



SBAR Communication Tool

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- Background
- Communication Tools
- What is SBAR
- SBAR in action



- Studies have shown that over 80% of avoidable adverse events are as a direct result of the failure to hand over effectively.



International literature demonstrates that 11% of hospital deaths can be attributed to patient deterioration not recognized or acted upon.

National Patient Safety Agency (2007) Patient deterioration not recognized in hospitalized patients.



Factors that contribute towards failure to identify & manage deteriorating patient.

- Uncertainty about when to call for assistance
- Delays by medical staff in responding to notification
- Ineffective communication and handover of critically ill patients
- Ineffective communication when alerting to concerns about patient condition



These factors may be compounded by

- Heavy workload
- Lack of confidence
- Inexperience of working in a particular ward
- Reluctance to disturb more senior clinicians 'unnecessarily'
- Fear of being reprimanded
- Distractions and interruptions



Where do things fall through the cracks?

- Systems – Information, test results, diagnosis.
- Communication – handovers, transitions in care.
- Failure to plan, failure to recognise, failure to rescue.



- A study in the United States of over 500 hospitals, found that between 25% - 40% of nurses would be reluctant to confront or challenge a doctor if they observed a doctor doing something wrong.



How to overcome these barriers :

- SBAR
- Assertion / critical language skills
- Rapid Response Teams
- Leadership walk around



Effective communication requires:

- Structured communication – SBAR
- Assertion / critical language – key words, the ability to speak up and stop the show e.g. “I just need a little clarity”
- Psychological safety
- Effective leadership
- An environment of respect



Aims of SBAR

- Provides a framework for communication between members of the health care team about a patient's condition.
- It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team.



Uses & Settings for SBAR

- Inpatient or outpatient
- Urgent or non urgent communications
- Conversations with a physician, either in person or over the phone
- Discussions with allied health professionals
- Conversations with peers - e.g. Change of shift report
- Escalating a concern
- Handover from an ambulance crew to hospital staff



What is SBAR?





- SBAR is a structured method for communicating critical information that requires immediate attention and action
- SBAR improve communication, effective escalation and increased safety
- Its use is well established in many settings including the military, aviation and some acute medical environments
- SBAR has 4 steps
 - **S**ituation
 - **B**ackground
 - **A**ssessment
 - **R**ecommendation

SITUATION , BACKGROUND, ASSESSMENT, RECOMMENDATION (SBAR)

SBAR a communication tool for health professionals re issues/concerns about a patient

Have available the following when speaking with the Health Professional: –

- The patient's medical record, most recent vital signs;
- List of current medications, allergies, IV fluids and pathology, and
- Reporting pathology results: provide the date, time test was done and results of previous tests for comparison

	<p>Situation I am calling about ... (state patient name and location.) The patient's condition is... (code status) The issue / problem I am calling about is _____. I have just assessed the patient personally: Vital signs are: Blood pressure _____/_____, Pulse _____, Respiration _____ and temperature _____ I am concerned about the: (state the abnormal findings e.g.)</p> <ul style="list-style-type: none"> • Blood pressure because it is over 180 or less than 90 or 30 mmHg below usual • Pulse because it is over 140 or less than 40 • Respiration because it is less than 10 or over 30. • Temperature because it is less than 35.5 or over 38.
	<p>Background The patient's mental status is: (give examples e.g.) Alert and oriented to person place and time Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation. The skin is: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm The patient is not or is on oxygen. The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____ % The oximeter does not detect a good pulse and is giving erratic readings.</p> <div data-bbox="1222 532 1802 818" style="background-color: #ffcccc; padding: 5px;"> <p>SBAR is a communication tool that can be used by any / every discipline, and in any situation – routine or emergency. Routine examples include: –</p> <ul style="list-style-type: none"> • Ward nurse to pharmacy re D/C medications • Medical to allied health referral • Hospital to community referral <p>See main section for examples</p> </div>
	<p>Assessment This is what I think the problem is: (say what you think is the problem). e.g.</p> <ul style="list-style-type: none"> • The problem seems to be cardiac / infection / neurologic / respiratory _____ • I am not sure what the problem is but the patient is deteriorating. • The patient seems to be unstable and may get worse, we need to do something.
	<p>Recommendation I suggest or request that you (say what you would like to see done), e.g.</p> <ul style="list-style-type: none"> • Transfer the patient to critical care; • Come to see the patient at this time; • Talk to the patient or family about code status; • Ask the on-call family practice resident to see the patient now, or • Ask for a consultant to see the patient now. <p>Are any tests needed:</p> <ul style="list-style-type: none"> • Ask - Do you need any tests like CXR, ABG, ECG, FBC, or E/LFT's or others <p>If a change in treatment is ordered then ask:</p> <ol style="list-style-type: none"> 1. How often do you want vital signs taken & recorded? 2. How long to you expect this problem will last? 3. If the patient does not get better when would you want us to call again?



