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Improving Clinical Communication Using SBAR

Acknowledgements

This guide has been produced by Julie Parry.

We would particularly like to thank healthcare organisations in Wales and their teams for their work in implementing this intervention and also feeding back lessons and experiences gained as a result. All of the example templates have been produced by NHS organisations in Wales.

1000 Lives Plus is run as a collaborative, involving the National Leadership and Innovation Agency for Healthcare, the National Patient Safety Agency, Public Health Wales and the Welsh Assembly's Clinical Governance Support and Development Unit.

We wish to thank and acknowledge the Institute for Healthcare Improvement (IHI) and the Health Foundation for their support and contribution to 1000 Lives Plus.

Date of publication

This guide was published in 2011 and will be reviewed in 2012. The latest version will always be available online at www.1000livesplus.wales.nhs.uk

The purpose of this guide

This guide has been produced to enable healthcare organisations and their teams to successfully implement a series of interventions to improve the safety and quality of care that their patients receive.

Further 'Tools for Improvement' guides are also available to support you in your improvement work:

- How to Improve
- How to use the Extranet
- A Guide to Mortality Measurement
- How to use Trigger Tools
- Reducing Patient Identification Errors

These are available from the 1000 Lives Plus office, or online at www.1000livesplus.wales.nhs.uk

We are grateful to The Health Foundation for their support in the production of this guide.



Improving care, delivering quality

The 1000 Lives Campaign has shown what is possible when we are united in pursuit of a single aim: the avoidance of unnecessary harm for the patients we serve. The enthusiasm, energy and commitment of teams to improve patient safety by following a systematic, evidence-based approach has resulted in many examples of demonstrable safety improvement.

However, as we move forward with 1000 Lives Plus, we know that harm and error continue to be a fact of life and that this applies to health systems across the world. We know that much of this harm is avoidable and that we can make changes that reduce the risk of harm occurring. Safety problems can't be solved by using the same kind of thinking that created them in the first place.

To make the changes we need, we must build on our learning and make the following commitments:

- Acknowledge the scope of the problem and make a clear commitment to change systems.
- Recognise that most harm is caused by bad systems and not bad people.
- Acknowledge that improving patient safety requires everyone on the care team to work in partnership with one another and with patients and families.

The national vision for NHS Wales is to create a world-class health service by 2015: one which minimises avoidable death, pain, delays, helplessness and waste. This guide will help you to take a systematic approach and implement practical interventions that can bring that about. The guide is grounded in practical experience and builds on learning from organisations across Wales during the 1000 Lives Campaign and also on the experience of other campaigns and improvement work supported by the Institute for Healthcare Improvement (IHI).

Where reference is made to 1000 Lives Plus, this includes the work undertaken as part of the 1000 Lives Campaign and the second phase of this improvement programme - 1000 Lives Plus.

The guide uses examples from the former NHS organisational structures, and where possible this has been acknowledged.

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Introduction

Since the launch of the 1000 Lives Campaign in April 2008, the use of SBAR as a communication tool has been tested by all secondary care organisations in Wales. The majority of testing has been in conjunction with the use of ‘Track and Trigger’ tools.

The tool can be used to shape communication at any stage of the patient’s journey, from the content of a GP referral letter, consultant to consultant referrals, and discharge back to the GP. Corporate use of the SBAR structure also provides a consistent approach to the information the organisation is receiving.

During an episode of care, a patient can potentially be treated by a number of healthcare practitioners and specialists in multiple settings, including primary care, specialised outpatient care, emergency care, surgical care, intensive care, and rehabilitation.

Additionally, patients will often move between areas of diagnosis, treatment, and care on a regular basis and may encounter three shifts of staff each day – introducing a safety risk to the patient at each interval.

The hand-over communication between units and amongst care teams might not include all the essential information, or information may be misunderstood. These gaps in communication can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm to the patient.

Hand-over communication relates to the process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregivers to the patient and family for the purpose of ensuring patient care continuity and safety.

