Why use SBAR? – Information for Physicians

Situation
SBAR (Situation, Background, Assessment, and Recommendation) is being implemented as the format for nurses to share relevant patient information with physicians.

Background
- The primary objective of SBAR is to provide accurate and concise information about a patient's care, treatment, current condition, and any recent or anticipated changes.
- Attributes of effective communication include allowing for the opportunity for questions between the giver and receiver of information, limiting interruptions, and providing a process for verification of the received information.
- Standardizing the communication between nurses and physicians ensures accuracy in the information to meet patient safety goals.
- Consistency of information content and sequence enables the giver and receiver to know what to expect.
- This format is being used by other disciplines in our community and across the country.

Assessment
- There is variability in the type and amount of information that nurses and physicians communicate with one another.
- Looking back after something has gone wrong usually reveal gaps in communication:
    - CONCERN was expressed
    - THE PROBLEM was stated, often not clearly
    - A PROPOSED ACTION didn't happen
    - A DECISION was not reached
- The "R" is the component most often omitted or not explicitly stated in the nurse's report to physicians.
- Many nurses feel that they provide this information; however, the sequence is not used.
- SBAR 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.

Recommendations
- Post a laminated copy of the attached one-page description of SBAR in all nursing units.
- Provide all nurses and physicians with a copy of the attached document.
- Use the attached tool when communicating about the patient between nurses and physicians.
- Provide feedback to staff on their use of SBAR and opportunities for improvement.

SBAR COMMUNICATION TOOL

Before Calling Physician:

- **Assess patient, know admit diagnosis, and review latest physician and nursing notes**
- **Determine level of urgency – can it wait until the next physician visit?**
- **If non-urgent, consult with charge RN, manager, CTL or specialty nursing units to problem solve (see nursing units list below)**
- **Review AMION for the correct physician**
- **Be ready to report allergies, medications, IV fluids, lab, and other test results**
- **Coordinate phone call with others on your unit – avoiding multiple pages**

S	**Situation: This is……. and I am calling about** (patient name and location) ______________________________ **The problem I am calling about is** (briefly state the problem-what it is, when it started and how severe) ______________________________
B	**Background: Reason for this Admission**______________________________ **Medical/Surgical History useful for this Call** ______________________________ **Pertinent Labs/Test Results**______________________________ **Current Therapy** (pertinent meds, IV's, treatments, Monitoring etc.) ______________________________ **Current VS:** BP___/___HR______ RR______ Sats_____% Temp____ **Other Clinical information to think about:** If cardiac issue, assess: chest pain, location, duration, radiating, troponin, ECG change, anxiety If pulmonary, assess: lung sounds, rales/rhonchi, SOB, chest tube, oxygen level, anxiety, pain If neuro, assess: LOC change, altered speech, numbness & tingling, paralysis If gastrointestinal, assess: bleed, pain, emesis, NG If renal, assess: I/O, urine output <30cc/hr or <240cc/8hr, edema, urine concentration, foley If pregnant: gestation age, fetal HR, fetal movement, contraction, bleed, NST
A	Assessment: **This is what I think the problem is:** (nursing assessment of what is happening)
R	**I suggest that we / Should we** (say what you would like to see done): ______________________________ **Any tests needed**: CXR, ABG, ECG, CBC, COAGS, Cultures etc. **Is a change in treatment needed? Does patient need additional consults? Is a higher level of care needed? Tele, ICU, etc.** **Do you need physician to come and see patient?**

Specialty Units and (extension)

Burn: 5N (40056), ***Cardiology***; 7S -CICU (40077), 7W (40079), 5S (40050), & 5W (45052), ***Dialysis***: 6S (40067)
Medicine: 7E -MICU (40073) & 8W (40089), ***Neurology***: 8S (40087), ***Oncology***: 8E (40083), ***Ortho***: 9S (40097) & 9E (40093), ***Rehab***: 9W (40099) ***Surgical/Trauma***: 3CM -SICU (40063), 6W (40069), 6E (40063) & 5E (40053)
ED: (43307), ***OB***: 2CM (40059, ***BH***: 4BH (40042), 5BH (40052), 6BH (40062), 7BH (40072)

Appendix

***2006 The Joint Commission Requirement 2E*:** Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.

Rationale: The primary objective of a "hand off" is to provide accurate information about a patient's/client's/resident's care, treatment and services, current condition and any recent or anticipated changes. The information communicated during a "hand off" must be accurate in order to meet patient safety goals. Research studies performed by NASA have identified effective "hand off" strategies in settings with high consequences for failure. These strategies are applicable to the health care environment.

In health care there are numerous types of patient hand offs, including but not limited to nursing shift changes, physicians transferring complete responsibility for a patient, physicians transferring "on-call" responsibility, temporary responsibility for staff leaving the unit for a short time, anesthesiologist report to post-anesthesia recovery room nurse, nursing and physician hand off from the emergency department to inpatient units, different hospitals, nursing homes and home health care, critical laboratory and radiology results sent to physician offices.

Guidelines: The following are attributes of effective "hand-off" communications.

- "Hand-offs" are interactive communications allowing the opportunity for questioning between the giver and receiver of patient/client resident information.
- Hand offs include up-to-date information regarding the patient's/client's/resident's care, treatment and services, condition and any recent or anticipated changes.
- Interruptions during "hand offs" are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.
- "Hand offs" require a process for verification of the received information, including repeat-back or read-back, as appropriate.
- The receiver of the "hand off" information has an opportunity to review relevant patient/client/resident historical data, which any include previous care, treatment, and services.