SBAR

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Ms. Iyer's two decades of involvement in helping attorneys handle medical and nursing malpractice cases has sparked her desire to help healthcare facilities avoid the kinds of errors that result in patient injury.

In 2015, Pat sold Med League, an independent legal nurse consulting business she established in 1989.

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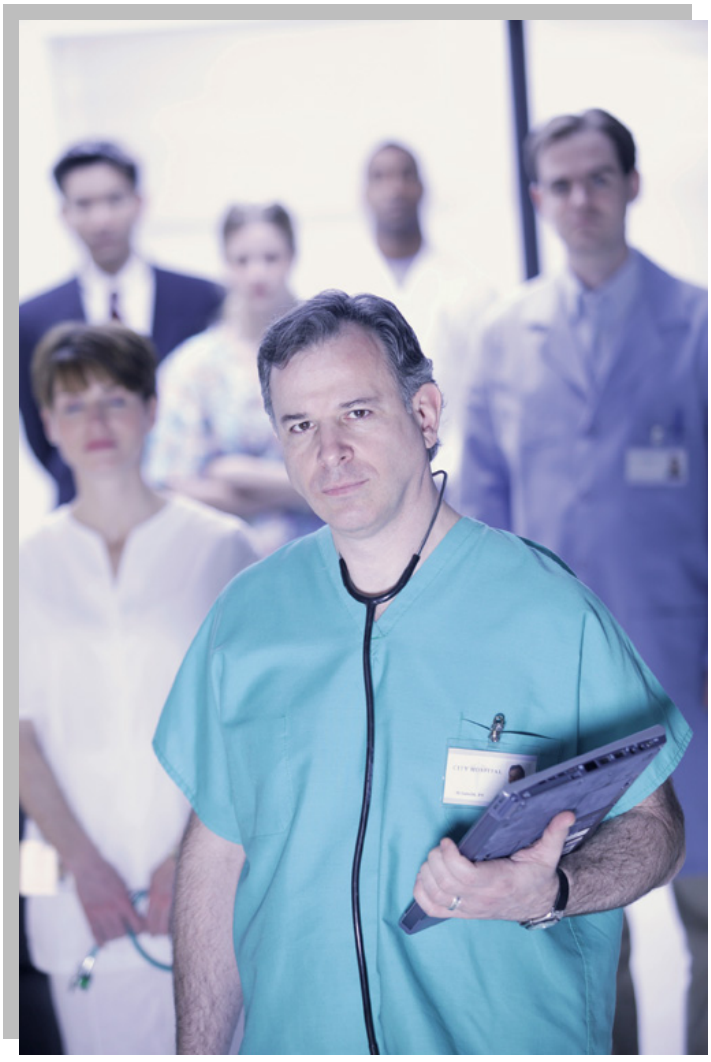

Chapter One: What Is SBAR?

Pronounced ***S-Bar***, this term refers to a methodology that was designed to ensure effective, accurate, mistake-free communication between medical staff and each other as well as with physicians and other healthcare professionals. It also promotes upfront dialog with the patients under their care.

Healthcare organizations are highly complex. They have been compared to high-reliability organizations (HROs) where individuals working together in high-acuity situations face great potential for error and disastrous consequences. High-reliability organizations consistently deliver care and positive results with minimal errors. Unfortunately, health care today can hardly qualify as an HRO. [1]

Proper medical care relies on precise communication. In order to coordinate any patient treatment, the professionals involved must interrelate with clarity. Nothing less is sufficient. Any unclear message, whether it is a question on how to interpret orders, or an action that was not logged in properly, or an inaccurate deciphering of handwriting, can be detrimental to a patient's well being in the least, and deadly at most.

SBAR may be used in written or oral communication. Written communication is necessary because, most of the time, not all of the parties involved in the patient's care can be present to verbally tell each other what steps have been taken thus far, what needs to be done, and what changes have been made in the person's treatment plan. Even staff and shift meetings can leave out an essential person who happens to be elsewhere at the time. Physicians may be in surgery or off the floor. Nursing staff may be off shift. Lab and X-ray techs may be in another building, therapists with other patients.

Therefore, all must rely on accurate, easy to understand written communication. Medical records must be readily accessible, clear in meaning, and precise in recording. Charting is a necessary function. As time consuming as it is, it must be done as close to the event as possible. The longer the period between the event and the charting of it, the greater the risk of inaccurate or incomplete documentation.

Every clinic, office and hospital has its own forms and systems it has developed over the years to improve the quality of staff communication.

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[1] Sundar, E., Sundar S. , Pawlowski, J. et al, Crew Resource Management and Team Training, *Anesthesiology Clinics*, 25 (2007) 283-300

Medical record keeping is hardly a new innovation. However, with the complexity of the medical field today, the various specialties and sub-specialties, the patient load and the scrutiny of insurance companies, and managers and attorneys looking for information, it is more paramount than ever for the medical records and communication to be error-free.

To err may be human and forgiveness divine, but when it comes to a person's life and well being, the stakes are raised.

Everyone who has been associated with patient care, whether directly or indirectly, has a horror story of what happened when communications broke down. Jobs can be lost, and so can patients.

Stories of injuries to patients are found in newspapers, on the internet, and in state and national jury verdict reports. One such publication, *Medical Malpractice Verdicts, Settlements and Experts*, reported the following case:

> An eighty-eight year-old man sustained bowel and bladder incontinence and neurological difficulties in his legs after undergoing spinal surgery. The man's anticoagulation medication had been resumed after surgery and he developed bleeding, which led to a compression of nerve roots, leading to the problems. The plaintiff claimed that the nurses did not recognize and inform doctors of the symptoms in time to prevent the injuries. A $1.8 million verdict was returned against the hospital only. [2]

This case involved a lack of critical thinking as well as a failure to communicate.

Definition and Origins

What does SBAR mean? It is an acronym for a formalized communication technique that is quickly becoming the standardized method in major hospitals and clinics throughout the United States. It stands for -

- ✓ **Situation**
- ✓ **Background**
- ✓ **Assessment**
- ✓ **Recommendation**

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[2] John Simcich et al v. George DePhillips, MD et al, LaSalle County (Il) Circuit Court, Case No. 06 L 34, reported in Laska, L. *Medical Malpractice Verdicts, Settlements, and Experts*, December 2009, p. 17

Originally established as a standard operating procedure of communication between the captain and the crew on US Naval submarines, this methodology was adopted by Kaiser Permanente of Colorado several years ago to be used within the medical field in an effort to slash the rising statistics of human error. Based in Oakland, California, this organization operates 30 medical centers. It was instrumental in pioneering SBAR as a model to assist both the nurses and doctors to systematize their thoughts so they could convey the most critical information in under one minute.

Each recorded medical update starts out with describing the **situation** surrounding the need for care, gives the **background** pertinent to that care, **assesses** what needs to be done and provides a **recommendation** as to a proper plan of action.

How SBAR Differs from SOAP

For decades, nursing and medical schools taught how to implement a method of charting known as SOAP. This is another acronym that means

- ✓ **Subjective**
- ✓ **Objective**
- ✓ **Assessment**
- ✓ **Plan**

The *subjective* describes patients' current state in their own words. "My throat feels scratchy and I ache all over." If the provider charts on a new symptom, or a new patient, an HPI or History of Present Illness is taken. This includes familial history, history of previous illnesses and surgeries, what medications the patient is taking, allergies, social history, etc. Some faculty taught what goes into the Subjective Report should always include O-L-D-C-H-A-R-T-S (Onset, Location, Duration, Character, Aggravating factors, Radiation of symptoms, Temporal pattern, Symptoms associated).

The *objective* component is what could be clinically measured as accurate. This included vital signs, X-rays, lab work results, physical examination, measurements, etc. A list of possible diagnoses ranging from most probable to least likely was often included as a precaution.

Finally an *assessment* of the situation or diagnosis and a *plan* of treatment is decided upon and logged in to the chart as well.

SOAP functions well, especially in an initial evaluation phase. However, what comes after the treatment? What if there is an adverse reaction, or no improvement, or a complicating incident? What if an error in communication occurs, an infection develops, or another underlying symptom crops up?

SBAR is a better model because it can be applied to every situation from the initial evaluation to the final orders, to discharge from care. SBAR facilitates a built-in pattern of communication and through the final action/recommendation - instills a sense of team work.

Let's take an example. Say that Mr. Sanchez receives a medication prescribed by the physician on rounds. Within ten minutes of its administration, he develops a rash on his chest and abdomen and starts exhibiting diaphoresis.

The nurse calls the physician to report the incident, giving his or her name, the patient's name, and a brief description of the ***situation***.

> "Dr Smith, this is Delores Schwartz on 4 South at Mercy Hospital. This is the situation. Mr. Jorge Sanchez in 420B at 10:05 this morning received the dose of 0.5 mg Xanax you prescribed for anxiety on your morning rounds. At 10:15 this morning, he buzzed the floor nurse complaining of sweating and itching on his chest."