Hand-over communication also relates to the transfer of information from one type of healthcare organisation to another, or from the healthcare organisation to the patient’s home. Information shared usually consists of the patient’s current condition, recent changes in condition, ongoing treatment and possible changes or complications that might occur.

Patient care hand-overs occur in many settings across the spectrum of care, including admission from primary care, transfer of clinician to another speciality, nursing change-of-shift reporting, nursing report on patient transfer between units or facilities, anaesthetic reports to post operative recovery room staff, emergency department communication with staff at a receiving unit during a patient’s transfer, and discharge of the patient back home or to another care setting.¹

References

¹ *Safety Solutions, volume 1, solution 3/ May 2007 World Health Organization*
<http://tinyurl.com/safesol>

What is SBAR?

SBAR - Situation-Background-Assessment-Recommendation

SBAR is an easy to remember mechanism that you can use to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help you to develop teamwork and foster a culture of patient safety.

Utilised extensively in medicine, and originating from the nuclear submarine service, SBAR stands for:

S - Situation: What is happening at the present time?

B - Background: What are the circumstances leading up to this situation?

A - Assessment: What do I think the problem is?

R - Recommendation: What should we do to correct the problem?

The tool consists of standardised prompt questions within four sections, to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition.

The tool helps staff anticipate the information needed by colleagues and encourages assessment skills. Using SBAR prompts staff to formulate information with the right level of detail.¹

Continuity of information is vital to the safety of patients.

With the move to shift patterns, which increase the number of individuals caring for patients, the need for comprehensive handover of clinical information is more important than ever.

Good hand-over does not happen by chance. It requires work by all those involved, from organisations to the individuals:

- shifts must coordinate;
- adequate time must be allowed;
- handover should have clear leadership;
- adequate information technology support must be provided.

Sufficient and relevant information should be exchanged to ensure patient safety:

- the clinically unstable patients are known to the senior and covering clinicians;
- junior members of the team are adequately briefed on concerns from previous shifts;
- tasks not yet completed are clearly understood by the incoming team.

Lastly, hand-over is of little value unless action is taken as a result:

- tasks should be prioritised;
- plans for further care are put into place;
- unstable patients are reviewed.

What changes can we make that will result in improvement?

Safe, effective clinical care depends on reliable, flawless communication between caregivers. Communication breakdowns between healthcare providers are a central feature in episodes of avoidable patient harm.

As clinical teamwork often involves hurried interactions between human beings with varying styles of communication, a standardised approach to information sharing is needed. This ensures that patient information is consistently and accurately imparted – especially true during critical events, shift hand-overs, or patient transfers.

Suggested actions from WHO² include:

1. Ensure that healthcare organisations implement a standardised approach to hand-over communication between staff, change of shift and between different patient care units in the course of a patient transfer. Suggested elements of this approach include:
 - (a) Use of the SBAR (Situation, Background, Assessment, and Recommendation);
 - (b) Allocation of sufficient time for communicating important information and for staff to ask and respond to questions without interruptions wherever possible (repeat-back and read-back steps should be included in the hand-over process);
 - (c) Provision of information regarding the patient's status, medications, treatment plans, advance directives, and any significant status changes;
 - (d) Limitation of the exchange of information to that which is necessary for providing safe care to the patient.
2. Ensure that healthcare organisations implement systems which ensure – at the time of hospital discharge – that the patient and the next healthcare provider are given key information regarding discharge diagnosis, treatment plans, medications, and test results.
3. Incorporate training on effective hand-over communication into the educational curricula and continuing professional development for healthcare professionals.
4. Encourage communication between organisations that are providing care to the same patient in parallel (for example, traditional and non-traditional providers).

Identify that a formal structured hand-over of care should include:³

- a summary of critical care stay, including diagnosis and treatment;
- a monitoring and investigation plan;
- a plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment;
- physical and rehabilitation needs;
- psychological and emotional needs;
- specific communication or language needs.

There are many opportunities available for the use of a structured communication which is consistent, structured and clinically relevant.

