Name a Four-Letter Word for Effective Communication: SBAR

MHCA Annual Meeting
May 15, 2008
2:00 - 3:15 p.m.

Presented by the MHCA Clinical Quality Team

StratisHealth

Session Goals

- Describe the SBAR communication model
- Describe successful strategies in applying the SBAR model in a home health agency
- Discuss how to streamline internal and external communication using SBAR

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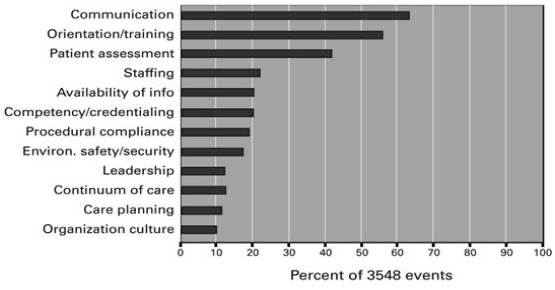
64%

70%

Root Causes of Sentinel Events 1995-2005



Source: The Joint Commission's Annual Report on Quality and Safety 2007
http://www.jointcommissionreport.org/performanceresults/sentinel.aspx

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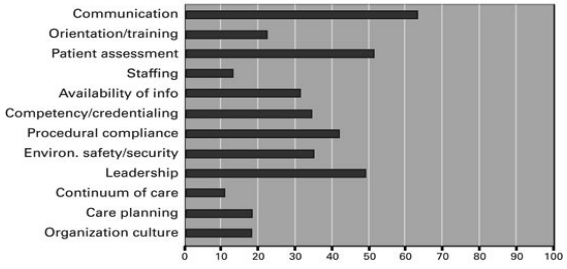
Root Causes of Sentinel Events 2006



Source: The Joint Commission's Annual Report on Quality and Safety 2007
http://www.jointcommissionreport.org/performanceresults/sentinel.aspx

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Why Communication?

- Majority of untoward events involve communication
- Majority of work-related frustration is due to communication inadequacies

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Factors that Affect Communication

- **Environmental Impact**
  - Interruptions and distractions contribute to the clinician's ability to remember pertinent information
- **Assertiveness Skills**
  - Not everyone is comfortable speaking up

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Factors that Affect Communication

Communication Style Differences:

- **Education**
  - Nurses are taught to be narrative and descriptive
  - Physicians are taught to be problem solvers, and want only the "headlines"
- **Teamwork**
  - Nurses do not necessarily see the care environment as collaborative
  - Physicians tend to view the care environment as fairly collaborative

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Teamwork

- Everyone who cares for the patient should be considered part of the team
- This multi-disciplinary team assumes the responsibility to coordinate communication in a timely and effective manner

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SBAR*

Situation

Background

Assessment

Recommendation

*Institute of Healthcare Improvement (IHI) 2006

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What Is the Definition of SBAR?

S = Situation
- What is going on with the patient; a concise statement of the problem

B = Background
- What is the clinical background information that is pertinent to the situation

A = Assessment
- What did you find? Analysis and considerations of options

R = Recommendation
- What action/recommendation is needed to correct the problem; what do you want?

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Situation

Describe the situation you are calling to report.

- Identify yourself, your home health agency, and the patient
- Briefly state the problem, what it is, when it happened or started, and how severe it is

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Background

Give the pertinent background information related to the situation

- The admitting diagnosis for home care, date of admission to the home care agency, date of birth, any recent hospitalizations
- List of current medications, allergies, IV fluids, labs, treatments
- Most recent vital signs

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Assessment

Relay the clinician's assessment of the situation:

- Accurately
- Clearly
- Concisely
- Confidently

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Recommendation

Recommend the action you would like to take:

- Change in the level of care, frequency, and duration
- Request an extra PRN visit to do _____ (lab, follow/up, assessment of lung status, etc.)
- Change, addition to, or deletion of a medication
- Implement agency disease management protocol

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Why SBAR?