Then a brief ***background*** is given. This is two-fold. It clarifies the patient's history, so there is certainty the right patient is being discussed, and it reminds all personnel involved of the patient's history and condition leading up to the incident.

> "Here is his background. As you know, Mr. Sanchez was admitted over the weekend for shortness of breath and chest pains. His EKG was unremarkable, but he had just lost his job, has a wife on disability, and has a son in Iraq. He has a reported history of medication sensitivity and is allergic to Codeine, penicillin and peanuts. He reports not sleeping well for the past month, and having bouts of severe indigestion. His vital signs are 185/96 with a respiration of 28 and a pulse of 82. Medication was verified as correct in quantity and dosage prior to administration via bracelet ID."

The ***assessment*** of the situation is given next. The nurse gives an analysis of the situation based on her observation and expertise.

> "My assessment is that the patient seems anxious, having had bad reactions to medications in the past. His wife is here with him. He does have small reddish blotches on his abdomen and they are spreading upwards into his chest. He is scratching vigorously. He is diaphoretic and his palms are clammy. His speech is clear and his tongue does not appear to be swelling. He can swallow without trouble and breathing is shallow but not labored."

Finally, the nurse gives her ***recommendation*** of what she believes would be the best course of action. The nurse is not telling the doctor what to do, but clarifying options. This is often offered in a form of a question. Additionally, the nurse offers the listener a chance to ask questions.

> "I would recommend he be prescribed Benadryl and a cortisone cream, or do you want us to run lab work, or do you wish to return and re-evaluate him? Do you have any questions?"

This e-book fully describes the SBAR technique, describes its benefits, and provides suggestions on how to implement it in any medical setting from critical care to a primary clinic to home health visits. Anywhere there is contact with patients as well as caregivers, this method of oral and written communication may be of benefit.

Chapter Two: Benefits of SBAR

Chapter Two: Benefits of SBAR

SBAR has several benefits. It

- ✓ **Reduces medical error**
- ✓ **Promotes clarity of communication between providers**
- ✓ **Encourages good listening skills**
- ✓ **Fosters effective teamwork**
- ✓ **Standardizes handoffs**
- ✓ **Reduces medical and nursing malpractice lawsuits**

A. SBAR Reduces Medical Error

The release of "To Err is Human" shocked the public with the statistic that there were an estimated 44,000-98,000 deaths contributed to medical errors.[3] That would be the equivalent of one 747 jetliner full to the capacity of 250 passengers crashing each day for approximately 13 months. The data that formed this conclusion was collected in the Harvard Medical Practice Study, which conducted a study in the early 1980s. It studied hospital records of a random sample of 30,000 patients from 51 hospitals located in New York State. The conclusion was astonishing. After combing over the medical records and calculating the data, the researchers predicted if this was a true representation of the level of care throughout the USA, that an estimated 1.3 million patients nationwide could be injured due to human error in one year, and of that number, 120,000 of them would die as a result. The cost of treating these adverse effects at that time was estimated to be above 50 billion dollars. Because medicine has continued to become more complex and diversified in the last twenty-five years, if the same survey was conducted today, the statistics could be close to double the findings in 1984 in both the number of patients and the total cost of treatment. And, that does not include any litigation fees or rewards, nor did the study look at care in outpatient settings, nursing homes, doctor's offices, and so on.

The study was not designed to collect data from any source other than hospital charts, and thus did not include errors that might have occurred but were not recorded.

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[3] *SBAR: A Technique for Improved Communication*, Donna Anderson, Ph.D., RN, Project Coordinator HHQIOSC, of PA, in a report for Home Heath Quality Improvement National Campaign 2007

We know, therefore, that the rate of medical error is far higher than that reported by the Harvard Practice Study.

The Wall Street Journal reported that, when questioned in a survey, 9% of surgeons admitted to having made a major error in the past three months.[4] The renowned publication reported that the survey was sponsored by the American College of Surgeons in which over 25,000 surveys were randomly mailed to surgeons. The tabulation was conducted based upon the 8,000 that were returned. Of the number that participated, 40% of these surgeons admitted they were "burned out" and 30% showed clinical signs of depression.

The Joint Commission's (The JC) analysis of the causes of sentinel or untoward events shows that communication is the most common reason why medical errors occur. [5] Miscommunication may occur because of:

- ✓ **Failure to communicate**
- ✓ **Delay in communicating**
- ✓ **Incomplete information provided**
- ✓ **Misunderstanding of information**
- ✓ **Fatigue**
- ✓ **Distraction**

B. SBAR Promotes Clarity of Communication Between Providers

Increased technology and complexity of care increase the risk of error. Advances in medicine create diverse and complex tasks and personnel must be qualified to perform them.

Specialties and subspecialties unheard of two generations ago are standard now. It is not uncommon for one patient in a hospital setting to have contact with six to ten staff members per day. In an office setting, it is likely the patient will come into contact with two to five staff members, depending on the specialty and patient load. All of those people need to be on top of what is going on currently with that patient and what the patient's history is, from diagnosis to dietary needs, to medication orders, to wound care, to mental status and beyond.

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[4] *Nine Percent of Surgeons Have Made 'Major' Errors Recently*, Wall Street Journal, November 23, 2009

[5] *The Joint Commission 2007 Annual Report* at www.jointcommission.org

In many operating rooms, for example, surgeons are required to visit with the patient prior to pre-anesthesia medication administration so they can discuss the procedure and literally mark the area for the incision. This reduces the chances of surgical errors such as making the incision on the wrong side of the body.

Wrong site surgery is the number one most common sentinel event. It comprises 13.5% of all reported sentinel events as of September 2009. [6]

In some medical centers, standard operating procedures require that two nursing staff must verify critical medication, such as insulin or chemotherapy, prior to administration. Electronic monitoring on ID bracelets similar to the UPC codes in grocery markets are often used to verify patient identity and order filling accuracy. Modern technology keeps coming up with ways to reduce errors. Yet, they still occur.

One reason for error, The JC discovered, is confusing abbreviations in orders. For example, **IU** (the standard abbreviation for international units) can look like **IV** (for intravenous). **I** can be a Roman numeral for the number one, or a capital letter. **Q.D.** (Latin for per day), **Q.O.D.** (meaning every other day) and **Q.I.D.** (meaning four times a day) can be confused with each other, leading to under-dosing, or over-dosing of medication.

Because they can be so easily misinterpreted, JC standards now frown on the use of certain abbreviations in record keeping and prescriptions. On April 4, 2004, the national patient safety goal was established that every organization must have spelled out "do not use" examples of abbreviations in their protocol. Many facilities have included the “do not use” abbreviations on preprinted order forms, progress notes, and within computerized documentation. This important safety feature was incorporated into the accreditation standard in 2010.

For a list of the most common "do not use" abbreviations, go to the website for the Institute of Safe Medication Practices at http://ismp.org.

In today’s world of texting and tweeting, abbreviations are standard in the world, but they should not be in the medical setting. Prescribers’ handwriting can be illegible and abbreviations just lead to more chances to misinterpret the medication administration and other orders.

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[6] www.jointcommission.org/sentineleventstatistics

By using the SBAR method, there is clarity.

SBAR is useful when two professionals of the same background (physician to physician, nurse to nurse) are communicating about a situation that needs attention. It is also essential when a nurse communicates with a physician about a change or need of a patient. "The SBAR tool provides a template for communicating information rapidly and allows the individual communicating to make a strong recommendation for action." [7] Both the nurse and the physician have been trained to follow the logical progression of documentation. It is an orderly, detailed recounting of the patient's care, condition and complications.

Once the orders are confirmed, they are referred to in subsequent nursing documentation so anyone else can see the conclusion of the episode, or follow-up knowing they are fully aware of what was going on.

That just seems logical. However, having a specified pattern not only sets a standard, but it helps ensure protocol is followed and that appropriate treatment is warranted.

It is a fact. Nurses and physicians communicate differently, and that often leads to stress and strife.

Nurses want to be thorough and report in a narrative style, whereas doctors, due to their time restraints, tend to communicate more in bullet points. SBAR can enhance communication between nurse and physician because both have a clearer understanding of what should be in the conversation or message.

For the physician, the process answers three major questions.

- ✓ What is the problem that needs to be addressed?
- ✓ What do you need me to do about it?
- ✓ When do I have to respond?

Some healthcare providers have found SBAR easier to remember when retranslated into key questions such as

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[7] Nielsen, P. and Mann, S. Team Function In Obstetrics to Reduce Errors and Improve Outcomes, *Obstetrics and Gynecology Clinics of North America*, 15 (2008) 81-95

- ✓ What is happening?
- ✓ What is the clinical background?
- ✓ What do I think the problem is?
- ✓ What would I recommend?

Let's look at another example of a lawsuit involving communication.