References

¹ *NHS Institute for Innovation and Improvement*
<http://tinyurl.com/qsitsbar>

² *Patient Safety Solutions , volume 1, solution 3 / May 2007 WHO World Health Organization*
<http://tinyurl.com/safesol>

³ *NICE (2007) Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital.*
<http://tinyurl.com/niceguid>

Case Study

Velindre NHS Trust has developed a communication sheet to be used when chemotherapy patients ring into the hospital to the bleep holder for help.

Situation	Assessment	Recommendations	Follow up/outcome
Date: Time of Enquiry: <hr/> Name: <hr/> Hosp No: <hr/> Cons: <hr/> Tel No: <hr/> Background <hr/> Chemo Treatment: Cycle No: Date of Treatment: Is Patient on a Clinical Trial?	Reason for call/ current symptoms: Temperature: Has the patient had diarrhoea? Episodes in 24 hours:	Advice given: Discussed with: Sign: Print:	 Annotation on ISCO: YES / NO Message left with secretary: YES / NO Ring back request: YES / NO Signed:
Situation	Assessment	Recommendations	Follow up/outcome
Date: Time of Enquiry: <hr/> Name: <hr/> Hosp No: <hr/> Cons: <hr/> Tel No: <hr/> Background <hr/> Chemo Treatment: Cycle No: Date of Treatment: Is Patient on a Clinical Trial?	Reason for call/ current symptoms: Temperature: Has the patient had diarrhoea? Episodes in 24 hours:	Advice given: Discussed with: Sign: Print:	 Annotation on ISCO: YES / NO Message left with secretary: YES / NO Ring back request: YES / NO Signed:

How to use SBAR to improve clinical communication

SBAR creates a shared mental model for effective information transfer by providing a standardised structure for concise factual communications among clinicians – nurse-to-nurse, doctor-to-doctor, or between nurse and doctor. Other tools like critical language, psychological safety, and effective leadership are central to providing safe care.

The SBAR technique provides a framework for communication between members of the healthcare team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism useful for framing any conversation, especially critical ones, requiring a clinician's immediate attention and action.

It can add clarity to an emergency call to a sleeping senior colleague for advice about patient management. When woken in the night it can take some time to absorb facts and respond. This is greatly aided by a clear presentation of the situation, the background, the assessment and the proposed treatment:

- Clarify what information should be communicated between members of the team, and how to formulate it with the right level of detail;
- Anticipate the information needed by colleagues and encourage assessment skills;
- Develop teamwork and foster a culture of patient safety.

Using the PDSA cycle:

- Work with one doctor who is supportive and agree that the next time you need to make an urgent call you will use the tool;
- Ensure you have a copy of the tool to hand. Keep it by the department phone or in your pocket at all times. When the time comes to use it you want to be able to find it;
- Use the tool;
- When appropriate discuss together how it felt from both sides of the conversation;
- Incorporate suggestions for improvement. For example, if you felt that something was missing from the discussion, discuss including this in the next test.

Once you have a process that works:

- Start introducing the tool to other nurses and doctors. Doing this gradually enables you to keep refining the process until it suits your team and your area;
- Make time for team discussion, reflection and refinement of the tool;
- If it is proving successful, the next step is to get this into people's everyday habits, so it becomes 'the way things are done around here'. Include utilisation of SBAR for other forms of communication.

In addition, it is worth noting the following:

A - Assessment: If you do not have an assessment, don't be afraid to say so. You could say: 'I'm not sure what the problem is, but I am worried.'

R - Recommendation: Know what you would like to happen by the end of the conversation. Any order that is given on the phone should be repeated back to ensure accuracy. The request for direct help should be made clear as part of the recommendation so there is no misunderstanding. This is particularly important in situations where staff may be new, inexperienced or need to communicate up the hierarchy. The use of 'Recommendation' creates a format for staff to clearly state what should happen next, without feeling awkward and uncomfortable.

How should hand-over happen?

The style of hand-over will vary depending on local need¹ – whole hospital handovers to night teams, local handovers on specific units, community-based specialties or those covering several sites. However, all types need a predetermined format and structure to ensure adequate information exchange.