- SBAR is similar to the SOAP model
- It provides answers to physicians' three main questions
  - **What is the problem?**
  - **What do you need me to do?**
  - **When do I have to respond?**
- It is a standardized approach that promotes efficient transfer of key information between physicians, nurses, and other team members
- SBAR helps create an environment that allows clinicians to express their concerns

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SBAR Example

Mr. Nelson is a 71 year old male with HTN and COPD. He c/o being tired and weak for the last 2 days.

After the nurse assesses the patient she determines that he has had episodes of syncope, with sudden movements, for the last day or two after starting "that new medication."

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SBAR Example (continued)

BP 102/60(R), 106/62(L), 98/52(L standing) P 72 bpm, & R 24. Previous VS were 164/82(R), 158/80 (L), P 74 bpm, R 22.

The nurse discovers that the patient's "new medication" was filled at a different pharmacy, and was really the same antihypertensive he was already taking.

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SBAR Example (continued)

Situation:

"Dr. Smith, this is Nancy Nurse from ABC Home Care. I am calling about Mr. James Nelson, your 71 year old patient, who is now having episodes of syncope."

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SBAR Example (continued)

Background:

"ABC Home Health has been seeing Mr. Nelson for the last 3 weeks for exacerbation of HTN. His previous vital signs were 164/82(R), 158/80 (L), P 74, R 22. Mr. Nelson has been complaining of lightheadedness, weakness, and syncope with sudden movement.

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SBAR Example (continued)

Background:

Vital signs today were: BP 102/60(R), 106/62(L), 98/52(L standing) P 72, & R 24. The nurse discovered that the patient was taking a double dose of his antihypertensive medication for the last 4 days by accident."

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SBAR Example (continued)

Assessment:

"The patient accidentally had a refill of the same antihypertensive medication filled at another pharmacy. He is hypotensive from the medication error."

Recommendation:

"I would like to hold his antihypertensive medication until tomorrow and schedule two extra skilled nursing visits starting tomorrow to recheck his blood pressure and for medication teaching. Can I have parameters when to restart the medication?"

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References

- Haig, K., Sutton, S., Whittington, J. (2006). SBAR: A shared mental model for improving communication between clinicians. *Journal on Quality and Patient Safety, 32(3),167-175.*
- Leonard, M., Graham, S. Bonacum, D. (2004). The human factor: The critical importance of teamwork and communication in providing self-care. *Qual Saf Health Care 2004.* 13, i85-i90. BMJ Publishing Group Ltd. and Institute for Healthcare Improvement.
- Maison, D. (2006). The interdisciplinary team perspective. Effective communications are more important than ever, a physician's perspective. *Home healthcare Nurse,* 24(3), pp.178-182.

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StratisHealth

Stratis Health is a non-profit independent quality improvement organization that collaborates with providers and consumers to improve health care.

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Using SBAR in Our Agency

2008 MHCA Annual Meeting

- Bonnie Engen, Director
- Clearwater County Nursing Service

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Clearwater County Nursing Service

- Bagley, MN
- Clearwater County, Northwest MN
- Very Rural (1 stoplight in the whole county)
- Headwaters for the Mississippi River at Itasca Park
- Class A License, Medicare Certified
- Home Care, Hospice, Public Health (Jail)
- PHN's, RN's, HHA, HMKR, PT, OT, ST, SW, Volunteers, Bereavement, Chaplains, etc.
- Average 115-120 Skilled Clients in Home Care

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Our Communication Process

- Need to communicate with MD/Therapist/SW/Psychiatrist
- Staff were using various methods, some unsuccessfully, time consuming (waiting for return phone calls)
- Medical providers not answering messages, use of rx pads, note pads, slips of paper, etc

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Our Communication Process

- Need for consistency, accountability and streamlining documentation (example)

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Why use SBAR?

