Implementation of the SBAR Communication Technique in a Tertiary Center

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Nurses, physicians, and other health care providers are frequently in situations requiring accurate and timely communication, particularly in high-stress areas such as the emergency department, ICU, and operating room.[1] Problems arise when messages are not clearly delivered by the sender or are misunderstood by the recipient. Variations in communication styles between physicians and nurses can also contribute to a breakdown in effective communication, which can lead to adverse outcomes for patients.[2] Nurses and physicians are trained to communicate in very different ways. Nurses are taught to report in narrative form, providing as many details as possible about the patient or situation, while physicians learn to communicate using an abbreviated "headline" format, focusing on key information. When one technique is utilized to deliver information rather than the other, pertinent points may be lost in translation.

National Patient Safety Goals

National Patient Safety Goals have been established to address issues such as decreasing medical errors, particularly by focusing on better communication between health care providers. The Joint Commission on Accreditation of Healthcare Organizations safety goal 2E[3,4] recommends a "standardized handoff communication between the health-care team, as well as providing for an opportunity for questions and response." One tool that has been found to assist with structuring and standardizing communication is the Situation-Background-Assessment-Recommendation (SBAR) tool. SBAR is an easy-to-remember technique that provides for consistent, structured communication between members of the health care team during a critical situation. The Institute for Healthcare Improvement[5] states the following with regard to the SBAR technique: "It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a culture of patient safety" (*http://www.ihi.org/ihi*).[5] Associated with the SBAR technique of communication is the trigger phrase "I need some clarification," which is used when at any time during critical conversation information is not understood by either communicator (Figure 1).

Initial Survey

In the fall of 2006, Magee Womens Hospital of the University of Pittsburgh Medical Center (UPMC) teamed up with its sister facility, UPMC Shadyside Hospital, to standardize and improve communication between health care team members.

Prior to the fall of 2006, Magee Womens Hospital did not have a standardized way of communicating during critical events. Physicians and nursing staff were surveyed regarding effective communication with use of 5 "profession specific" questions (Figure 2). A 5-point Likert scale rating was used and was randomly distributed throughout the hospital, including all inpatient care areas, the Women's Cancer Center, Labor and Delivery, the Emergency Department, Heart Center, Radiology, and the Outpatient Clinic.

The results of the initial survey indicated that most health care providers saw room for improvement regarding communication as evidenced by the following initial results.

Gaining Support and Educating Staff

Based on the initial survey, the SBAR technique was introduced hospital wide in an effort to standardize the transfer

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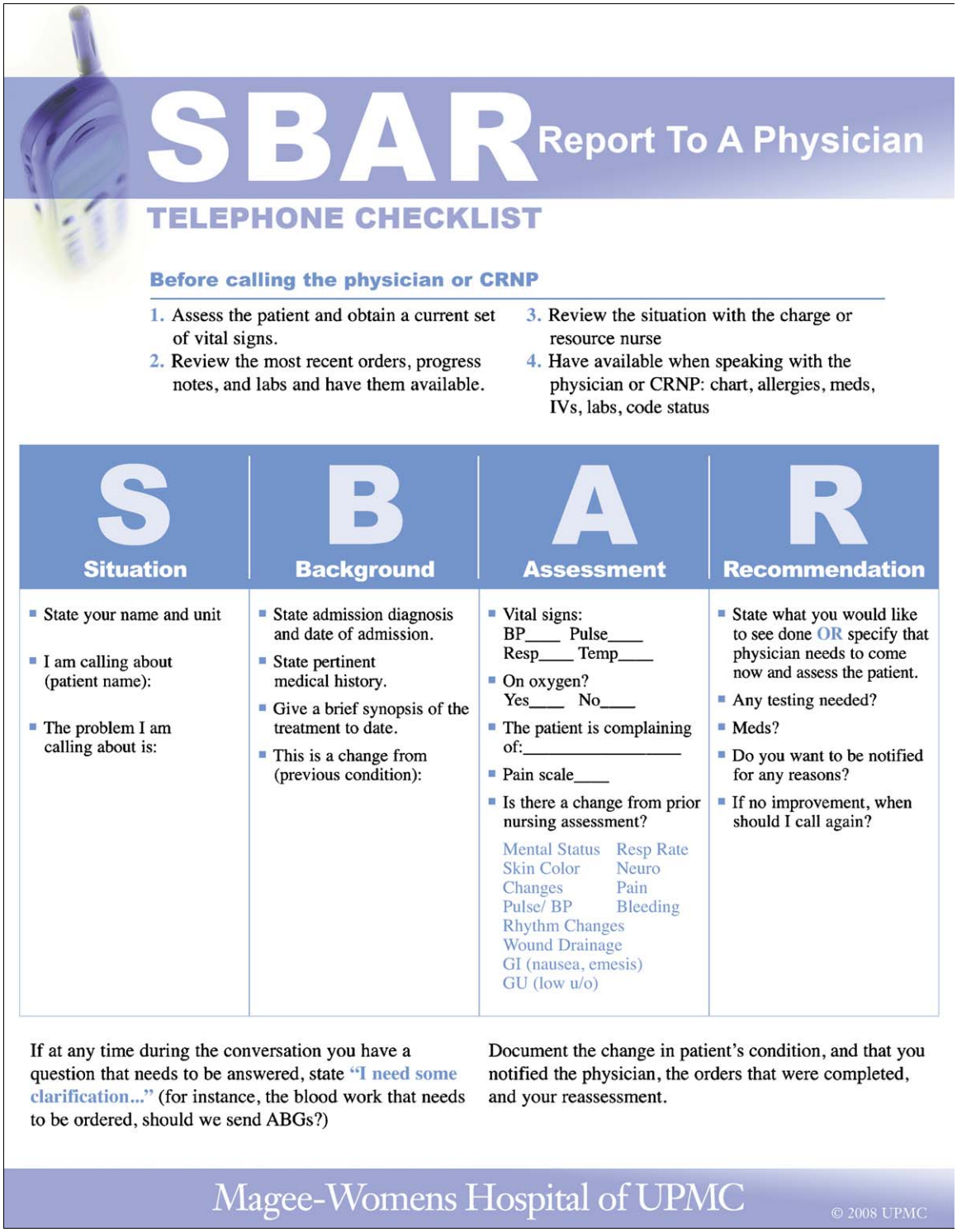