- Ad hoc hand-overs often miss out important aspects of care.
- Handover should be supervised by the most senior clinician present and must have clear leadership.
- Information presented should be succinct and relevant.
- Ideally, this can be supported by information systems identifying all relevant patients.²

An example of the need for structured communication

The 'Hospital at Night' model is a competency-based approach to clinical care and out-of hours medical provision. Doctors, nurses and other healthcare workers work in teams that are not demarcated by traditional boundaries and work is allocated on the basis of skills and competencies. This approach to working relies on co-operation at all levels of the clinical team.

Doctors working in shifts alongside senior nurses provide out-of-hours cover.

One of the major recommendations to come out of the pilot project was that handover was an integral part of successful implementation of such an approach. Successful implementation relied on medical and nursing teams communicating effectively and efficiently both within their teams and also with other teams and shifts. Safe handover = safe patients.³

Case study
 Cardiff and Vale University Health Board have developed a Hospital at Night Single Patient handover template.

Addressograph	Date:	Ward / Patient Location:					
	Time Patient Reviewed:	Date Patient Admitted:					
	Consultant:	Completed by:					
	On call team informed: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Designation: _____ Bleep No: _____						
Situation:							
EWS:	BP:	HR:	RR:	O ² Sats:	A V P U	Temp:	Blood Glucose:
Time:		Rhythm:		O ² therapy:			
The problem is: I am concerned about: When did this start?							
Background:							
Admission diagnosis:							
Relevant medical history and treatment to date:							
DNAR: Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment limitations:							
Assessment:							
AIRWAY:							
BREATHING:							
CIRCULATION:							
DISABILITY:							
EXPOSURE:							
Recommendation:							
I would like you to review:							
When?							
Referral Follow-up:							
Review Time(s)							
Patient Reviewed by:				Role:			
Bleep:							

Safety Briefings and other uses

SBAR can be used to structure Daily Safety Briefings, which frontline staff can use to share information about potential patient safety problems and concerns on a daily basis. They can help to raise staff awareness of patient's safety issues e.g. a particular patient may have had a medication change resulting in increased drowsiness and this raises awareness of the need for increased observation of that patient. It can be based on any area of concern and gives brief time-out for a snapshot of current safety issues.

Case studies for use of SBAR

Betsi Cadwaladr University Health Board (North Wales Trust, East) adopted the SBAR format for many senior management reports including reports for Board meetings and Executive team meetings.

Velindre NHS Trust has developed a Serious Clinical Incident Forum form that is completed when serious incidents may require investigation.

Case Study for use of SBAR

Velindre NHS Trust have developed a template for reporting incidents to Serious Case Investigation Forum using the SBAR format.

Report to SCIF Form				
Situation	Patient name:	Hospital number:	Consultant:	
	_____	_____	_____	
	_____	_____	_____	
	Date incident occurred:	Date reported to SCIF:	IR1 Form completed?	
	_____	_____	_____	
	Reported to SCIF by (please tick):			
	Consultant <input type="checkbox"/>	Staff-internal <input type="checkbox"/>	Staff-external <input type="checkbox"/>	
	Other <input type="checkbox"/>	Please specify: _____		
Background	Outline apparent circumstances of incident:			
Assessment	Please tick the appropriate event category:			
	E: Contributed to or resulted in temporary harm to the patient and required intervention	<input type="checkbox"/>		
	F: Contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalisation	<input type="checkbox"/>		
	G: Contributed to or resulted in permanent harm	<input type="checkbox"/>		
	H: Required intervention to sustain life	<input type="checkbox"/>		
	I: Contributed to patients death	<input type="checkbox"/>		
	No harm	<input type="checkbox"/>		
Recommendations (please tick)	Not appropriate for SCIF	Case logged and closed	Further investigation required?	Case requires Root Cause Analysis?
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SCIF log number	Date consultant informed:	Date RCA initiated:	Who will undertake the RCA?	
_____	_____	_____	_____	

Education and training

Successful implementation of SBAR will require a training programme to be developed and delivered within the area where the tool will be piloted. This training may also be incorporated in other organisational training e.g. ALERT training package and the organisation's induction programme. Several examples demonstrate that using scenarios during the training session is the most effective way of demonstrating the merits of using SBAR as a communication tool.