- OBQI team was working on decreasing emergent care/acute care hospitalizations
- Included hospital respiratory therapist and hospital pharmacist when discussing standing orders for CHF and COPD
- When reviewing standing orders communication tool, the hospital pharmacist asked if we had ever used the SBAR format for communication

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Implementing SBAR

- SBAR introduced at staff meeting
- Staff were highly encouraged to use this format for communication from this point on

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Implementing SBAR

- Note to Nurses with SBAR form attached:

SBAR Protocol for Clearwater County Nursing Service

- *Clearwater County Nursing Service Home Care/Public Health/Hospice staff will utilize SBAR reporting to physicians and other health care practitioners when relaying critical information about a client.*
- *The purpose of this format is to offer consistency in communication to practitioners. Each nurse will keep a copy of this format and may make copies to fill out prior to contacting the provider if they wish. If you have questions about the format, please contact Becky, Sharon or Terri (OBQI team)*

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Implementing SBAR

- Sample SBAR form (handout)
- We asked the nurses to review the process/try it and make suggestions
- Continue review/reinforce use at annual evaluations

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Success Story

My Grandchildren

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Success Story

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Success Story

- "Situation"
- "Background"
- "Assessment"
- "Recommendation"

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Success Story

- Nurses presenting the information in this format SBAR…..then being able to ask….
- "What are your recommendations?"
- "It sure is nice to be able to ask nurses following the SBAR protocol, it facilitates communication and promotes an interdisciplinary team approach to patient care." Maggi Engen, University of MN Medical School

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Success Story

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Lessons Learned

- Practitioners respond quickly to this communication, even 'thorny' ones
- Previously a nurse would call with a message and leave it. The office would call back and then we would take a message in the office. None of this was in documentation form (from notes – documentation would have to be done later)
- SBAR provides the documentation and it is added into the chart

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Key Recommendations for Other Agencies

- Staff who are comfortable using the SBAR will recommend it to others- Staff not as comfortable will not change overnight – keep checking with staff about using the tools
- Involve staff in the decision making process and developing the tool specific to your agency

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Key Recommendations for Other Agencies

- Our OBQI team reports at staff meetings once a month – we continue to encourage use of the tools we have developed and share success stories at those meetings

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PHONE AND FAX MESSAGES TO HEALTH CARE PROVIDERS
FROM CLEARWATER COUNTY NURSING SERVICE

TO: _____ **DATE:** _____

FROM: _____

REGARDING: _____

DATE OF BIRTH: _____

- **URGENT**
- **Needs attention today**
- **Can wait until tomorrow**
- **For your information**

Situation:

Background:

Assessment:

Recommendation:

Signature: _____

REPLY:

Signature: _____

Bagley Office
212 Main Ave. N.
Bagley, MN 56621
(218)694-6581
FAX (218)694-6594

Gonvick Office
PO Box 103
Gonvick, MN 56644
(218)487-5272
FAX (218)487-5274

SBAR report to physician/practitioner about a critical situation

S	**Situation** **I am calling about _____ who is receiving Home Care/ Hospice** **The client is _____[DNR or not]** **The problem I am calling about is _____** **I have assessed the client personally:** **Vital signs are: BP _____ Pulse _____ Resp. _____ Temp. _____** **Lung sounds _____** **I am concerned about the:** • BP because it is over 200 or less than 100 or 30 mm below usual • Pulse because it is over 140 or less than 50 • Temp. because it is over 104 or less than 96 • Weight because it is _____ • Shortness of Breath because _____ • Skin condition/wound because_____ • Other because _____
B	**Background** **The client's mental status is:** • Alert and oriented to person place and time. • Confused and [cooperative or non-cooperative] • Agitated / striking out –shaking fist –verbally threatening –picking in the air • Lethargic but conversant and able to swallow • Stuporous and not talking clearly and possibly not able to swallow • Comatose: Eyes closed. Not responding to stimuli **The skin is:** • Warm and dry • Pale • Mottled • Diaphoretic • Extremities are cold • Extremities are warm **The client is not / or is on oxygen.** • The client has been on _____lpm or % oxygen for ____ minutes [hours] • The oximeter is reading _____ % • The oximeter does not detect a good pulse and is giving erratic readings
A	**Assessment** **This is what I think the problem is _____** • The problem seems to be cardiac / infection / neurological / respiratory • I'm not sure what the problem is but the client is deteriorating The client seems to be unstable and may get worse. We need to do something.
R	**Recommendation** **I would like to see the following done: _____** • I don't feel comfortable letting this go on longer and would like _____ • I am requesting that the client come in and see you • I would like to initiate the standing orders for **CHF / COPD** • I would like the on-call provider to see this client now [ER] **Is there any lab work you would like me to do?** [If the client is not sent in] **If a change in treatment is ordered then ask:** • When would you like the next RTC? • Would you like us to see this client again tomorrow, or what are your recommendations? • If **CHF or COPD** standing orders are initiated, follow those orders for follow up and let the practitioner know when you will contact them again.