> An eighty-eight year-old woman who suffered an arm fracture was admitted to St. John Detroit Riverview Hospital for surgery. She was transferred to the inpatient rehabilitation area after five days. She complained of pain in the right shoulder and cramping in her left leg; subcutaneous Heparin was ordered. She experienced a drop in blood pressure after two days. An EKG and CT scan were ordered. The patient became diaphoretic with shortness of breath and dyspnea. She became unresponsive and was transferred to ICU. She died that day due to a pulmonary embolism. The plaintiff alleged negligence in the failure to timely diagnose and treat the embolism. The hospital and one of the doctors settled for $112,500 and the other defendants were dismissed. [8]

Given the facts above, let's outline a typical SBAR formulated communiqué. This is a hypothetical conversation:

> Barbara Kingley RN calls Doctor Sarah Smith about her patient Nancy Logan. "Doctor Smith, this is Barbara Kingley at St. John Health System Riverview Hospital, 2 North. I am calling in reference to your patient, Nancy Logan. Here is the <u>situation</u>: Mrs. Logan is having increased dyspnea." **(S)**
>
> "The supporting <u>background</u> information is this: she had a right arm fracture surgically repaired seven days ago. She was placed on Heparin subcutaneously twice a day for complaints of left leg cramps and a suspected deep vein thrombosis. Her blood pressure had been running 150/90 but it is now 100/50. We're awaiting the result of an EKG and CT scan that were done this morning. She is now diaphoretic and has a respiratory rate of 40." **(B)**
>
> ***Note the nurse does not use abbreviations such as BP and SOB.***

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[8] James Logan, Jr. as PR of the Estate of Nancy Logan, decreased v. St. John Health System-Detroit-Macomb Campus d/b/a/ St. John Detroit Riverview Hospital et al, Wayne County (MI) Circuit Court, Case No. 07-713837-NH, in Laska, L. *Medical Malpractice Verdicts, Settlements, and Experts*, December 2009, p. 7

"My assessment of this situation is that she might be having a pulmonary embolism." **(A)**

"I recommend you see her immediately and that we start her on Oxygen 2 liters STAT. Do you agree? Do you have any questions of me?" **(R)**

The nurse feels she has completely explained the whole thing; the doctor feels she has communicated in bullet points (what did doctor communicate?). In a way, both are correct. More importantly, both have a clear understanding of the situation and it has been effeciently passed on. Also, if the doctor is in clinic, and the message is received by her staff, they can triage it and get her on the phone ASAP. Everyone knows the form, what to listen for and how to respond.

By following the **S-B-A-R** pattern in a hospital setting, key information is more likely to be transferred back and forth between the persons treating the patient, writing the orders and doing the rounds. In a clinical or office setting, the same procedure can make the time with the patient more efficient. The doctor can quickly scan the nurse's notes and access the reason for the patient's visit. That means the physician can spend more time treating the patient than chasing down information. The patient feels more confident because the information was related clearly, and the visit has a more positive outcome.

C. SBAR Encourages Good Listening Skills

There are, according to Safe & Sound, [9] six main factors that can impair communication. They are gender, cultural ethnicity, personalities, behavior, literacy and socioeconomics. Each of us has a frame of reference we bring into a conversation. That may be rooted in preconceptions, prejudices or anxieties. For example, in a stat situation, one person may appear to be over-anxious, the other too calm. Both feel they are not being understood by the other because they are not reacting in the same way.

These factors can sometimes become stumbling blocks to effective listening. Going over these can help make staff aware of any listening hang-ups they may have and not really be aware they do. That is when role playing can be a valuable exercise. Couple that with the statistic that the average worker in any situation may be distracted every 3 minutes, [10] and no wonder we often are "listening impaired".

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[9] *SBAR Communication Standardization in Arizona*, offered by Safe & Sound, an Arizona Public Safety Initiative

[10] C-Net News, *Driven to distraction by technology*, http://news.com. reference 2100-1022-3-579028

Hearing and listening are two separate issues. Through using SBAR techniques, listening is enhanced, because the ear and brain are being trained to pick upon the key elements.

Listening skills do not end with our colleagues. Oftentimes, the patients have a hard time explaining exactly what their needs are. The same barriers of gender, ethnicity, behavior, socioeconomics, etc. make communication with the patient difficult as well. It is too often tempting to rely solely on physical data and objective observation and not listen to the patient. Yet it is the patient we are treating, not just a disease or a wound.

The Safe & Sound SBAR Tool Kit offers two distinct ways to communicate with the patient. One is termed **A-I-D-E-T** meaning

A *cknowledge* the patient and family with eye contact and a smile.
I *ntroduce* yourself.
D *uration* of the task or test - let patients know what it is and how long it'll take.
E *xplain* what the procedure will be.
T *hank* the patients for allowing you to touch their bodies, perform the service, etc.

By following this outline, courtesy is extended, the patients are calmed and the procedure is put into the realm of doing something for them, not to them. Likewise, a similar acronym describes its purpose - **R-E-S-P-E-C-T.** This was established at John C. Lincoln Deer Valley Hospital in Phoenix, AZ as a method of communication between staff and patients as well as staff and each other. It means

R *Respect* everyone's role and them as a person.
E *Expect* everyone's participation.
S *Smile* - a simple gesture that speaks volumes.
P *People* - patients, peers and physicians deserve to be treated with respect.
E *Each* time you greet someone for the first time, provide your name.
C *Communicate* before you act.
T *Take* the time to ask if there are any questions before proceeding.

So how do these methods dovetail into the SBAR concept? They promote the four C's - collaboration, cooperation, communication and clarity. Both examples above set an attitude of servitude for each person, making communication productive. Both encourage ongoing dialog, so each situation can be ascertained, and eventually resolved correctly, be it calming a patient down, or reassuring a coworker.

When patients see friendly people working as a team, it relaxes them and gives them confidence they are in the hands of a well-run, caring organization, no matter if it is a hospital unit, a therapy, X-ray or lab facility, an exam room in a clinic, or in their own home with hospice or homecare staff.

By keeping the doors to communication open, when a situation does arise, it can be quickly and efficiently handled. SBAR is the wedge that keeps the door open.

D. SBAR Fosters Team Work

SBAR automatically instills teamwork, coordination of duties, and a clearer understanding of what has occurred, what should take place and what problems need to be addressed and resolved.

As described below, healthcare providers who have implemented this plan over the past five to six years report a significant reduction in error as well as the underlying stress that errors may occur. [11] Leading medical centers throughout the country are seeing a vast reduction in human error and an increase in patient safety. [12] [13] Medical malpractice claims are reduced because patient outcomes are improved, [14] [15] and surveys from patients show a significant increase in confidence.

The result of effectively used SBAR is a well-oiled functioning team and a lot less time wasted on trying to interpret each other's messages. SBAR constitutes a welcome change. Andreas Theodorou, M.D. is the Professor of Clinical Pediatrics and Chief Pediatric Critical Care Medicine at the University of Arizona, and is also Co-Director for the Center for Quality and Safety at the University Medical Center in Tucson. In an article [16] he stated that physicians think it is great because the nurses get straight to the point. All the essential information the doctor needs to make decisions is presented clearly and the guessing game no longer exists.

The nurse does not waste time by not having the basic information available - medical record number, patient name, age, diagnosis, medication list, allergies, vital signs, lab and x-ray results. By being trained in what to gather, provide and relay -

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[11] Arizona Hospital and Healthcare Association, *The Benefits of SBAR*? 2007

[12] Landro, L. *Hospitals Combat Errors at the Hand-Off*, www.post-gazette.com/pg/06179/701770-114.stm#ixzz0Z8krl6K8

[13] www.ihi.org/IHI/Programs

[14] *Improving Patient Safety with Team Training*, www.laedarl.com

[15] Berlinger, N. *Fair compensation without litigation: Addressing patient's financial needs in disclosure*, ASHRM Journal, 2004

[16] See note 9.

- precious time is saved,
- patient care is improved, and
- mistakes are significantly reduced.

A nursing administrator commented: “Of course, the doctors are rushed and want the 'meaty' reason for the call, but when SBAR is consistently done, everyone benefits. The short time needed to use the SBAR technique will pay off in the end by creating a standard for which all communication is based. The lack of communication leads to poor outcomes all the time.” [17] SBAR helps the nursing staff compose a precise and concise statement of the problem. That makes them present as more knowledgeable (which they are) and saves the physician's time (something they covet).

SBAR helps to triage the urgency of the situation. The "if this, then that" protocols become clearer. Time frames can be established and solutions offered. The nurse can clarify what is needed from the physician, and vice versa. The dialog is a productive one. And above all, the patients win: they receive the proper treatment.

Many inexperienced nurses like SBAR because it helps them remain organized and gives them a crutch as they gain skills. It builds their confidence. Veteran nurses also appreciate this system because it gives them more permission to voice their recommendations without sounding too aggressive or know-it-all. It reinforces the concept that the doctor-nurse relationship is a team effort and each role is important in the patient's care and safety.

The more people who are in a team-oriented atmosphere, the more mutual respect develops, and the easier it is to listen to each other's opinions and requests.

