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Use of the SBAR tool in patient handover: a strategy for effective communication

Emprego da ferramenta SBAR na transição do cuidado: uma técnica para a comunicação efetiva

Empleo de la herramienta SBAR en la transición del cuidado: técnica para la comunicación efectiva

ABSTRACT

Objective: To report the experience of implementing the Situation-Background-Assessment-Recommendation tool for standardizing staff communication during patient handover. **Method:** Experience report of activities carried out in a university hospital which included discussion and analysis of adverse events resulting from communication failures. **Results:** The actions in the patient handover process were standardized through the development and review of protocols, use of the Situation-Background-Assessment-Recommendation tool in patient handover between units, and establishment of admission and care flows. **Conclusion:** The tool provided the standardization of actions in the patient handover process, contributing to improvements in the work process of the interdisciplinary team and, consequently, in patient safety.

Descriptors: Continuity of patient care; Patient safety; Communication; Quality of health care; Nursing.

RESUMO

Objetivo: Relatar a experiência da implantação da ferramenta Situation-Background-Assessment-Recommendation para a padronização da comunicação entre profissionais durante a transição do cuidado. **Método:** Relato de experiência de atividades realizadas em hospital universitário, que abrangeu discussão e análise de eventos adversos decorrentes de falhas de comunicação. **Resultados:** As condutas no processo de transição do cuidado foram padronizadas por meio de elaboração e revisão de protocolos; emprego da ferramenta Situation-Background-Assessment-Recommendation nas transferências de pacientes entre unidades e estabelecimento de fluxos de admissão e atendimento. **Conclusão:** A ferramenta propiciou a padronização de ações no processo de transição do cuidado, contribuindo para melhorias no processo de trabalho da equipe interdisciplinar e, consequentemente, para a segurança do paciente.

Descritores: Continuidade da assistência ao paciente; Segurança do Paciente; Comunicação; Qualidade da assistência à saúde; Enfermagem.

RESUMEN

Objetivo: Relatar la experiencia de la implantación de la herramienta Situation-Background-Assessment-Recommendation para la estandarización de la comunicación entre profesionales durante la transición del cuidado. **Método:** Relato de experiencia de actividades realizadas en hospital universitario, que abarcó discusión y análisis de eventos adversos resultantes de fallas de comunicación. **Resultados:** Las conductas en el proceso de transición del cuidado fueron estandarizadas por medio de elaboración y revisión de protocolos; empleo de la herramienta Situation-Background-Assessment-Recommendation en las transferencias de pacientes entre unidades y establecimiento de flujos de admisión y atención. **Conclusión:** La herramienta propició la estandarización de acciones en el proceso de transición del cuidado, contribuyendo para mejoras en el proceso de trabajo del equipo interdisciplinario y, consecuentemente, para la seguridad del paciente.

Descriptores: Continuidad de la Atención al Paciente; Seguridad del Paciente; Comunicación; Calidad de la atención de salud; Enfermería.

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INTRODUCTION

In recent years, the development of global policies and strategies aimed at patient safety has been observed in countries with different levels of development[1]. In Brazil, in April 2013, the Ministry of Health instituted the National Patient Safety Program (NPSP) through Ordinance 529, with the objective of creating a contribution program for the qualification of care in all health establishments[2].

The NPSP is based on the six Patient Safety Goals: identify patients correctly; improve staff communication; improve safety in the prescription, use and administration of medications; make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body; sanitize the hands to prevent infections; reduce the risk of falls and pressure injuries[2].

The goal "improve staff communication" deserves to be highlighted because communication and teamwork are essential elements to strengthen the patient safety culture. Somehow, all the other goals established by the NPSP depend on adequate communication.

Furthermore, communication failure is one of the main causes of adverse events that result in death or serious harm to patients[3]. From the patients' initial care, through all stages of care, until hospital discharge, communication is essential for a favorable outcome.

Furthermore, research has shown that the patient handover is a critical process in which communication failures may occur[4-7].

The World Health Organization (WHO) plans to improve the effectiveness of information transfer through the use of interactive and effective technologies. The tool known as Situation-Background-Assessment-Recommendation (SBAR) was the first method recommended to improve staff communication[7].