Using
SBAR in Our Agency
2008 MHCA Annual Meeting

Mary Ann Mastel, RN, PHN
Director of Home Health

Wilder Home Health
Amherst H. Wilder
Foundation

WILDER FOUNDATION
Here for good.
www.wilder.org

Amherst H. Wilder Foundation
Home Health & Supportive Services

- Non-profit foundation - St. Paul, East Metro
- Medicare Certified Class A Agency
- Skilled Care and on going services, Nursing, PT, OT, ST, SW and Home Health Aide
- Home Care employs 55 people, serves 400 clients
- Services to the Elderly Division: 2155 Clients
- Meals on Wheels, Assisted Living, Adult Day Health, Care Giver Services, Dental Clinic, Homemaking
- Grant funded Health and Wellness program

Our Communication Process

- Opportunities for improvement in communication processes:
  - Staffing Department requested clinical staff to provide clear, concise authorization information and aide schedule requests
  - Referral sources/medical providers
  - Internal OT and PTs requested improved reporting by nursing staff

Why use SBAR?

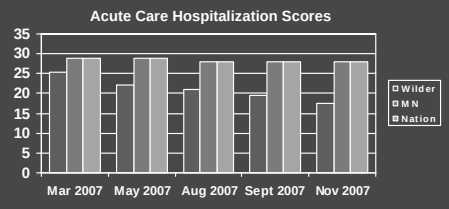
- Stratis Health recommended SBAR at conference
- SBAR Webinar 03/15/07
- Customer service focus
- Improved client outcomes
- SBAR selection process

Implementing SBAR

- Culture Change Project laid ground work for SBAR
- All departments participated in culture change project
- SBAR communication guide for change of status (COS)
- Therapists developed communication guide for internal communication
- All clinical staff training on SBAR
- Laminated SBAR Templates for all staff

Success Story

- Customer Survey – client satisfaction with overall quality of care
- Hospital Readmission rate decreased after SBAR training
- Client success story



SBAR Example

Angie Richie is a 78 year old with CHF, coronary artery disease, hypertension and is an insulin dependent diabetic

Situation:

Wilder home care nurse reports to MD from Angie's home, she is complaining of slight chest tightness and SOB with activity

SBAR Example (continued)

Background:

Weight gain of three pounds since last week. Weight one week ago 178, today 181. Vital signs today were: BP 170/68, P 80, R 24. One week ago: BP 152/60, P 72, R 20.

SBAR Example (continued)

Assessment:

Nurse found client had not taken Lasix for three days, "I don't want to get up at night". She has increased SOB and weight gain due to missed diuretic.

SBAR Example (continued)

Recommendation:

I would like to give her a double dose of Lasix today (40 mg this morning and evening) and resume 20 mg BID tomorrow. I would like to make one extra visit this week to assess her status. I will institute our "Heart Failure Symptom Awareness and Action Plan" with Angie.

Lessons Learned

- SBAR creates a more efficient way to communicate
- Physicians rely on home care to assess, report, and recommend
- Improved communication improves outcomes
- Excellent communication will improve customer service at all levels

Key Recommendations for Other Agencies

- Communication is the central factor in providing quality, safe services
- Involve employees from all departments
- Include SBAR in new employee orientation
- Provide periodic training on SBAR to ensure staff are using this proven model

Change of Status (COS) Procedure

SBAR – Communication for authorization, service changes, home health aide scheduling.
E-mail only. Must be done within 24 hours of change.

