## EDUCATOR MASTER CARD - FRAME 3: A CRITICAL RESULT

Complete from reviewed material. Give the learner facts and policy only; keep expected answers and future orders separate.

Patient: name; age; second identifier; bed

Admission and day

Allergies and code status

The condition and, if applicable, the medications that make this result more likely or more dangerous

The result: test; value flagged critical by your laboratory; sample time

The previous value and when

What the laboratory confirms about the sample: that the common spurious cause has been excluded

Current vital signs, normal

The concern the nurse should state

The expected ask: required actions and assessment; appropriate responder and time required by the reviewed case/pathway; next step if that response is unavailable

The receiver's orders after agreement: time-specific actions, assessment plan and call-back requirements from the institution's reviewed case and policy

Critical-result policy elements from the policy card: receipt and reporting times; caller and recipient; value and units; read-back confirmation; actions and follow-up

## ESCALATION CALL CHECKLIST (FRAMES 1 AND 3)

Scenario: _____ Date: _____

Caller: _____ Observer: _____ Receiver: _____ Attempt: 1 / 2

Done: all described parts demonstrated. Not done: a part is missing; note what was present and missing. Record supplied cues as prompts. If there was no opportunity, leave the mark blank and write No opportunity with a reason. No total or pass score. Example: an action without a time is Done for the action row, Not done for timing.

| # | Behavior | Done / Not done | What I heard |
|---|---|---|---|
| 1 | Identifies self, role and unit, and the patient by name and the local second identifier | | |
| 2 | States the reason for the call and the level of concern in the first two sentences | | |
| 3 | Declares the call type: urgent, update, advice, or critical result | | |
| 4 | Gives available baseline findings and the change over time | | |
| 5 | Includes the history, medications, allergies and results that change the decision | | |
| 6 | Leaves out what does not | | |
| 7 | Reports current findings with the trend (and the early-warning score where used) | | |
| 8 | States a clinical concern or working problem, even when uncertain | | |
| 9 | Asks for a specific action | | |
| 10 | States a time frame | | |
| 11 | Agrees a contingency from the policy card for deterioration or delayed help | | |
| 12 | Answers clarifying questions without losing the structure | | |
| 13 | Holds the concern when dismissed and escalates by the policy card's chain | | |
| 14 | Records orders, reads them back with timing, and obtains confirmation or correction | | |
| 15 | Documents per the policy card | | |
| 16 | Activates emergency help without waiting when indicated; otherwise note No opportunity | | |

## SHIFT HANDOFF CHECKLIST (FRAME 2)

Scenario: _____ Date: _____

Outgoing nurse: _____ Observer: _____ Oncoming nurse: _____ Attempt: 1 / 2

Done: all described parts demonstrated. Not done: a part is missing; note what was present and missing. Record supplied cues as prompts. If there was no opportunity, leave the mark blank and write No opportunity with a reason. No total or pass score. Example: an action without a time is Done for the action row, Not done for timing.

| # | Behavior | Done / Not done | What I heard |
|---|---|---|---|
| 1 | Introduces the oncoming nurse; confirms who the patient wants present | | |
| 2 | Identifies the patient by name and the local second identifier; states the day and trajectory in one sentence | | |
| 3 | Includes the history, medications, allergies and events that change today's care | | |
| 4 | Leaves out what does not | | |
| 5 | Reports current status with the trend | | |
| 6 | States the risks being monitored | | |
| 7 | Gives every pending item an owner and a time | | |
| 8 | States what to watch and the contingency for each | | |
| 9 | Does the safety checks on the policy card together | | |
| 10 | Uses plain language and invites the patient to add or correct | | |
| 11 | Handles the selected sensitive finding honestly, with privacy and the agreed discussion plan | | |
| 12 | Confirms what the patient agrees may be shared, answers the family member with a specific commitment, and returns to the handoff | | |
| 13 | The receiver summarizes the plan, and the summary matches | | |

## THE RECEIVER'S TEST - ESCALATION CALL (FRAMES 1 AND 3)

Answered by the person who played the receiver.

Did I know how urgent this was from the opening? Yes / No

What did I still need to ask before I could decide?

Should the caller have covered it without being asked? Yes / No

## THE RECEIVER'S TEST - SHIFT HANDOFF (FRAME 2)

Answered by the person who played the receiver.

Could I take over this patient's shift from the handoff alone? Yes / No

What did I still need to ask? Should the outgoing nurse have covered it? Yes / No

Do I know what to watch, and what to do if it changes? Yes / No

## OVERALL (BOTH CHECKLISTS)

One thing that worked:

One change for the second attempt:

## LEARNER SELF-CHECK - ESCALATION CALL

Complete this before anyone gives you feedback.

1. Did emergency criteria require activation before the call?
2. Did I say why I was calling before any history?
3. Did I say how worried I was, in words?
4. Which three facts did I choose to leave out?
5. Did I state my concern, or only the numbers?
6. What exactly did I ask for, and by when?
7. What did the receiver say back, and did I repeat it?
8. If the receiver had said "wait and watch", what would I have said?
9. What will I change on the next attempt?

## LEARNER SELF-CHECK - SHIFT HANDOFF

Complete this before anyone gives you feedback.

1. Did I state today's priorities before the history?
2. Which three facts did I choose to leave out?
3. Did every pending item leave with an owner and a time?
4. What did I decide not to say at the bedside, and why?
5. What would the patient say they learned from the handoff?
6. Did the receiver's summary match my plan?
7. What will I change on the next attempt?

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