In 2005, Abington Memorial Hospital in Pennsylvania began a pilot program implementing SBAR because they found that communication in their critical care unit needed improvement. Duran Schneider, MD., who was one of the program's associate directors, stated that "We've had instances where there have been adverse events, and where we did not see proper communication." [18] Dr. Schneider continued to say it too often became a "he said, she said" issue.

> "We've noted 60% to 70% of medication errors are related to communication, so the way we deliver information and anticipate delivery as

[17] Christina Turner RN, Administrative Resource Coordinator, personal communication 1/12/2010
[15] *SBAR Initiative to Improve Staff Communication,* Healthcare Benchmarks and Quality Improvements, April 2005

a receiver of information can go a long way to alleviating some patient safety problems."

The doctor explained the pilot program was utilizing an SBAR model that had been explained at a conference held by the National Patient Safety Foundation. The hope was that it would achieve a unidirectional form of intercommunication from the ground up the chain to the head of command.

E. SBAR Standardizes Handoffs

Poor communication at the time of hand-offs is implicated in near misses and adverse events in a variety of healthcare contexts, including nursing hand-over, physician sign-out of patients, and emergency medicine shift changes, among others. [19] No act of information exchange in medicine is more important than the patient handoff, which occurs whenever any information about a patient is transferred from one caregiver to another. Ineffective handouts are omnipresent in any busy medical center. The post anesthesia care unit, ICU or nursing units are often seemingly chaotic, noisy places where effective verbal communication or remembered information is rendered difficult if not impossible. Recent reductions in housestaff duty hours have benefitted both residents and their patients, but studies have shown it has also greatly increased the number of hand-offs in academic medical centers. [20]

Often competing priorities and time constraints hamper an effective hand-off, potentially resulting in failures of communication, such as content omissions, which can have a negative impact on patient care. It is during times of transition, such as shift changes, service changes, admission, hospitalization, and discharge that patients' vulnerability is revealed. Patient safety may be compromised.[21]

In 2006, the Wall Street Journal stated that handoffs in hospitals were the Bermuda Triangle of healthcare. [22]

Gaps in information can occur when the patient is transported to another unit, or a shift changes. The article goes on to state

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[19] Arora, V. and Farnan, J. Care Transitions for Hospitalized Patients, *Medical Clinics of North America*, 92 (2008) 315-324

[20] O'Byrne, W., Weavind, L. and Selby, J. The Science and Economics of Improving Clinical Communication, *Anesthesiology Clinics* 26 (2008) 729-744

[21] See note 19

[22] See note 10

"At OSF St. Joseph Medical Center in Bloomington, Ill., cases of harm to patients fell by more than half in the year after the SBAR program was implemented in October 2004."

When everyone is trained to recognize the format, they can have realistic expectations that the vital information on the patient's care will be transmitted throughout the departments. Lab techs can know if a patient has a phobia to needles. Therapists and techs can know each other's schedules and orders so there is less conflicting times booked. Assistants can communicate with floor nurses who can then properly triage patient care priorities. Shift changes run more smoothly, and staff meetings have built in agendas. Each patient is more fully re-evaluated at every shift, orders confirmed and explained, and steps clarified.

What makes this SBAR pattern so useful is it can be developed into a simple fill-in-the-blank form that can become a permanent addition to the chart. The SBAR format can be documented as a written prompt for use during hand-offs. SBAR provides a communication medium having both interpersonal and structured written elements, which has been shown to be more effective than either verbal or written communication alone. [23] Sample forms can be found at the end of this e-book. See also the www.IHI.org website for sample tools.

“Patient hand-offs are more efficient”, according to Peter Angood, MD, who in 2006 was the Vice President and Chief Patient Safety Officer for The JC's International Center for Patient Safety. He stated in December of 2005 that

> ". . . one of the most important areas is handoffs. It's a high-risk period, and there is a tendency to under-communicate." [24]

Hospitals have been adopting the SBAR model as a way to meet the Joint Commission National Patient Safety Goal for standardized hand-offs for physician to physician communication and nursing shift change. [25] Processes must be in place to ensure the most information possible is quickly transferred from one caregiver to another in a hospital setting, especially in care units where the patient's condition can rapidly change. When efficient and timely information is given, there is more time for questions and responses to those questions.

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[23] See note 20

[24] *JCAHO to look closely at patient handoffs: communication lapses will be key focus,* Healthcare Benchmarks and Quality Improvement, Dec 2005

[25] See note 19

Many acute care settings use 12-hour nursing shifts and organized hand-off sessions. In hospitals that have implemented this program, each patient bed is visited during rounds, the situation fully disclosed and the SBAR forms reviewed. Could this be done with tape recorders? Possibly, but the temptation to provide minimum information so a staff member can get off duty remains a key issue. At the end of a grueling shift, people are tired. While the new shift is settling in and trying to listen to taped messages, patients are arriving or calling for help, therapists and techs are on the floor, and doctors are doing rounds. Distractions occur and gaps in information may result.

A change of shift report that uses an SBAR format is instantly recognizable and easily scanned for pertinent information. The form encourages completion of the description of each situation from initial reporting through to the completion of the recommendation given.

In one hospital setting, a pilot program in 2005 consisted of five teams. Each one had a distinct role in ensuring that the clinical information they had was accurate, communicated correctly and current. The five teams were the Continuity of Care team, the Data Elements team, the Performance Standard team, the Transfer of Info team, and the Research and Publication team. Through each team, SBAR was evaluated and assessed for its ability to provide clear communication formats. Feedback was the impetus to revise or revamp the forms. The forms worked. The only addition was a special, separate SBAR form for admission since there was more specific data that needed to be referred back to frequently in order to ensure accuracy of orders. [26]

One hospital developed a peach colored "tag" with the SBAR format as a standard guideline. When a patient was handed off to another floor, unit or department for a procedure, a tag was generated. Each medical staff person during the process was responsible for reading and initialing the tag. [27]

A home health agency developed a form used by the nurse to report to the physician a concerning change about the patient. The form is divided into four sections to correspond to each step of SBAR, and requests that the physician write an order or respond in some way. The use of this type of form facilitates communication between two professionals who may have trouble reaching each other to discuss a patient need.

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[26] See note 7.

[27] At Doctors Hospital in Coral Gables, FL, part of the Baptist South Florida System. Read more at www.post-gazette.com/pg/06179/701770-114.stm#ixzz0ZrnJp59h

However a hospital, clinic, home health or office staff uses SBAR, they can be guaranteed they are complying with The JC's recommendation for a standardized, tested and approved form of communication. Introduced as a national patient safety goal in 2006, handoffs became one of the regulated aspects of communication in 2010 when the goal was absorbed into the standards. As long as the form is adhered to and completed, the staff can have confidence that they did everything feasibly possible to remedy a situation with a patient. That eases tension between departments and makes hand-offs easier between shifts.

Ever play the game "Telephone" or "Whisper down the lane" as a child? The first person whispers a phrase and then the next person tries to parrot it to the next hearer, and so on. The more people who pass on the information, the more jumbled it has a tendency to become. Oral communication just is not as efficient as written communication. Our minds are more trained today to absorb what is written than what is heard.

Study after study shows that since 2004, information quality is consistent and patient safety elevated when staff implement this program. Critical information is passed quickly and miscommunication is minimal. [28]

In December, 2007, the Department of Defense took the SBAR model and developed their own system of hand offs. It is called I PASS THE BATON. [29]

Here is what it stands for -

I *ntroduction* - Introduce yourself and your role/job.

P *atient* - Confirm the patient's name, identifiers, age, sex, and location.
A *ssessment* - Provide your assessment of the patient's chief complaint, vital signs, symptoms, and diagnosis.
S *ituation* - Describe the patient's current status/circumstances, including code status, level of uncertainty, recent changes, response to treatment.
S *afety concerns* - Provide critical lab values/reports, socio-economic factors, allergies, alerts (e.g. falls, isolation).

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[28] See footnotes 9-13, also see www.aiamc.org/public/AIAMC_Hand-offs_resources.pdf
[29] Department of Defense Patient Safety Program. Healthcare Communications Toolkit to Improve Transitions in Care. (2005). Retrieved December 28, 2007, from http://dodpatientsafety.usuhs.mil/files/Handoff_Toolkit.pdf

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B *ackground* - Identify comorbidities, previous episodes, current medications, history.
A *ctions* - Describe actions that were taken or are required AND provide a brief rationale.
T *iming* - Explain the level of urgency, explicit timing, and prioritization of actions.
O *wnership* - Identify who is responsible for the next steps including patient/family responsibilities.
N *ext*—Confirm what will happen next. Anticipated changes? What is the plan?

Their reasoning for establishing this method was explained in the same article -

"Ineffective handoff of information can lead to delays in diagnosis, the wrong treatments, life-threatening adverse events, patient complaints, an increased cost and length of stay, and litigation. Patients are at particular risk for errors during transitions in care. . . Flexible organizations use structured communication tools to decrease the risk to patients during handoffs and transitions in care. During effective handoffs, information, authority, and responsibility are clearly transferred by including an opportunity to ask questions, clarify, and confirm information. The SBAR format is one tool to structure handoffs in care."