Case Study

Betsi Cadwaladr University Health Board (North Wales Trust, Central) based their training around the NPSA foresight training video scenario (available at NPSA website). Using a hand-over example with, and without, the use of SBAR.

Time invested in training all staff involved in the hand-over process to understand its use is essential for effective implementation. Incorporating SBAR or other communication tools may seem simple, but it takes considerable training and local engagement in the process of change for improvement. It can be very difficult to change the way people communicate, particularly with senior staff.

Case study

Welsh Ambulance Service NHS Trust included SBAR in their annual paramedic update training and as a result has a high percentage of staff trained.

Organisations using SBAR have found the following useful:

- Stickers with the tool printed on them;
- Pocket cards to remind staff of the process;
- Stickers on or next to telephones to act as a visual prompt;
- Ensuring people feel it's okay to prompt each other using your agreed framework. For example 'Can I make sure I understand you, what is your recommendation here?';
- Sticking or attaching your SBAR sticker or note in the patient records as documentation of the call made - a helpful reference for the responder and other team members;
- Auditing the use of SBAR after a call to the response team and feeding back the effectiveness and quality;

Finally, disseminate your good practice to other teams by modelling the communication behaviour you're aiming for from them. Allow staff to shape the SBAR hand-over to fit their needs.

Case study

Welsh Ambulance Services NHS Trust developed their prompt card following initial PDSA cycles and testing carried out by ambulance crews.

Betsi Cadwaladr University Health Board (North Wales NHS Trust East Division) developed their prompt card and this has been shared across Wales as an example of good practice.

Welsh Ambulance Service NHS Trust SBAR Prompt Card

Welsh Ambulance Services NHS Trust SBAR Reporting

- **S**ituation
 - Patient's name, Age, Presenting complaint.
- **B**ackground
 - History of Presenting complaint, Previous Medical History, Drug History (allergies).
- **A**ssessment
 - Clinical Observations, Signs & Symptoms.
 - Treatment given
- **R**ecommendation
 - State what you would like to see done.
 - E.g. Resuscitation team required or patient requires additional pain relief.*

Important; Please state the SBAR headings for each category

Welsh Ambulance Services NHS Trust SBAR Reporting example.

- | | | |
|---|---|--|
| Patient's name, Age, Presenting complaint. | → | • <i>Situation; Joe Jones, 52 years, central chest pain.</i> |
| History of Presenting complaint, Previous Medical History, Drug History. | → | • <i>Background; Pain increasing for past 1 hour, previous AMI 2years ago, current meds; GTN spray, Aspirin 75mg, Inderal 40mg.</i> |
| Clinical Observations, Signs & Symptoms.
Treatment given. | → | • <i>Assessment; Resps 16, pulse 99, BP 170/80, ECG ST elevation..., BM 6.4, GCS 15.
GTN 800mg, aspirin 300mg, morphine 2.5mg.</i> |
| State what you would like to see done.
<i>eg: time to see doctor, how often obs done, specialist care required (trauma / resus team)</i> | → | • <i>Recommendation; Patient may require further analgesia.</i> |



SBAR Reporting

- S**ituation
- B**ackground
- A**ssessment
- R**ecommendation

- State your name and ward / department
- I am calling about 'patients name'
- The reason I am calling is.....
- Observations are.....

- State the admission diagnosis and date of admission
- Relevant medical history
- A brief summary of treatment to date

- State your assessment of the patient and have records ready of vital signs, Early Warning Score, mental state, mobility

- I would like (state what you would like to see done)
- Determine timescale e.g. NOW!
- Is there anything I should do? E.g. Outreach Team
- Record name and contact number of contact



North East Wales NHS Trust

Examples

- **Need to alert a doctor**
- **Any deterioration in condition of a patient**
- **Staffing levels**
- **Drug alert**
- **Any form of communication**

Do not forget to document the call

Face to face hand-over on the change of shift

Many staff delivering care may consider that hand-over does not require any further change to improve it. Identifying areas for testing of the SBAR tool could be done by a review of the current processes for hand-over or following a patient safety incident. It is important for staff to be engaged in the PDSA process to understand the need for the test of change and what is hoped to be achieved by it.