SBAR Report To A Physician

TELEPHONE CHECKLIST

Before calling the physician or CRNP

1. Assess the patient and obtain a current set of vital signs.
2. Review the most recent orders, progress notes, and labs and have them available.
3. Review the situation with the charge or resource nurse
4. Have available when speaking with the physician or CRNP: chart, allergies, meds, IVs, labs, code status

S Situation	B Background	A Assessment	R Recommendation
▪ State your name and unit ▪ I am calling about (patient name): ▪ The problem I am calling about is:	▪ State admission diagnosis and date of admission. ▪ State pertinent medical history. ▪ Give a brief synopsis of the treatment to date. ▪ This is a change from (previous condition):	▪ Vital signs: BP____ Pulse____ Resp____ Temp____ ▪ On oxygen? Yes____ No____ ▪ The patient is complaining of:_____ ▪ Pain scale____ ▪ Is there a change from prior nursing assessment? Mental Status, Resp Rate, Skin Color Changes, Neuro, Pulse/ BP, Pain, Rhythm Changes, Bleeding, Wound Drainage, GI (nausea, emesis), GU (low u/o)	▪ State what you would like to see done OR specify that physician needs to come now and assess the patient. ▪ Any testing needed? ▪ Meds? ▪ Do you want to be notified for any reasons? ▪ If no improvement, when should I call again?

If at any time during the conversation you have a question that needs to be answered, state "I need some clarification..." (for instance, the blood work that needs to be ordered, should we send ABGs?)

Document the change in patient's condition, and that you notified the physician, the orders that were completed, and your reassessment.

Magee-Womens Hospital of UPMC

FIGURE 1

Situation-Background-Assessment-Recommendation (SBAR) Telephone Checklist used by nursing staff at Magee Womens Hospital. *ABGs*, Arterial blood gases; *BP*, blood pressure; *CRNP*, certified registered nurse practitioner; *GI*, gastrointestinal; *GU*, genitourinary; *u/o*, urinary output; *IVs*, intravenous lines; *labs*, laboratory tests; *meds*, medications; *Neuro*, neurologic; *Resp*, respiration; *Temp*, temperature.

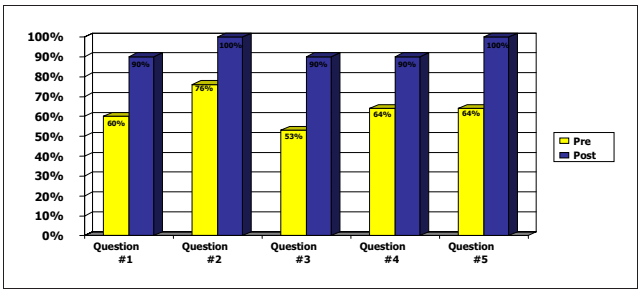

FIGURE 2

Summary of survey results. *Pre*, Before implementation of the Situation-Background-Assessment-Recommendation (SBAR) technique; *Post*, after implementation of the SBAR technique. The following questions were on the survey:

1. I receive clear concise information when called about a patient situation.
2. The nursing staff is clear about why they are calling me.
3. The staff is organized and prepared when calling regarding a critical situation.
4. I receive the right information that I need to make the appropriate clinical decision.
5. I am satisfied with the communication from the nursing staff when there is a critical situation.

of information.[6] Nursing management led the charge by strategically garnering support from physician leaders. Implementation included educating all personnel in all the areas that participated in the initial survey, as well as through presentations at the Med Exec Committees, Patient Safety Committee, Nursing Grand Rounds, and new employee orientation for nursing and physicians.