Clearly, if the Department of Defense finds the need to improve hand off communications, every hospital should likewise. But it does not stop there. Even primary care physicians in a clinic or office setting can use the SBAR format to dispatch precise notes to the specialists to whom they are referring patients, as well as to Health Maintenance Organizations (HMOs) for approval of the referral.

Any medical organization can benefit from using the SBAR model as a tool to enhance communication, convey vital information in a concise, organized way, and to avoid possible misinterpretation and confusion in handing off care.

F. SBAR Reduces Medical and Nursing Malpractice Lawsuits

Prevention of errors
SBAR is becoming recognized as a standard format that is promoted by leading patient safety researchers and safety-oriented organizations, such as the Institute

for Healthcare Improvement and the Agency for Healthcare Research and Quality. [30]

In everyone's best interest (the patient, physicians and staff), SBAR helps reduce error, identify how to resolve it when it occurs, and provides a line of clear communication. SBAR may by far be the best way to reduce the need for litigation.

Baker, Sterchi, Crowder & Rice, LLC, litigation attorneys in the Kansas City area have this to say -

"We believe the best approach to litigation is prevention. Policies and procedures designed to reduce or eliminate circumstances giving rise to litigation can significantly reduce a company's exposure to claims." [31]

Clearly, a method that reduces errors meets this criteria. One healthcare professional stated that by implementing the SBAR approach at their hospital, litigation was decreased by 30-40% in just 2 years. [32]

Incidence of suits

According to the 10th Annual Hospital Professional Liability and Physician Liability Benchmark Analysis, [33] the number of hospital professional liability claims is increasing and is expected to increase by 1% per year. The study, released by Aon Corp. and the American Society for Healthcare Risk Management, both based in Chicago, polled more than 1,500 facilities to examine trends in claims and loss costs related to hospital and physician professional liability. The study attributes the rise in claims to the economic downturn, less public sympathy toward healthcare providers, and a 2008 rule that prevents the Baltimore-based Centers for Medicare and Medicaid Services from reimbursing hospitals for certain errors known as "never events" because they are considered preventable and should never happen.

"Worsening economic conditions in 2008 may have influenced individuals to assert claims against hospital systems," Erik Johnson, healthcare practice leader for Aon's Actuarial and Analytics Practice and author of the analysis, said in a statement. The frequency of hospital liability claims had been decreasing for about a decade before this year, the study said. Claims severity, which includes indemnity and defense

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[30] See note 20
[31] www.bscr-law.com
[32] See note 12
[33] Business Insurance, October 20, 2009

costs, is now projected to increase 4% per year. Hospital loss costs per occupied bed, which is a major part of the total cost of risk, is anticipated to rise 5% in 2010, according to the study.

The critical role of documentation

Plaintiff attorneys carefully scrutinize medical records to try to reconstruct what occurred and to look for evidence that the providers followed the standard of care. Thorough documentation is important in most aspects of medical and nursing care, but never so more essential than when healthcare providers are faced with a change in the patient's condition, or the patient is critically ill. I have read many depositions taken of healthcare providers years after they rendered care, and they usually have no recollection of what they did or said. Their defense often hangs on what is in the chart.

Amidst the apparent chaos of a medical environment, documentation often suffers. The chart serves as the sole means for the provider to note the details of care provided. Aside from the provider and patient memory, it is the only lasting record of care. Every aspect of the providers' interactions with their patients and the subsequent documentation and communication is a potential medical legal risk. The management of critically ill patients will often be scrutinized after the fact, especially if there are poor outcomes. [34]

Timely and complete documentation of SBAR communication answers the question of what was said to whom. Plaintiff attorneys and their expert witnesses who review a chart in the earliest phase of litigation make decisions to accept or reject claims based on what they see in the medical record. A well-documented chart that verifies the standard of care was followed may stop a suit in its tracks.

Disclosure of errors

When I interviewed Peter Berge, [35] a plaintiff attorney at a busy plaintiff's attorney law firm in New Jersey, and asked him about his volume of calls from potential plaintiffs, he said, "Between direct calls and referrals from other firms (we do get a lot of referrals from other attorneys in another law firm) we get several a day. So monthly, it could probably be fifty or sixty to well over a hundred a month."

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[34] Yu, K., and Green, R. Critical aspects of Emergency Department documentation and communication, *Emergency Medical Clinics of North America*, 27 (2009), 641-654

[35] *Screening Medical Malpractice Claims*, teleseminar http://www.medleague.com/teleseminars/medical_malpractice.htm

Pat What do people tell you about why they are contacting your firm, not specifically your firm but picking up the phone to contact an attorney about an unhappy experience or a bad outcome?

Peter There are two general issues; one is seeking redress for feeling like they've been injured through someone's negligence in one way or another. The other is just simply seeking answers. And there's a small subset of cases where people aren't interested even in redress but simply want to know what happened and why did someone die or why did this outcome occur and either they can't understand the provider's explanations or, more commonly, they didn't get an explanation at all.

Pat Specifically, the Joint Commission requires healthcare providers to offer an explanation when there's an untoward outcome. Are you saying that that's not necessarily occurring?

Peter Ah, it's frequently not occurring. Sometimes it's outside of the purview of the Joint Commission if it's not part of a hospital or involving a hospital. But often it does not occur or often the "explanation" is either cryptic or presented in medical terms the person does not understand.

Pat So the plaintiff is coming to you and trying to get an explanation about what occurred in language that he or she can understand. Is that what you're saying?

Peter That's often the case and sometimes we're able to, just by reviewing the chart, let them know what was done and why. And sometimes, actually, even when the doctor explains a series of procedures or series of events, we can say, "Oh, well, in such and such circumstance, this is commonly the procedure, so this is likely why they did that." And sometimes that's the extent of the conversation.

Pat Do you find the plaintiffs are telling you that physicians simply won't talk to them or become unavailable or won't return phone calls after there's been a bad outcome?

Peter In the subset of cases, absolutely. I wouldn't say it's necessarily the majority of the time but that occurs in a fair amount.

Litigation is less likely when a patient is told of any errors that occurred during his or her care, whether minor or major. More patient advocate rights groups have surfaced in the last five to six years. Healthcare costs and tort reform laws are on everyone's minds. Tort reform is a big topic in legislative chambers. In recent years, moves to pass legislation that will put a cap on pain and suffering compensation have been debated and, at some state levels, passed as well as overturned.

It is human nature to try to cover up our errors. However, when it comes to patient safety and well being, that behavior cannot be tolerated.

The potential loss of a position or the need to avoid litigation makes any cover-up tempting. But our healthcare ethics forbid it because our primary loyalty is to our patients. It is a moral dilemma that is addressed every day.

In July 2001, The Joint Commission passed new patient safety standards with the goal of forcing healthcare professionals to tell the truth when it came to medical errors. This standard set forth new mandates to create an environment which can promote the recognition of possible patient risks as well as medical and safety errors. The standard was deemed necessary when it was estimated that only 5% of medication errors were ever logged in on incident reports. Here is a quote from that standard:

> "Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes."

The JC directive went on to clarify that it is the responsibility of the licensed professionals to clearly explain to the patient or his/her family members the outcomes of treatment, especially if they deviate from the anticipated outcomes. In other words, full disclosure is a patient's right. They must be told when errors occur, and also when the patient's care does not improve. Now, any organization seeking accreditation must adhere to these national patient safety goals. [36]

Anyone who has been through The JC accreditation process knows how rigorous it can be. But the fact that this revered organization felt it necessary to set this standard points to the increasing concern over medical errors, especially in patient care, medication dispensing and record keeping and the obligation to reveal a medical error.

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[36] 2001 Joint Commission Accreditation Manual for Hospitals

Medical malpractice suits are a reality every medical facility faces.

The public is more aware of the errors that can be made. The news media is quick to focus on any discrepancy or slip-up. So, even though prevention and precaution procedures may seem burdensome to many healthcare professionals, they are necessary because across the board checks and balances are crucial. The alternative is way too costly. Too many patients suffer at the hands of over-tired, over-worked staff from the janitorial care personnel up to the chief physician in a department. Error is not confined to any one level of education, care management or expertise.

Studies have shown that the prime reason a patient decides to pursue a malpractice suit was due to the lack of communication or full disclosure from the provider of care over why the outcome was not what was expected to occur.

Patients may not be well versed in medical terminology, but they know when someone is not being truthful, or evasive, or is downright lying about a situation.