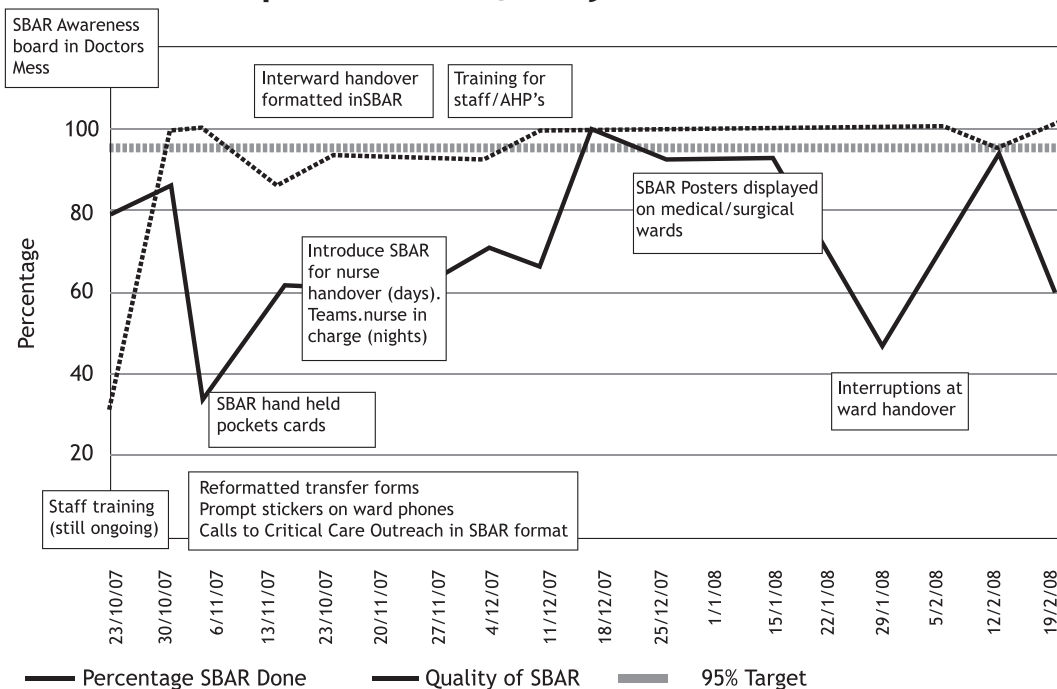
Other questions which may prompt its use:

- How long does the hand-over take?
- Are all the pertinent points about each patient included in the hand-over?
- Does the hand-over facilitate the oncoming staff to deliver the care needed during the next shift?
- Does the hand-over prioritise what each patient requires on commencement of the shift?
- Does everyone understand what should be included in the hand-over process to ensure consistency?

