SBAR Basics
A RESOURCE GUIDE FOR HEALTHCARE MANAGERS

Susan W. Hendrickson, MHRD/OD, RN, CPHQ, FACHE
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Susan W. Hendrickson, MHRD/OD, RN, CPHQ, FACHE, is the director of clinical quality and patient safety for the Via Christi Wichita (KS) Health Network. The network is made up of two acute care campuses, a behavioral health campus, a freestanding physical rehabilitation hospital, and a variety of outpatient and physician clinics. In her role there, Hendrickson has oversight responsibilities for patient safety, core measures, quality management/process improvement, clinical risk management, infection control, patient grievance resolution, regulatory compliance, and survey readiness activities.

Hendrickson has held several administrative positions during her career. Prior to joining Via Christi, she was the executive director at a large home health agency, with four branch offices across Kansas. Other positions she has held include chief executive at a long-term acute care hospital, regional director of quality for a physical rehabilitation hospital company, and director of quality and risk management at a freestanding physical rehabilitation hospital. She began her career as a staff nurse working primarily in neonatal intensive care.

Hendrickson received her master’s degree in human resource development/organization development from Friends University in Wichita, KS, and her bachelor’s degree from Eastern Montana College in Billings, MT. In addition to being a registered nurse, Hendrickson is certified in healthcare quality and is a fellow in the American College of Healthcare Executives. She has been a guest presenter in a variety of venues and has authored several articles.
I wish to acknowledge the many staff members at Via Christi Regional Medical Center who worked diligently to bring SBAR into our organization. There were numerous people who participated on teams and carefully sorted through the nuances of how to implement this communication technique.

I am especially grateful to the staff members in the clinical quality and patient safety department. They continue to lead teams and remain focused on our goal of improving communication between caregivers in order to provide safe, quality care for our patients. Many of the tools in this book were created by these dedicated professionals and the teams they led.

I also wish to acknowledge the members of the Wheat Plains Health Network, who worked together to develop a interfacility communication tool, which appears in this book as well.

I am particularly thankful to my husband, Bob, for his loving support of this project. Despite the many hours I spent working on this book, he continued to encourage and support me.

Finally, my editor, Mary Stevens, deserves a lot of credit for this book. She provided great expertise, insight, and encouragement.
Effective communication is just as crucial to delivering optimal patient care as is having the right equipment, staff, training, and resources. Good communication is a Joint Commission National Patient Safety Goal (NPSG), as well as a requirement of several standards. The Centers for Medicare & Medicaid Services (CMS) also emphasizes effective communication, and it is a rallying cry of patient safety organizations, including the Institute for Healthcare Improvement, World Health Organization, and many others.

Unfortunately, breakdowns in communication remain a leading cause of unexpected outcomes, sentinel events, and near misses. You don’t have to look very far to find a well-publicized incident in which communication failure among caregivers led to a tragic or potentially dire situation for a patient.

If everyone agrees that effective communication is a key to excellent patient care, why is it so difficult for staff members to give each other the information necessary to make it happen?

This question has as many answers as there are people working in healthcare. Every healthcare system includes a diverse group of people, of all ages and backgrounds, working in shifts. Patient populations are just as diverse, with a wide variety of needs. Often, more than 10 caregivers will see a patient during a hospitalization. These conditions add up to myriad opportunities for incomplete or inadequate communication.

And yet, public and regulatory scrutiny is greater than ever before. New initiatives at CMS make costs for preventable errors—such as those that can result from poor
communication—non-reimbursable. Not only will hospitals have to pay for these expenses, they also will have to deal with the consequences of negative publicity of such errors (i.e., fewer patients, lower patient satisfaction, and lower morale among staff members). Tools for fostering effective communication in healthcare have never been more important.

This is where SBAR (Situation, Background, Assessment, Recommendation) comes in. SBAR was developed by the military and has been used successfully in many other high-risk industries to deliver key information quickly. Now healthcare organizations are turning to SBAR to help them deliver better patient care and comply with The Joint Commission’s NPSGs and other standards.

Using this acronym, one person can quickly apprise another of a present situation and provide essential background information, an assessment, and a recommendation. Information is given in an orderly manner, with minimal extraneous details. And if it’s effective enough for the U.S. military, shouldn’t it work in your hospital?

In reality, it might not. Although some hospitals have rolled out SBAR and kept it working well, many other facilities have tried to implement SBAR only to see early success wither away as new, more urgent matters arise. Staff members might become familiar with the acronym but have no idea how to use it to communicate. If a hospital lacks the resources and widespread commitment to make it succeed, SBAR can end up as little more than a sticker by the phone or a laminated reminder card that stays in a clinician’s pocket.

If you’ve been charged with deploying, fine-tuning, or reviving SBAR at your hospital, bring this book along to help you avoid the pitfalls that would hinder implementation.
How to Use This Book

SBAR Basics: A Resource Guide for Healthcare Managers will show you what you need to do to make SBAR work in your facility. In the following pages, you’ll learn how to:

- Enlist support from leadership and every department
- Educate staff members effectively
- Pilot-test SBAR in one area
- Fine-tune your rollout based on pilot results
- Follow up to determine what’s working and what isn’t
- Keep SBAR going in your facility

In my experience with SBAR, I’ve seen what it takes to get nurses, doctors, administrators, and leadership to “speak the same language” and learn how to provide vital information quickly. I hope you can use the knowledge I gained from rolling out SBAR to make it a success in your facility. Helpful tools and additional resources will help you stay on track, and customizable versions of many tools in this book are included on the CD-ROM.