Flyers explaining the use of SBAR during nurse-to-physician report during critical situations were distributed and displayed on the units. Creative SBAR pocket cards were given as reference guides to all nursing staff. In addition, laminated nursing shift report templates and report-to-physician telephone checklists were provided to all inpatient nursing station areas (Figure 1).

Initial Resistance

The physician staff initially had some reservations regarding the Recommendation portion of the SBAR tool. They questioned whether a nurse should recommend a medication or procedure prior to the physician's examination of the patient. This point was clarified to explain that nurses would use the R to communicate "exactly what you need from the physician at that moment." Nurses were educated to use the R even if they were unsure about what was happening in a situation, did not know how to remedy a situation, or both. (For example: R = "I think something is wrong; I need you to assess this patient now.")

Other resistance was minor. Some nurses and doctors questioned the need to resort to such basic templates for conversations. However, eventually the value of consistency and overall better communication became the best argument. Eventually providers were overheard asking residents and new nurses to rephrase critical information in the SBAR format.

Results

Use of the SBAR technique was generally well received, especially because of its simplicity and ease of understanding. All of our nursing units now require shift report using this technique, including the emergency department and medical/surgical units. The vice president of nursing requires her nursing directors and managers to utilize the SBAR technique when communicating critical information among the management team.

In January 2007, we surveyed the same hospital areas again to evaluate the perceived efficacy of the SBAR technique. Dramatic improvements were made in all 5 areas of communication (Figure 2). Nursing staff were consistently using SBAR during shift report, and both new and experienced nursing staffs were more confident when calling a physician about a critical situation. Physicians appreciate communication that is abbreviated, concise, and to the point. One newer nurse stated, "I like the template; it gives me the ability to streamline information and the confidence to communicate with the doctors" An experienced nurse shared, "In the emergency room, the SBAR tool has eliminated errors due to assumptions. Now the physician and nurse are on the same page from the very beginning." One physician commented, "I have seen a dramatic improvement in communication with the use of the SBAR technique."

Conclusion

Emergency nurses are one of the health care provider groups most in need of clear, concise handoffs and physician communication techniques because of the urgency of emergency health care. The SBAR tool provides the translation between narrative and "headline" communication, thus bridging differences in nursing and physician training. Consider the volume of persons an ED registered nurse (RN) communicates with during an average work day: multiple physicians, other nurses and health care providers, prehospital personnel, and patients and their family and friends. Complicating matters further, ED RNs may need to communicate by telephone and radio as well as person to person. Experienced ED RNs may feel confident in their communication skills, but an increasing number of inexperienced nurses are now being hired into the ED setting (Figure 3). Employing a standardized tool for clear

A newly hired graduate nurse in the emergency department was noted to use SBAR during the following critical incident.

A 44-year-old female patient arrived at the triage window in acute respiratory distress. Per protocol, a breathing treatment was implemented, and the patient's oxygen saturation was measured at 88%. The patient did not respond to the breathing treatment and was becoming agitated, and her oxygen saturation had dropped to the low 80s. Using the SBAR technique, the graduate nurse effectively communicated the following information to the resident physician on duty:

S: Mrs. _____ arrived approximately 10 minutes ago with symptoms of a severe asthma attack.

B: She presented in acute respiratory distress with an oxygen saturation of 88%. We started an Albuterol breathing treatment, which is almost complete.

A: The patient is now extremely agitated with an oxygen saturation of 80%.

R: She may need to be intubated, and I need you to examine her immediately.

FIGURE 3
An example of SBAR communication in the emergency department.

and concise communication ultimately can be the difference between patient safety and an adverse outcome or medical error.

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Correction

An error was found in a reference listed in a Clinical article in the April issue (Management of the mechanically ventilated patient in the emergency department, 2008;32:121-5). Reference 1 should read as follows:

1. Chalfin D, Trzeciak S, Likourezos A, Baumann B, Dellinger P. Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit. Crit Care Med 2007; 35:1477-83.