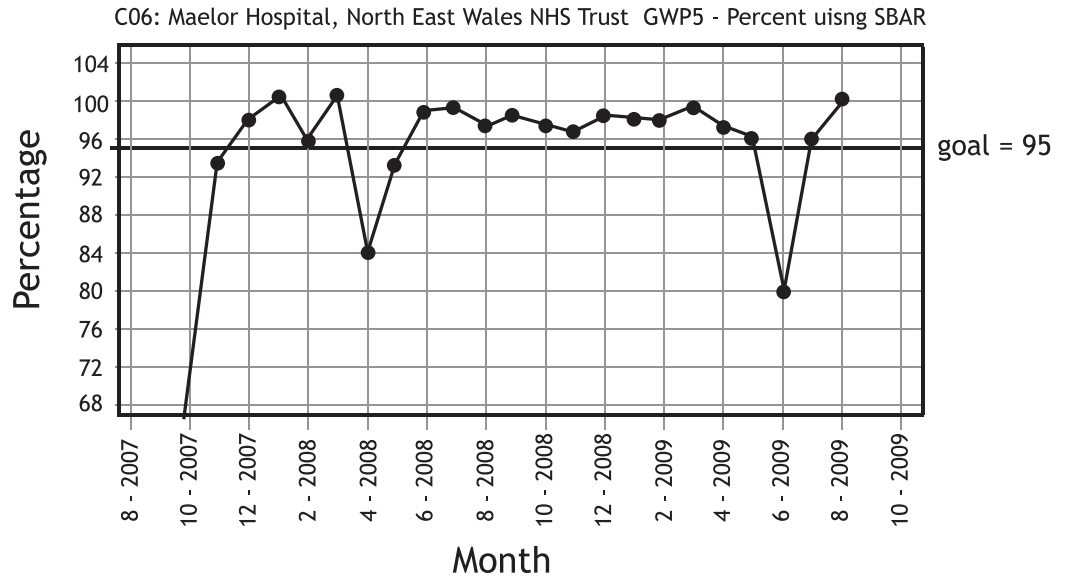
Case study

Betsi Cadwaladr University Health Board (North Wales Trust, East) have developed an audit tool for collecting data on compliance with SBAR and the quality of SBAR being carried out and this is demonstrated on a run chart below.

SBAR completed and Quality



Example of a run chart from Betsi Cadwaladr University Health Board (North Wales Trust, East) demonstrating percentage using SBAR





Tips for introducing a structured clinical communication tool (SBAR)

These examples are drawn from across Wales through the 1000 Lives Campaign

- Identify an area that would benefit from structuring clinical hand-over, for example:
 - step down from ITU;
 - transfer from ED;
 - calling for assistance when a patient deteriorates;
 - after patient safety incident where hand-over/communication is found to be a contributing factor or Root Cause;
 - discharge notification from secondary to primary care.
- Identify frontline champions working in the area who will help to promote the use of SBAR
- Involve the frontline staff in producing the ‘right tool for the job’. Develop relevant SBAR structures for local use.
- Develop PDSAs and use the principles of a small test of change to evolve the SBAR tools.
- Identify all staff that will be involved in the process and ensure they have received the appropriate training.
- Use scenarios in the training package to demonstrate the effectiveness of the SBAR process.
- Develop a simple tool for measuring the quality of the SBAR hand-over.
- Hold meetings to review the use of the tool and any improvements / changes needed.
- Agree the opportunities for SBAR to be used and measure compliance of use in each of the opportunities.
- Review the organisation’s existing communication systems / documentation and consider changing the format (when next due for update) to reflect the SBAR process.
- Identify the successes of use and the quality benefits of using this approach - what works well and what needs improving (PDSAs).
- Spread its use to other clinical communications, e.g. nurse to nurse hand-over at shift change, or communication between primary and secondary care.
- Broaden the use of SBAR to other corporate communications so that it becomes common practice e.g., Executive/ Board reports.
- Report progress on the 1000 Lives Plus Extranet.

Helpful Resources

1000 Lives Plus resources

www.1000livesplus.wales.nhs.uk

The programme's Extranet carries copies of templates developed across Wales:
<http://tinyurl.com/1000lpenet>

All programme areas have the potential to use SBAR as a communication tool within their processes, e.g. Leadership - develop a template for reporting on WalkRounds in an SBAR format.

Links to national and international online resources

A 'Deterioration Incident' video:
<http://tinyurl.com/detincident>

Patient Safety First

<http://tinyurl.com/ptsafety1>

<http://tinyurl.com/ptsafety2>

Institute for Healthcare Improvement

<http://tinyurl.com/ihisbar1>

<http://tinyurl.com/ihisbar2>

NHS Institute for Innovation and Improvement

<http://tinyurl.com/qsitsbar>

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Improving care, delivering quality

If we can improve care for **one person**,
then we can do it for **ten**.

If we can do it for ten,
then we can do it for a **100**.

If we can do it for a 100,
we can do it for a **1000**.

And if we can do it for a 1000,
we can do it for **everyone in Wales**.