



# Critical Conversations:

## Using the SBAR Communication Tool to Prevent Medication Errors

### Part 1 Training Participant Quiz

This quiz will be monitored. A score of 80% is required to pass the training.

#### Grand Garden Medical Center

Staff Name: \_\_\_\_\_ Date: \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

This participant quiz must be submitted to your supervisor, no later than: \_\_\_\_\_

#### Section 1: Knowledge and Understanding (10 points)

**Instructions:** Circle the correct answer for each multiple choice or true/false question.

**1. What is the main goal of using SBAR in healthcare communication?**

- a) to complete documentation faster
- b) to create detailed care plans
- c) to ensure clear, concise, and structured communication
- d) to provide emotional support to patients

**2. Which component of SBAR includes your professional judgment about the situation?**

- a) situation
- b) recommendation
- c) background
- d) assessment

**3. Which of the following would be least appropriate in the “Assessment” section?**

- a) “Blood pressure is dropping despite IV fluids.”
- b) “She likely has an infection due to fever and elevated WBC.”
- c) “The patient has new confusion, different from baseline.”
- d) “We should increase the pain medication dosage to alleviate the pain.”

**4. Which is the best description of the “Background” component?**

- a) focuses on what’s currently happening
- b) includes your recommendation for next steps
- c) provides relevant medical context and history
- d) summarizes the patient's lab values

**5. Which of the following would be least appropriate in the "Situation" section?**

- a) "The patient is experiencing chest pain."
- b) "The patient's heart rate is elevated."
- c) "I think we should run more tests."
- d) "He's short of breath and diaphoretic."

**Section 2: Application Scenario (12 Points)**

**Instructions:** Read the scenario below and answer the following questions.

**Scenario**

During a night shift, Nurse A handed off a patient to Nurse B, stating the patient was "doing fine" but leaving out a recent medication change and changes in vital signs. Nurse B was delayed in checking the chart and assessing the patient due to multiple high-acuity demands. When she did assess the patient, she found hypotension and bradycardia. Unaware of the medication change, she delayed notifying the provider, and the patient required emergency intervention.

**1. Which components of SBAR were missing or incomplete during the handoff from Nurse A to Nurse B? (2 pt)**

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**2. How could using the SBAR tool have changed the outcome of this situation? Explain how using the tool might have led to earlier intervention for this patient. (2 pt)**

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**3. What specific information should Nurse A have included in the "Background" section of SBAR? (2 pt)**

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**4. What should Nurse B's "Assessment" and "Recommendation" have included once she discovered abnormal vital signs? (2 pt)**

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**5. If you were Nurse B in this situation, how would you use SBAR to communicate with the provider after discovering the abnormal vitals? Outline a brief SBAR response. (5 pts)**

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