Sources show that the patients who sought litigation not only wanted compensation for their suffering, but also to make sure it never happened again to anyone else. Yet, in order for the system to be changed to improve patient safety, attitudes towards the mistakes by medical professionals need to change as well. One lecturer at Columbia University in 2001 remarked -

> "To promote a culture in which we learn from our mistakes, organizations must re-evaluate just how their disciplinary system fits into the equation. Disciplining employees in response to honest mistakes does little to improve overall system safety. Yet, mishaps accompanied by intoxication or malicious behavior present an obvious and valid objection to today's call for blame-free error reporting systems." [37]

If the patient and the family is informed every step of the way, confidence is built. The Catholic Healthcare West program "Mistakes Project" confirmed this to be the case. Patients were far more likely to seek legal counsel if they felt information was being concealed. One Colorado malpractice insurer encourages the implementation of what they call the three R's -

- ✓ Recognize

[37] Marx, D. (2001). *Patient Safety and the "Just Culture": A Primer for Health Care Executives.* Prepared for Columbia University under a grant provided by the National Heart, Lung, and Blood Institute.

- ✓ Respond to
- ✓ Resolve

This is applied to any patient injury or adverse occurrence in order to keep it from escalating into legal action. Their risk managers move in swiftly to avoid miscommunications and hard feelings. The results significantly reduced settlement pay-outs. In 2003, they averaged under $2,000 in comparison to the $250,000 for claims paid out for healthcare providers who did not immediately use the 3 R platform. [38]

Since its findings in 2001, The JC has strongly encouraged full disclosure to patients. Initially this decision was met with objections from physicians and risk management staff. They feared full disclosure would lead to more malpractice suits, loss of reputations, and possibly their careers. The attitude of "what they don't know won't hurt them" had long prevailed. Colleagues covered up mistakes for each other, leaving the patients without any advocate other than an attorney. The JC in a statement in June 2006 [39] emphasized the opposite was true. Patients and/or their family members should be encouraged to become actively involved in the care as part of an overall safety strategy. In other words, the patient should be prompted to ask questions, communicate more openly and be involved in the decision process when it comes to his or her care. Staff should reciprocate, gaining the patient's trust and bridging the gap between medical technology and common sense knowledge. Increasingly, healthcare professionals are recognizing the need to make an apology. See www.sorryworks.com for more information.

The Institute for Healthcare Improvement conducted a study [40] as part of its 100,000 Lives Campaign. Their success in implementing initiatives for patient safety and the reduction of morbidity and mortality incidents due to infections, adverse reactions and slow response times resulted in the saving of over one hundred-twenty two thousand lives in 18 months across the United States.

Though it was a common myth among healthcare professionals that there was no ethical reason to disclose even minor errors to patients, the reality is, patients are a lot more forgiving if they are told immediately and believe every effort is being done to correct the mistake.

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[38] See note 13
[39] www.jointcommission.org
[40] See note 11

As stated in the article in the ASHRM (American Society of Health Risk Management) Journal dated 2004 [41] previously referenced, a third of the physicians interviewed admitted they would not disclose the whole truth if an error on their part resulted in death of a patient. They feared losing their practice, their reputation and/or the trust of their other patients. The pressure to be perfect in all things, coupled with the anxiety that they were not, often swayed their decision as much as the fear of litigation.

Yet only a small percentage of patients who are injured due to medical error pursue litigation. And once a person does, there is an increased likelihood that the doctor will, due to the added stress of the legal proceedings plus his own doubts about his competency, err again and become a defendant in a second suit. It becomes a slippery slope.

[41] See note 13.

Chapter 3: Flawlessly Implement SBAR

Chapter Three: Flawlessly Implement SBAR

Pros and Cons

Any change agent who recommends SBAR can anticipate some resistance, some applause and some neutral stares. So, in order to fully evaluate the SBAR technique, it is wise to weigh the pros and the cons.

The positives are many. The benefits of SBAR are that it -

- ✓ **Reduces medical error**
- ✓ **Promotes clarity of communication between providers**
- ✓ **Fosters effective teamwork**
- ✓ **Encourages good listening skills**
- ✓ **Standardizes handoffs**
- ✓ **Reduces medical and nursing malpractice lawsuits**

Not everyone advocates the use of SBAR or is ready to accept it. Resistance to change may be evident in more conservative healthcare professionals who do not want to provide or receive such structured communication. Some older physicians may resist direct recommendations, particularly from those they perceive as being lower in status. The "power distance" (or "psychologic size difference") between team members deters "inferiors" from making themselves heard. [42] Critics of SBAR note that people may comply with the structure of SBAR, but if they lack critical thinking skills, the SBAR format alone will not guarantee patient safety or the correct information is conveyed. This is true, of course, of other ways of structuring communication.

Those points alone should win over a majority of the participants. But to state that SBAR is the end-all product would be misleading. The one possible pitfall to SBAR is that it is missing a letter. What comes after the recommendation? Where is it ensured that the Result will be logged in? Where are the checks and balances that the recommendation was carried through successfully?

Perhaps, it should then be SBAR - R. Any form should include a final note as to how the situation was ***resolved, reported, or responded to*** and what those ***results*** were. It of course is implied, but not stated in the formula. If a department is out to improve communications, reduce human error and assure better patient safety, then SBAR may be perceived as an incomplete model.

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[42] See note 20

The other thing to realize is that SBAR is a tool, and tools can be improved. As each facility or organization gets used to using this concept of effective information exchange, each will find ways to better adapt it to their unique way of operating as a team. Even so, until it is fully implemented and becomes the norm, the evolution of the concept cannot be defined.

Planning the Process

The first step of implementation of SBAR or any patient safety/team training is to consider the context of the change. King and colleagues [43] outlined five steps:

1. Establish a vision.
   The leaders must create a long-term vision for improving the culture of safety within the organization, be committed to the goal and use leadership to share this vision with staff.

2. Plan and prepare the environment.
   Assemble a change team to identify and develop the training and implementation strategies.

3. Train and implement behaviors and expectations.
   Train the trainers or the first generation of educators who will train other caregivers within the organization.

4. Monitor and coach to sustain behaviors.
   Give feedback to team members, as well as real-time monitoring and evaluation of behaviors.

5. Align and integrate the behaviors.
   Instill the culture of safety and the team-based approach to crisis or situational management as part of the work ethic.

Changing the way people communicate can be a daunting task. Significant costs are associated with any training effort. Patterns are set, personalities are already interpreted, priorities cemented. Mixing that all up can lead to resistance. Therefore, it is important to prepare for a more positive reception.

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[43] King, H., Kohsin., B, Salisbury, M. System-wide deployment of medical team training: lessons learned in the Department of Defense. In: Advances in Patient Safety, Vol 3. Rockville, MD, Agency for Healthcare Research and Quality, 425-435

First of all, consider in what areas you wish to implement the SBAR technique. Is it to be used with clinical staff only, or will it involve the non-clinical as well? Are you going to establish the SBAR method as the proper form of communication only in written documentation, or in verbal communication also?

Secondly, nobody likes surprises. Advertising and notification are paramount. Yes, it may create a buzz. Understand that oftentimes change is perceived negatively because it forces people out of their routines. Assign a spokesperson or two, be it from HR or the nursing managers and physician chairs, to "talk it up" and answer any trepidations. Send out emails; put up posters and notices. Hand out flyers.

Commercials feed on our curiosity. They give us just enough tidbits to whet our appetite and make us want to know more, try it out, or buy into something. It is like a purposeful "leaking" of information. "To be continued. . ." When planning how to publicize the SBAR switch-over, keep that in mind.

Thirdly, if SBAR is going to be successfully implemented, it is best to inform all parties as simultaneously as possible so no one feels left out of the loop or less important. SBAR thrives on the concept of teamwork.

Fourth of all, decide how wide the implementation will become. Are you going to have a pilot program first or is it going to be a facility-wide change of procedure? Many organizations have chosen to start with a pilot program for several reasons.

1. It allows whatever kinks develop to be ironed out, and for SBAR to be customized if necessary.

2. It helps establish a few who can be won over, or the “champions” of the model, who can then spread the news. People are more receptive when they know someone who recommends it.

3. It provides a "success story" and shows people it can be done. "See, it worked well in CCU, so it can work on the Ortho ward."

One idea is for people to inadvertently "see" it being implemented in inter-departmental communiqués. Utilize the format in memos. State the situation, the background, assess the need, then recommend the solution. Make it a template for meeting discussions as well. Get people used to thinking in a positive, teamwork way of solving problems.

Bring the leaders onboard first, especially the directors, the physicians and managers. Convincing the important leaders is primary because the chain of command filters down from them. This also will ensure more overall compliance and establish a teamwork atmosphere into which you can inject the SBAR method.

Prepare the handouts, sign in sheets, and so on that will be necessary for the introduction meeting. Have brochures, sample forms, posters all ready to go. Will you have a speaker or an authoritative professional from another facility? Who will provide the hands-on training of the staff?

Make sure all is documented per your facility's or organization's protocol and policies. The more organized the launching is, the better the program will succeed.

Finally, organize the staff training and decide how long it will take. One informational session may not be enough. Set a start date several weeks into the future so you can make sure everyone is trained. Have a review session about a month later to encourage feedback and future suggestions on improving the method. Announce that session prior to the start date so people will know they are involved in the process. Finding the fine line between set-in-stone procedures and room for improvement is paramount in nurturing team work.

Obviously the first step in implementing SBAR is to develop standardized forms that have the four points already in them. That encourages follow-through and thoroughness.