Implementing SBAR

If SBAR is a process that could add real value to patients and staff, the next questions are:

- How do we make SBAR the norm in the organisation or team?
- How will we know it has improved care?



Why take a structured approach to implementation?

- Clarify exactly what your team or organisation wants to accomplish through SBAR
- Allow you to measure and demonstrate its true impact for patients and staff
- Give you a chance to modify or change your approach if it's not working or could be even better.



Using the Model for Improvement

The Model for Improvement is based on 'Plan, Do, Study, Act (PDSA) cycles.

- It will take you through three key questions and four key steps (PDSA):
 - What are we trying to accomplish?
 - How will we know that a change is an improvement?
 - What change can we make that will result in improvement?



Answering the 3 Key Questions -

- Agree and communicate a clear aim for SBAR
- Decide how you will measure the Improvements
- Decide which SBAR tools to test: e.g. SBAR aide memoire pads
- An example aim for SBAR might be:
For SBAR to be the way everything which requires an urgent response is escalated in this organisation



Measuring SBAR does not have to be complicated

A simple value and efficiency measure might be:

- Reduction in handover time using SBAR.
- Number of staff who report using SBAR each week.
- A safety and reliability of care measure might include seeking regular feedback from clinicians about whether urgent issues are being clearly and concisely articulated.



Plan Checklist:

- Get strong, visible leadership from your senior managers and clinical champions.
- Decide where to start your SBAR test
- Review the SBAR tools and agree which you will use.
- Decide how you will train staff to use the SBAR process and tools.
- Plan how you will assess the competency of staff using SBAR.
- Communicate your decisions widely.



Do Checklist:

- Deliver SBAR training to all staff
- Provide a safe environment and opportunities for staff to practice and develop their SBAR skills during non-critical communications.
- Emphasise that the point is to experiment, to try ideas that the team wants to test.
- Monitor the progress of staff practicing SBAR
- Be sure to brief or train *all* those likely to receive SBAR communications.
- Keep communicating about your progress.



Study Checklist:

- Assess the impact of SBAR using your set of agreed measures.
- Collect feedback from staff.
- Gain regular feedback from clinicians.
- Review the SBAR tool with the test team.
- Don't lose momentum



Act Checklist

- Decide if your SBAR tool is ready to be implemented.
- Plan how you will roll it out to the wider department or organisation.
- Have a training pack readily available.
- How you will sustain the use of the tool in the long term.



Training staff to use SBAR

- Incorporating SBAR within an organisation or team will require training and commitment from the top down and bottom up.
- It can take time and effort to change the way people communicate, particularly with senior staff.



Some examples of SBAR in action....



Nurse's View of Life:

- 55 year old man with Hypertension, admitted for Gastro Intestinal Bleed who has received 2 units of blood, last haematocrit 31. Vital Signs: BP 90/50, Pulse 120. Patient is now looking pale, sweaty.
- Patient states that he feels confused and weak, some problem with “heavy chest”



Physician's View of Life

- Working a 24 hour call, busy service, late PM
- Currently working on an Emergency Department patient:
 - 65 year old Diabetic with productive cough, fever, chills. History of angina.
 - Heart Rate 127, Blood Pressure 78/40



Example SBAR briefing

- **Situation:** Dr. Jones, this is Nurse Smith on 2 East. I am calling about Mr Murphy in room 214, who was admitted yesterday. He is a 55 year old man who looks pale, sweaty and is complaining of chest pressure
- **Background:** He has a past history of Hypertension and was admitted yesterday for Gastro Intestinal bleed. He has received 2 units of blood, with his last haematocrit two hours ago being 31. His vital signs on admission were BP 102/80, pulse 94, Respirations 16 and O2 Sats 98% on room air, however his vitals have deteriorated and are now: BP 90/50, Pulse 124, Respiration Rate 28, and O2 Sats is 92% on room air.
- **Assessment:** I think he may have an active bleed and we can't rule out a Myocardial Infarction but we don't have a troponin or a recent haemoglobin & haematocrit.
- **Recommendation:** I have commenced him on O2 via nasal cannula. I'd like to get an EKG and additional labs – including a Troponin and H&H. I need for you to evaluate him right away. Is there anything else you would like me to do in the meantime?



Observer Check List:

- Got the person's attention
- Made eye contact, faced the person
- Used person's name
- Expressed Concern
- Stated the problem (clear, concise)
- Proposed action
- Re-asserted as necessary
- Reached decision
- Escalated if necessary

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Thank you....

Questions?