The SBAR tool is a mnemonic used to help professionals list important information to be transmitted during patient handover. It consists of quick questions, standardized in four sections: S – Situation: identifying the patient and the reason for his hospitalization and/or procedure; B - Background: informing the patient's history, medications in use, allergies and relevant test results; A – Assessment: informing vital signs, clinical impressions, changes in physical examination, presence of devices and concerns; R – Recommendations: indicating complementary exams, specific care and other recommendations[8].

Although communication in healthcare is quite complex and involves the entire multidisciplinary team, it tends to be underestimated, putting patient safety at risk. With the objective of encouraging discussions about strategies to improve communication between health professionals and patients, this paper aims to report the experience of implementing the SBAR tool for standardizing communication between professionals during patient handover in a university hospital in the southeastern region of Brazil.

METHOD

This is an experience report on the use of the SBAR tool to standardize staff communication during patient handover in a university hospital in the Southeast region of Brazil. The information contained in the report comprises activities carried out from January to December 2014: the first stage, which involved the survey of events, discussion and preparation of the action plan, took place from January to March; the second stage, referring to the review and elaboration of protocols, forms and description of flows, took place from April to July; and the third stage, in which training and implementation of protocols, forms and flows were carried out, took place from August to December.

The search for a tool to guide and standardize the communication process arose from the observation that 71% of a sample of 263 adverse events reported at the institution in the 2011-2013 triennium presented communication flaws as a contributing factor to their occurrence.

Starting from monthly meetings held at the institution in which the prevalent adverse events were presented to the Boards, Middle Management and the multidisciplinary care team, reports of communication failures were discussed, and it became evident that most occurred during patient handover. The analysis of the events was carried out by the multidisciplinary team, listing the root causes and demonstrating the need to develop an action plan to improve the process.

The study was approved by the Research Ethics Committee (REC) of the university, opinion nº 447.736, CAAE: 21793013.0.0000.5392.

RESULTS AND DISCUSSION

This study was motivated by concerns about how the communication process among health team members took place and the hindering factors of this process. The expectation of being able to contribute to the improvement of communication processes enabled actions to be implemented in partnership with professionals from the institution in question. The working group defined actions, objectives, locations, persons in charge, and way of doing things, costs and deadlines.

The improvements derived from this process were: elaboration and revision of protocols for standardizing the conducts in the patient handover process; use of the SBAR[8] tool in patient handover between units; establishment of admission and patient care flows in patient handovers.

A working group was created for the preparation and revision of protocols. First, the existing protocols in the institution that covered any of the stages related to patient handover - for example the protocol of transport and transfer of patients - were surveyed. Next, processes related to patient handover that were not described as change of shift report, transfers between units, and referrals for exams or discharge were identified.

It was established that the entire patient handover process should be described in the patient's medical record in its own form or in the daily clinical record.

Thus, the review and development of protocols related to patient handover processes was initiated under the coordination of nursing managers and in conjunction with the multidisciplinary team. Interactions between the multidisciplinary teams and support teams were promoted, aligning patient admission flows in the care units and in the diagnostic and therapeutic support units, so as to ensure the annotation of this information in the medical record.

During this process, a need to acquire certain materials to improve the conditions during patient handovers was detected and a schedule was drawn up for the purchase of wheelchairs, cribs and transport stretchers with bars and boards for transferring patients.

The SBAR tool was studied by the executive nurses of the units, adapted and implemented in some units of the hospital, such as the Intensive Care Unit (ICU) and Emergency Room (ER), in order to highlight the patient handover in the patient's record through of a specific form and standardize the relevant information to be shared among the professionals who were to assume the care of those patients.

Specific documents were created, based on the four sections of the SBAR, to describe the patient handovers between units. In the urgency and emergency units, the nurses were responsible for filling in the information when referring the patient to hospitalization in the ward and/or ICU, and the nurse who received the patient checked the information and signed the form, validating the process. In the discharge of patients from the ICU to the wards, various care actors were responsible for the filling of the form: nurse, physician, physical therapist, nutritionist, among others, depending on the complexity of the patient and validation by the nurse receiving the patient.

It was also observed that the patient handover process could not be linked solely and exclusively to a tool/print and that the work processes of each unit should be considered for its implementation.

Thus, after several discussions, it was decided to use the notes in the medical records for the registration of the patient handover from other units. These notes should contain all relevant information about the patients.

The Surgical Center also adopted the SBAR tool, reformulating the existing pre-, intra- and postoperative registration forms, adding information about the patients' conditions for continuity of care.