S = Situation

- Client home, ID# and date of change, name of clinician e-mailing

B = Background

- Admission - funding, discipline, if pp $ amount, who is case manage
- Change of funding – new funding source, date to start change, disciplines
- Resumption of care (ROC) - which services resumed and the funding
- Hold – reason on hold
- Adding or discontinuing discipline – what discipline
- Change in frequency – what is change
- Discharge – date of last visit
- Demographic changes – address, phone, SS#, apt #, change in case manager, billing address

A = Assessment

Assesment of client need for aide service

- Service need changes, type of bath, add grocery shopping, etc.
- Need to change schedule
- Report services not meeting client expectation

R = Recommendation

- Arrange aide visit to coincide with supervisory visit
- Recommend visit day of week and time

A = Assessment

Assesment of client need for aide service

- Service need changes, type of bath, add grocery shopping, etc.
- Need to change schedule
- Report services not meeting client expectation

R = Recommendation

- Arrange aide visit to coincide with supervisory visit
- Recommend visit day of week and time

SBAR: Internal Script for Communication - Nurse to Therapist

S = Situation

- Who message is for, OT, PT or both
- Client name
- Name of nurse
- All disciplines involved in care
- Nursing report of observations, both home environment and client status

B = Background

- Date client opened to skilled care
- Date of last hospitalization or TCU stay if known
- If nurse has seen client in the past, describe changes in client function, mobility or mentation

A = Assessment

- Nursing assessment of client need for PT or OT

R = Recommendation

- What nurse sees as goals for therapy – nurse to recommend equipment needs.

SBAR: Clinician Communication to Physician

SBAR – should take no more than 90 seconds

SBAR Purpose:
The **SBAR** tool is a strategy to **improve communication** from clinician to physician, clinician to clinician and/or staff to manager. **SBAR organizes the message in a consistent and concise manner.**

SBAR

S = Situation
What is going on with the patient? A concise statement of the problem.

B = Background
What is the clinical background information that is pertinent to the situation?

A = Assessment
What did you find? Analysis and considerations of options.

R = Recommendation
What action/recommendation is needed to correct the problem? What do you want?

I am Fairview.

Using SBAR for
Interdisciplinary Communication

Fairview Home Care
Sylvia Haroldson, Clinical Manager

fairview.org FAIRVIEW

I am Fairview.

Fairview Home Care:

- Located: Minneapolis with Branch Office Princeton
- Free Standing Agency with Fairview Healthcare System Affiliation
- Both Urban and Rural settings
- Cover 12 Counties, Metro and north to Milaca
- 75 Nurses, 35 PTs, 11 OTs, 5 SLPs
  1 Chaplain and 35 HHAs
- Active census of 800 patients, 600 admits per mo
- Specialty Teams include Cardiac, Diabetes, Multiple Sclerosis and Complex Care, WOCN, Mental Health
- Telemonitor Program and Lifeline

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Our Communication Opportunities

- Largest user of Voice Mail in FV System
- Patient Care Communication time intensive
- Room to improve our Customer Service scores
- New Centralized Scheduling Department
- Patient Safety as Fairview System Goal

fairview.org FAIRVIEW

I am Fairview.

Why use SBAR?

- Fairview Healthcare System Quality Improvement
- TeamStepps - evidence-based teamwork system
- Demonstrated positive impact in Hospitals
- Our Management Team identified need
- Implementation Team is mostly visit staff

http://www.ahrq.gov/qual/teamstepps/

fairview.org FAIRVIEW

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Implementing SBAR

2007 Agency Competency
- Included Office and Patient Care employees
- Roll out tools include:
  - Patient Care Rounds Template
  - Laptop reminder sticker
  - Embedded terminology into written processes
  - Posted reminders at sites

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Success Story

- New sense of empowerment
- Decreased time spent on Voice Mail
- Improved communication within agency
- Some reduction of stress in Scheduling Department
- Common language to promote communication

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Lessons Learned

- Not quick to change Old Habits
- Need for ongoing reinforcement
- Leaders need be role models

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Key Recommendations for Other Agencies

- Needs to be included into daily practice
- Involve visit staff early and often for planning and rollout
- Implement useful tools as daily reminders
- Culture change takes time

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Questions ?

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FAIRVIEW

Fairview Home Care and Hospice

S B A R Communication

S ituation What is happening?

Hello, Dr. Peterson, my name is _____, calling from FHCH about your 81 year old patient, Polly Doe. I'm calling because Polly is experiencing increased pain in her abdomen tonight.