Effective incorporation of the concepts of the people who will use the forms will result in stronger documents and an easier implementation process.

Have a task force in place to review the forms you will use and to gather the feedback responses. Make sure all staff knows to whom they should report their ideas, complaints, concerns and suggestions. As a team effort, this should be encouraged. Try to involve all levels on the task force. Nurses, physicians, techs and clerical staff may all have valuable insight, just from different perspectives. Multidisciplinary procedure must also be multidimensional.

Above all, work to establish a positive atmosphere for change, teamwork and collaboration. That is the foundation of SBAR. Any program needs to be built on a firm foundation or it will topple and shatter into pieces.

Next, extensive training must occur. Veteran employees may be set in their ways and used to doing things in a certain manner. Or they feel this is just another cock-eyed scheme and they have seen many others fail. They may not see the need to re-invent the wheel, so to speak, and roll their eyes at yet another innovative idea to improve things where they work. Newer, fresh out of the classroom employees may be confused because that was not how they were taught.

However, when the transition is handled properly by stressing the benefits to the users, providing pertinent statistical proof that it works well, coupled with showing that The JC highly recommends implementing something similar to this technique, most nay-sayers will be convinced it is worth a try. Tell them it is their safety net; it increases patient safety and decreases the risk of being sued, and they will be more likely to listen.

Tips for Training

As part of the training session, try role playing scenarios, then ask the employees to analyze the following steps:

1. ***Has all the pertinent patient information been gathered?*** Until the patient's name, room number and bed designation, history and allergies, diagnosis, vital signs and lab results have been located, the background can not be completed.

2. Has ***a hands on physical assessment been made***, or is the nurse reporting the information second hand? If the latter is true, there may have already been a chance of communication error occurring.

3. If the answer is yes to the above two questions, only then call the physician, using the SBAR format.

The information presented in one seminar conducted by Donna Anderson, PhD, RN as a HHQIOSC Project Coordinator in Pennsylvania, stated that when relaying the SBAR to the physician it is "all right to C.U.S.".

The nurse can relay that he or she is -

C *oncerned* about the patient's current condition, and is
U *ncomfortable* with the situation as it stands and believes the
S *afety* of the patient is at risk.

* Perhaps another **S** can be added - "Seems we need new orders."

Run through a series of scenario exercises with realistic problems that nurses may have with their patients such as allergic reactions, shortness of breath, inability to sleep, being agitated, running a temperature, just fallen out of bed, etc.

Next, discuss the worst case scenarios as a further training exercise. What if the recommendation does not improve the patient's condition? What if the CUS is not resolved? What if the physician does not want to take action, yet the nurse believes it is necessary? What if the orders are not correctly interpreted after all? What if someone still "drops the ball"?

Just telling your staff that SBAR is going to be implemented is not enough. To encourage team work and cooperation, seminars and hands on exercises are the best training tools. Work with the physicians to explain SBAR, the benefits of using this system, and what kinds of structured communications they can expect to receive from others.

Staff must initially be monitored closely to make sure the process is followed. Everyone on the team from the physician on down must become used to looking for the four steps in every scenario. When dealing with interdisciplinary teams, coordination of care is the main concern, and the main pitfall. Team leaders must explain how SBAR addresses this issue and provides a viable solution. Until all parties are clear and willing to participate, the implementation will not be effective. Any plan is doomed to failure unless it is approved, proven to work and all parties are proceeding with it.

Chapter 4: Answers to Frequently Asked Questions

Chapter Four: Answers to FAQs (Frequently Asked Questions)

Safe & Sound developed a FAQ sheet about SBAR. Here are the twelve main questions that they found staff members asked the most often - and a bit of the answers they gave. [44]

1. ***What is SBAR?***

"SBAR provides a mechanism to frame a conversation so information is conveyed between people in a consistent and reliable way."

Explain what the acronym means.

2. ***Is SBAR evidence based?***

SBAR has already been used for several years in hospital settings around the nation. Prior to that it was used in the US Navy and also the airline industry. The JC highly recommends it and is making like methods a criteria for accreditation.

3. ***I don't feel I have a communication problem. Why should I use it?***

Communication can always improve between caregivers to help thwart negative patient outcomes and strengthen teamwork. "When a standardized approach is implemented, the effectiveness of that approach increases." Listening is enhanced because the listener knows what to listen for. Remember in the examples, the nurse actually used the words "situation, background, assess and recommend" in her report.

4. ***So why SBAR and not other techniques?***

This is a valid question. SBAR is result-oriented so positive outcomes are more likely. It supports good information and decision making as well as accurate documentation of each incident.

5. ***What is the difference between this and SOAP of the good old days?***

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[44] See note 7

As has already been reviewed, the difference is in the last letter. SOAP ends with a Plan, whereas SBAR ends with a Recommendation. That encourages team approaches to situations.

6. ***What if it is too time consuming and the physician needs to be contacted STAT?***

If the SBAR technique is in place, it becomes a time saver. It saves unnecessary questions that can stall the recommendation. Physicians or other clinicians need to know the background and the situation fully. Getting quickly to the point is the beauty of using SBAR. It also helps the nursing staff assess the situation more effectively.

7. ***How do you differentiate between background and assessment?***

Background is what has happened up to the time of the situation. Assessment is what you think the situation is. One feeds into the other.

8. ***Why do we need to use a form?***

Learning a new process requires practice. Forms ensure thoroughness by providing a checklist just like airline pilots use prior to take off. Forms are also a safety net. If they are completed, there is less chance of error. Besides, any new employees will need to become acquainted with it as well.

9. ***Once I become comfortable with SBAR, why can't I just do it in my head?***

Staff is always fluctuating so not everyone will always be familiar as you are with the process. Uniformity is the key to error-free communication. Everyone must follow the same format. Tools are to be used and the form is also a reference. Again, it is your safety net. It eliminates skipped steps and he said/she said scenarios. Documented proof is a necessary aspect of practice in the clinical world.

10. ***What if the physician gets upset that I made a recommendation?***

Many nurses and support staff have that anxiety. You are the doctor's eyes and ears because they are not there. They're relying on your data and observation. Remind them you are following protocol and the SBAR

technique. Ask them what their orders are. If the physician gets aggressive, get a supervisor involved.

11. ***What if I don't have a recommendation?***

Then be honest and say so. You are the conveyor of information and it is the patient who should benefit, not your ego. Open, honest communication fosters trust and listening.

12. ***Is JC mandating this?***

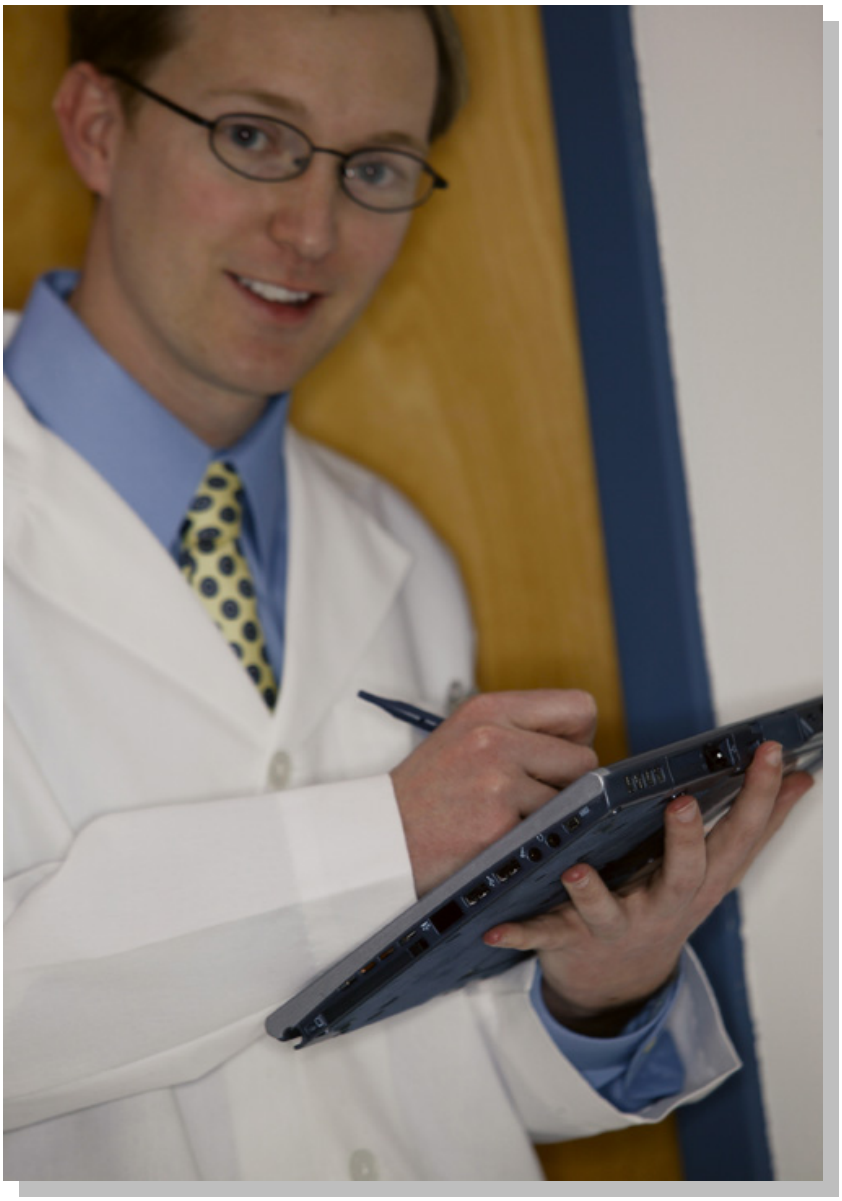
No, however, they have issued several national patient safety goals that they look to be implemented and SBAR meets these goals. Goal 2E asks for a standardized approach to effective handoff communication.