Finally, a form was created by the executive nurses of the units to record the patient handover at the time of referral for exams, including essential information regarding the process, such as fasting time and specific preparations, in order to ensure the performance exams at the correct time and in an adequate and safe way.

All flows were described in order to support the standardization of the process and training of teams. The protocols were institutionally disseminated and trainings were held at various dates and times. In a second moment, training was carried out *in loco*, in each care unit, in order to reach the largest number of professionals in the multiprofessional team. The forms were implemented in their entirety and remain in use at the institution, providing safety and quality to the patient handover process.

The interventions proposed in this study were motivated by the desire to improve patient safety through effective communication in patient handovers.

Several studies[4-7,9-10] show that standardizing the information used by professionals at each stage of patient handover can reduce the occurrence of incidents and minimize complications.

The implementation of protocols and guidelines has a great impact on clinical practice, as in addition to directing and standardizing care, it helps for the reading of the results, comparing them with indicators and other standards of care[11].

Communication in patient handover processes is more efficient when it involves the record and standardization of the information and not just the verbal transmission of data. Patient safety is reinforced when there is standardization of procedures, leaving no margin for the professional to decide whether or not to provide certain information or impressions about the patient[9].

However, it can be observed that verbal communication prevails among some professionals. In addition to promoting direct and quick feedback, verbal communication makes it possible to solve some problems with the priority they need[10]; however the lack of standardization in this type of communication can generate unsafe situations, due to the omission of important information.

When patients are admitted to emergency units, communication failures between health professionals and the consequent loss of information can result in incorrect decisions in terms of acuity assessment or order of prioritization. Screening decisions determine the patient's destination and, when mistaken, they can expose patients to a greater risk of adverse events[4].

The literature highlights several safety risks during patient handover in the perioperative period. When transferring from an inpatient unit to the operating room, patients are often transferred by a third person. This process increases the risk of losing important information, making it impossible for professionals in the operating room to identify possible risk factors[12], which confirms the importance of implementing the tool for transitioning care to the Operating Unit mentioned in this study.

The transfer of patients from the ICU to inpatient units is another important moment. These patients are at high risk of adverse outcomes, including readmission to the ICU and increased nosocomial infections and mortality, with a consequent increase in hospital costs. Transfer time, factors that affect care at these units, and the recognition of signs of deterioration must be addressed in this process, in order to ensure optimal care for this group of complex patients[13].

Both nurses and physicians recognize the importance of good interdisciplinary communication and collaborative work to sustain an effective workflow and enable a supportive work environment and patient safety. However, care and safety flaws were found mainly due to difficulties in communication and work flow. Existing communication systems do not always contribute to effective communication, making the improvement of communication strategies necessary, removing barriers to decision-making and the effective flow of patients[14].

The qualification of the patient handover process between all units is essential for safe and quality care. Lack of communication during transfers can lead to diagnostic delays, unnecessary and even contraindicated procedures and treatments[3].

From this perspective, all the studies presented corroborate the need and the importance of improving the communication process in health. The lived experience demonstrates the path taken from the mapping of the different moments of patient handover to the implementation of a standardized registration model, in order to make it possible that all the information necessary for the continuity of patient care be transmitted to the professionals who assume that responsibility.

CONCLUSION

The use of the SBAR tool to standardize the patient handover process, in all its variations and extensions, contributed to improvements in the work process of the interdisciplinary team, supporting a body of knowledge that favors health care with better outcomes.

We believe that when the multidisciplinary team develops clear and precise communication, it contributes to greater safety in the care process, improving the quality of care and ensuring that the care provided does not harm the patients.

We understand that the occurrence of adverse events due to communication failures can be drastically reduced with the implementation of the actions listed above.

As for the limitations of this study, the process of standardizing communication between professionals during the transfer of care and its results are sensitive to the studied context, thus preventing the generalization of the findings, but which can possibly be applied to institutions with similar scenarios.

Regarding the contributions of the study, the mapping of the different moments of the patient handover and the implementation of standardized forms for recording provide qualification and safety in the nursing care process, allowing for the identification of opportunities to improve the care provided to patients and prevent adverse events.

Based on the above, it is evident that the challenges for the implementation of strategies linked to the NPSP are enormous, but not insurmountable. Effective strategies that involve professionals at all stages and provide an understanding of its importance and imminent need are necessary.

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