B ackground What were previous events?

Polly recently had a Rt total hip replacement and was discharged from the hospital 5 days ago. While in the hospital she had a foley cath placed which was removed before she came home. She has a history of recurring UTIs. She has no known allergies. She is currently taking Vicodin for pain and is on meds for hypertension.

A nalysis Summary of what you found?

Polly called our triage line tonite complaining of new pain in her low abdomen rated as an "8". During my home visit I found she is having difficulty urinating, her bladder is distended, and her temp is 100.4 degrees.

R ecommendation What action do you want?

Polly has requested she stay in her home. I would like to catheterize her to obtain a urine culture and relieve the pressure and will call you with the lab results to see if she needs an antibiotic. What are your thoughts?

FAIRVIEW

Fairview Home Care and Hospice

S B A R / Patient Rounds

S ituation What is happening?

I am following a patient named_____. The primary diagnosis for this episode of care is ____. Other pertinent diagnoses include _____. Other disciplines currently involved with me in this care are _____. The skilled need/qualifying criteria for home care is ____. The patient's discharge goal is ____.

B ackground What were previous events?

The patient is ___ years old. He was admitted to home care on ____ following changes in his medical condition subsequent to a hospitalization for____, or outpatient provider concerns about____. The patient's primary caregiver is ____. The patient is discharged from disciplines including ____ (ex: SN for____, therapies for____, HHA for___, SW/Chaplain for ___). Additional support and community resources include ____ (ex: non-primary caregivers, county programs, meals on wheels, church, adult day care, others). The patient/caregiver has progressed in the areas of___ (ex: learning med management, wound healing, understanding disease management, tolerance to progressing home exercise program, ADL management, other). The remaining barriers to progressing the plan of care include_____ (ex: lack of caregiver support, frequent re-hospitalizations, financial concerns, home safety, inability/unwillingness to follow the plan of care, lack of identified community resources to support patient's discharge goals or transition to community care other than home health, complex medical care, resources to manage custodial needs, payer changes, lack of MD support, others…).

A nalysis Summary of what you found?

I need assistance from the team to resolve my concerns about _____ (the barrier as stated above).

OR

This has been a challenging case. The team working with this patient has been successful in progressing this patient's plan. I would like to share strategies I learned, or new and interesting information that could benefit others (ex: new medication, new treatments protocols, complicated diagnosis, new community resource, other).

Team Discussion: What possible interventions could resolve the stated concern?
What other agency resources may be needed to assist the clinician? (referrals to disciplines, managers, medical director, information from support departments, other).

R ecommendation What action do you want?

Based on team input:
Next action steps to take.
Revision of patient home care goals as deemed appropriate.

OR

Discuss how peers may apply new information learned while managing this case.

Person presentation case to document that care was discussed at Patient Care Rounds. Update patient's Plan of Care with recommendations.

S B A R / Patient Rounds
Example

S ituation What is happening?
Mrs. D lives with daughter who is overwhelmed with personal cares required, having trouble accepting diagnosis and impending death.

B ackground What were previous events?
88 yo female with end stage metastasis breast cancer. Is unnresponsive and totally dependent for all cares. Daughter is only caregiver. Pt. is in full sized bed 24 hours a day.
SN, SW, OT and HHA on palliative care team are involved in care.

A nalysis Summary of what you found?
Team Discussion: Physically care needs of patient not being met. Concern for daughter's ability to understand disease progression and need for equipment and additional assist. Refused to consider Hospice.

R ecommendation What action do you want?
Based on team input: SN to teach physical changes that are expected and minimum care necessary. OT for equipment needs, like hospital bed. SW to facilitate end of life discussions with daughter and offer community resources for respite. HHA for assist with personal cares.

SBAR Resources

SBAR Toolkit: www.medqic.org

Under "Care Transitions"

- SBAR Tool
- COPD SBAR
- SBAR poster
- SBAR interdisciplinary communication
- SBAR pocket card template
- SBAR discipline worksheets
- Recorded SBAR Web Ex/audio

Under "HHQI Best Practice Intervention Packages"

- Physician Relationships