The report goes on to recommend that the nurse state again her name, extension and when her shift ends to further demonstrate the need for collaboration and accommodation.

SBAR had been proven to work well in all clinical situations over the past several years. Since The JC recommends establishing some policy to comply with the safety standards for effective handoff communication, SBAR seems to be a good model to adopt. But as shown in the examples so far, variations on the theme have already been developed. Inevitably, departments or facilities will decide as a group to improve the proverbial mousetrap. Over the next ten years, as more clinics, office, physicians, and hospital units begin to use SBAR techniques, it is a certainty that new variations will begin to spring up in conference rooms, clinical settings, and lecture halls.

But the basic formula seems to be valid in achieving what it set out to do. It passes pertinent information fairly flawlessly up the chain of command resulting in clearer communication, better team work and improved patient safety.

Chapter Five: Resources



Chapter Five: Resources

When planning how to implement SBAR at your facility, or in your organization, it is best to have ample resources available in order to help explain the process and its importance. This e-book is designed to provide that. However, there are a myriad of other sources available, which, in itself speaks to the excellence of the SBAR communication techniques. Here are some good places to look for further information -

Safer Healthcare has products and tools to assist your organization in further understanding the SBAR technique, and making it simple to use.

The National Patient Safety Foundation (NPSF) offers patient safety material in both HTML and data formats.

See the Institute for Healthcare Improvement at www.ihi.org for sample SBAR tools.

Medically Induced Trauma Support Services (MITSS) also has educational resources available for both patients and clinicians in the effort to help adjust to trauma, and to promote open and honest communication.

John Hopkins Bloomberg School of Public Health has a 25 minute training video called "Removing Insult from Injury: Disclosing Adverse Effects" to help educate physicians on the need for full disclosure.

Open Safety is an organization that is dedicated to building a network of professionals who will share solutions for improving safety in the healthcare environment. It offers free tools and videos.

Safe & Sound, an Arizona Patient Safety Initiative through the Arizona Hospital and Healthcare Association recommended SBAR in April 2007. Their seminar notes are extensive, and the site offers a tool kit that is 120 pages full of information.

Visual aids are always a great way to help people see the whole picture. Part of effective communication is getting the other person to "see" what we are talking about. Visualization is a key tool in recognition and comprehension.

Several Microsoft Power Point programs on SBAR are also available. Here are just a few -

1. www.snjourney.com/ClinicalInfo/WrAndReport/SBAR.ppt

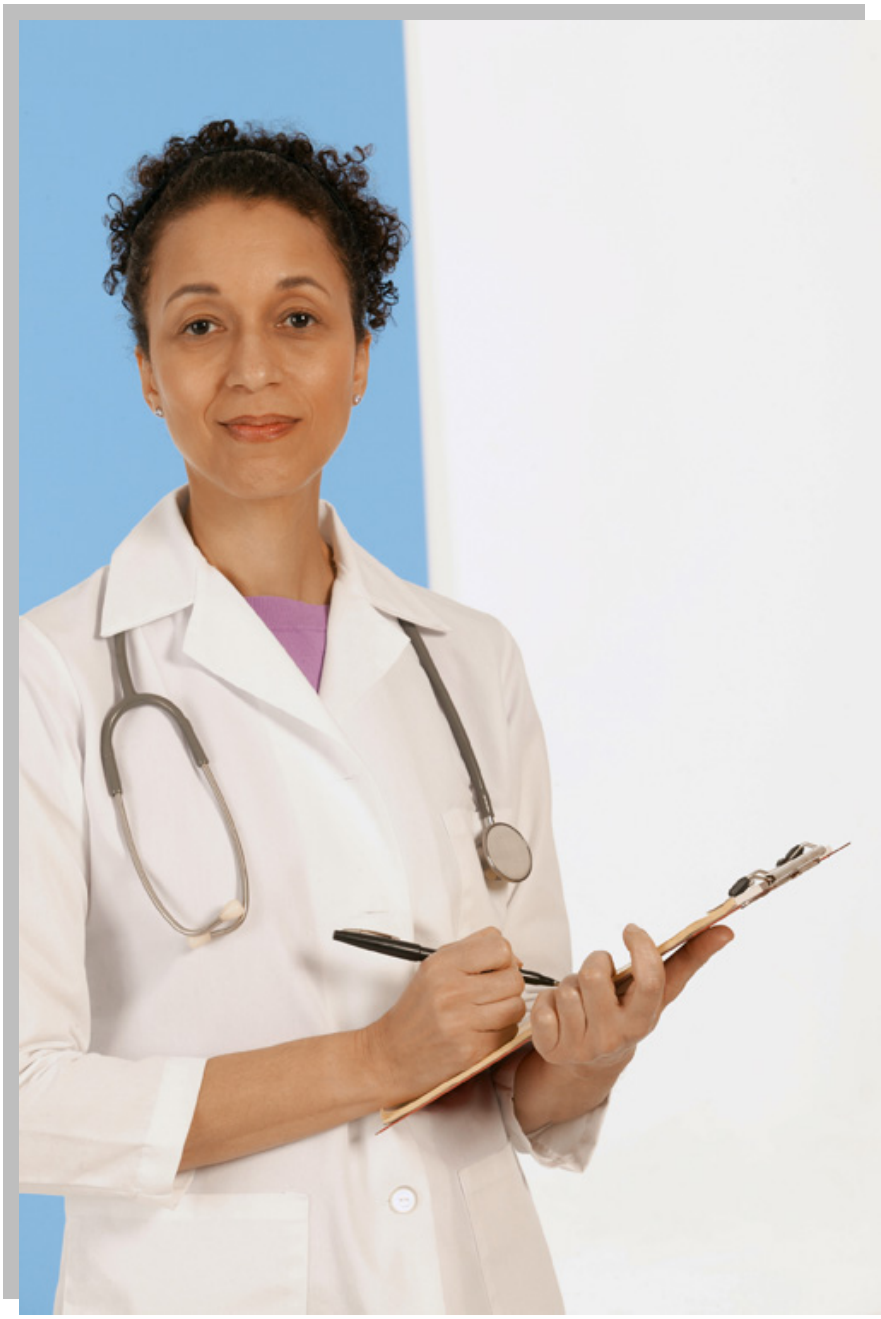
2. cchealth.org/groups/ems/pdf/inst_notes_sbar.pdf

3. www.homehealthquality.org/shared/.../SBAR_Made_Easy_pub_.ppt

4. www.chw.org/staff/FVSBARR.ppt

Search on www.youtube.com for SBAR. You will find some examples of skits of poor versus effective communication.

Chapter 6: Sample Forms



Chapter 6: Sample Forms

The final section of this e-book contains sample forms that you may copy, or use as a template in developing your own. These are in addition to the other hand-outs, posters, buttons, ready-made forms, etc. that you may have found using the information in Chapter 5: Resources.

Tailor each to your specific needs, once you have implemented the basics.

SBAR FORM

SITUATION_____

_____

_____

_____

_____

BACKGROUND_____

_____

_____

_____

_____

_____

_____

ASSESSMENT_____

_____

_____

_____

RECOMMENDATION_____

_____

_____

_____

_____

SBAR Feedback Form

What was the situation? _____

_____

_____.

What was the recommendation? _____

_____

_____

What was the outcome? _____

_____

_____

What is your concern or suggestion? _____

_____

_____

_____

_____

_____

(continue on back if need be)

Chapter Seven: Post Test

Chapter Seven: SBAR Post Test

1. True / False When The JC studied the root causes of errors, communication breakdown was the third most likely cause.

2. True / False SBAR only works between physicians and nurses.

3. True / False When you convey the "S" portion, take your time to make sure you say everything you believe will communicate your needs.

4. True / False The JC has a standard that specifies the need for standardized handoff communication procedures.

5. True / False Even though we are using SBAR, I still should end my conversation with "What questions do you have for me?" in order to ensure two-way communication.

6. True / False The majority of patients who are injured due to medical error seek a plaintiff's attorney.

7. The "S" stands for _____

8. The "B" stands for_____

9. The "A" stands for_____

10. The "R" stands for_____

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