Six Letters, Two Of Them R

and the second R carries two obligations — repeat the order back, and document the communication.



What goes in each letter

OPEN RN 2.4

Introduction · Situation · Background · Assessment · Request and Recommendations · Repeat back.

I — INTRODUCTION
Your name, your role, and the agency you are calling from

S — SITUATION
Name and location, why you are calling, recent vitals, status

B — BACKGROUND
Admitting diagnoses, code status, recent labs, allergies

A — ASSESSMENT
Abnormal findings — and your evaluation of the situation
Both halves. The evaluation is the half students omit.

R — REQUEST
What you would like the provider to do
Reassess, order a lab or diagnostic, prescribe or change a medication.

R — REPEAT BACK
Confirm the order aloud, then chart the call

The second R, in full: *"If you are receiving new orders, repeat them to confirm accuracy. Be sure to document communication with the provider in the client's chart."* And §1.6 says what that documentation must contain — **date, time, person notified, follow-up actions taken**.

ISBARR or SBAR — both are in the same 2024 book

2.4 AND 5.3 VS 1.3

This is not a disagreement about the tool. It is the difference between the full nurse-to-provider version and the four-letter shorthand.

§2.4, §5.3 and both glossaries — **ISBARR**, six letters, with **Request/ Recommendations** then **Repeat back**.

§1.3, same book — *"SBAR (Situation, Background, Assessment, and Recommendation)"*, four letters, no Introduction and no Repeat back.

Answer with ISBARR and its six components. §2.4 is the section that **teaches** the tool and defines it three times across the book; §1.3 mentions it in passing as an example of a National Patient Safety Goal in action. §2.4 itself acknowledges the short form — ISBARR *"or a simpler version called SBAR."*