As you read these chapters, the related case studies, and other resources, you’ll see that SBAR is a communication tool, not a cure-all for eliminating errors. It takes time and sometimes more than one attempt to make SBAR work, and it’s only as effective as practitioners make it. However, the benefits of SBAR, including better patient care and clearer communication throughout your hospital, can resonate for years to come.
If you look up “communication” in a dictionary or online, you’ll find definitions similar to this one: The act or instance of transmitting; a process by which information is exchanged.¹

Communication is a cornerstone of healthcare, and you cannot have good care if you do not have good communication. As healthcare workers, we engage in communication continuously. Think about your day or that of any healthcare worker: At any given
time, you’re writing in a record, transmitting information verbally to a coworker, or entering data into a computer. Patients and clients move between disciplines, departments, and settings many times in the course of a healthcare encounter. Each move is accompanied by communication of information that the next provider needs in order to care for the patient.

You know that effective, clear communication is an essential component of teamwork. However, if you’re like many practitioners, you may be having a hard time communicating well or getting others in your facility to communicate effectively. Although there is plenty of evidence that communication breakdowns are a major cause of breakdowns in patient care, many hospitals and healthcare workers continue to struggle to deliver information in a clear, concise way.

Barriers to effective, clear communication include:

- Lack of time
- Hierarchies
- Defensiveness
- Varying communication styles
- Distraction
- Fatigue
- Conflict
- Workload

All these barriers are found frequently in healthcare.
If everyone in healthcare has the same goal—to provide the best patient care possible—what causes these barriers? The healthcare team is composed of individuals who come together from different walks of life and from different training programs. These background differences result in varying communication styles. Healthcare workers are frequently pressed for time and are struggling to balance competing priorities. When you add a hierarchy—whether real or imagined—to the mix of staff members with less seniority or different educational backgrounds, it’s easy to understand why communication breakdowns occur.

**Mental Models and Communication**

Mental models are powerful influences on behavior. They define how we will react in situations.

The “Ladder of Influence” or “Reflexive Loop,” developed by Chris Agyris, describes how mental models are formed and how they become a person’s reality.³

The formation of a mental model starts with observable data that are absorbed and then interpreted based on the norms of the culture in which the data are observed. Conclusions are based on the interpretation. A classic example of a mental model is the case of EuroDisney, which opened in 1992. After two years, the company had amassed $3.6 million of debt. Michael Colombe, the mayor of a nearby village, said, “Disney came in here like conquerors, knowing everything, wanting advice from no one. They had a product they thought was perfect that they wanted to transpose in Europe.” The leadership at EuroDisney had an ingrained mental model of what successful businesses were. They were not able to make the transition to the European culture. Financial restructuring, layoffs, and new management followed.⁴
In healthcare, we have similar mental models. We assume that physicians will not make mistakes. We believe that staff members with more education or more experience are making fact-based decisions. “Surely,” we whisper to ourselves, “she knows what she is doing.” These mental models compel us to remain silent when we should speak up.

Actions that conflict with ingrained mental models will not be put into practice even when ample evidence suggests that the action is reasonable and will create the desired result. Decisions based on information obtained from someone else can only be sound when the communicators have a shared mental model.

Allan Frankel, MD, director of patient safety at Partners Healthcare System in Boston, defines a shared mental model as “the degree of accuracy with which one’s perceptions of the current environment mirror reality.”

Frankel further describes individuals with a shared mental model as actors playing “in the same movie,” versus actors playing on different sets. Figure 1.1 demonstrates how two professionals can work with the same patient and yet have very different assumptions about the situation. In healthcare settings, clinicians’ existing mental models result in assumptions about what is being communicated. These assumptions, when false, can lead to medical errors.
The Scenario
Two patients are scheduled for a hernia repair by the same surgeon.

• Patient A is having a right hernia repair at 9 a.m.
• Patient B is having a left hernia repair at 1 p.m.

The surgeon reviews the schedule at 7:30 a.m. and sees that his first case is a right hernia repair at 9 a.m. At 8:20 a.m., preop staff members find that Patient A, scheduled for 9 a.m., has a blood sugar level of 210. They notify the patient’s attending doctor, who determines that the patient’s blood sugar needs to be controlled prior to surgery. The preop staff, in an effort to maintain the surgery schedule, decides to bring Patient B down early and reschedule Patient A for 1 p.m.

At 9 a.m., the surgeon enters the operating room and begins prepping and draping the right side. The nurse says, “Doctor, you are prepping the right side?” The physician nods, “Uh huh,” and continues. After a few minutes, the nurse asks, “Is that the right side?” to which the physician, now aggravated, says, “Yes, it is the right side.”

The nurse continues with her setup and the case proceeds until the surgeon discovers after the incision that no hernia exists on the right side.

Discussion
In this case, the surgeon’s perception of the current environment was flawed. No one had informed him that the schedule had changed. He assumed that this was Patient A. The nurse’s perception was also flawed. She believed that the physician understood her questions about whether he was prepping the correct side. In truth, neither was communicating well.
Chapter 1

Communications barriers frequently occur because of the different training that clinical staff members receive. For example, physicians are trained to be problem solvers. They want to be given the pertinent facts of a patient’s case and the headlines, and they want to fix the problems. Nurses, on the other hand, are taught to be narrative and descriptive. Most do not make medical diagnoses.

Nurses are trained to relay pertinent information and nursing assessments to physicians so that the physicians can draw conclusions and act on them.

For these and other reasons, doctors and nurses have traditionally played communication games. For example, nurses make recommendations to doctors while trying to appear not to do so. In Figure 1.1, a nurse hints that the surgeon might be prepping the wrong side for surgery. Likewise, doctors request recommendations from nurses while trying to appear not to do so. Does this scenario sound familiar?

Perhaps these communication games are one reason that medical professionals recognize the need for something more effective. In one survey, two-thirds of doctors and nurses indicated that improved communication was needed to improve safety.

As a communication tool, the SBAR model allows medical and nursing staff to offer information, including recommendations for action, in a safe manner. When the “recommendation” is an expected part of communication, clinicians do not have to play the doctor-nurse communication game, hinting at ideas and hoping that everyone will make the right decisions.
Evidence of the Need for Improved Communication

You probably know where communication is likely to break down during your workday, and you likely have some personal observations that indicate which areas need improvement. But is the problem limited to your hospital? Research says absolutely not. As you build a case for SBAR, use the information in this section to convince your teams that it’s in everyone’s best interest—especially your patients’—to have a communication system that works.

Multiple studies have shown that hospitals of all sizes and in all parts of the country struggle with communication gaps:

- Between disciplines (e.g., nurse to physician and vice versa)
- Between specialties within disciplines (e.g., emergency physician to hospitalist)
- Within and across locations (e.g., postop unit to nursing unit)

A study consisting of interviews of emergency room (ER) physicians and hospitalists at a large tertiary medical center in the Midwest cited numerous and recurring examples of emergency physicians providing insufficient, incomplete, or unclear information about patient conditions and treatment needs to admitting physicians. The participants identified three themes in this type of communication:

1. Uncertainty over patient diagnosis
2. Lack of clarity about patient disposition
3. Vagueness about who is responsible for the care of admitted patients who wait in the ER for an inpatient bed
Chapter 1

In this study, a hospitalist summarized a case in which the ER physician called him about a patient who was to be admitted to the hospitalist’s service. The hospitalist was told that the patient had chronic renal failure, had missed dialysis, had multiple other medical problems, and required admission. The hospitalist was seeing other patients as well, and he didn’t see his newly admitted patient for two hours. He then discovered that the ER physician had failed to communicate that the patient’s potassium level was high. The patient was now critically ill.

This study highlights the influence of professional philosophies and expectations on patient handoffs. The results show a need to align physician views on what constitutes an appropriate handoff communication.

In addition, Greenberg et al found that serious communication breakdowns leading to surgical malpractice claims tended to occur in verbal communication between a single transmitter and a single receiver. They recommended the standardization of content and format as a potential approach to improving communication.\(^\text{10}\)

Another study on communication gaps discovered that verbal communication between healthcare team members was inconsistent, if it occurred at all. In that study, which included interviews with physicians and nurses who were caring for the same patient, there was full agreement on patient priorities in only 17% of cases.

The study provided examples of the physician’s and the nurse’s priorities for the same patients. In one example, the nurse’s priorities included:

- Keeping the patient in bed
• Keeping the patient clean
• Providing tube feedings

The physician’s priorities for this patient included:
• Getting her out of bed
• Improving kidney function
• Planning for discharge

The author points out that there was no overlap of priorities by these two healthcare providers and that, in fact, they had opposite plans regarding bed rest. The study concluded that the lack of consistent systems for communicating between caregivers resulted in a “fragmented approach that yielded discordant priorities.”

The Joint Commission’s Goal

In testimony given in May 2002 before the House Committee on Energy and Commerce Subcommittee on Health, Dennis O’Leary, then-president of The Joint Commission, cited communication breakdowns as the most common underlying factor across all types of sentinel events. In response to these findings, The Joint Commission added a new requirement (#2E) to National Patient Safety Goal (NPSG) #2 in January 2006. The purpose of this goal is to reduce communication failures and improve patient safety across organizations.

This NPSG requires accredited organizations to implement a standardized approach to handoff communication, including the opportunity to ask and respond to questions, as one way to improve the effectiveness of communication among caregivers.
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Note: SBAR itself is not required by Goal #2E. However, it is a standard approach for structured communication, which, when used properly, can help organizations comply with this goal.

How SBAR Can Help

SBAR is an acronym for a technique known as Situation, Background, Assessment, Recommendation. Adapted for healthcare by Michael Leonard, MD, physician leader for patient safety at Kaiser Permanente of Colorado in Evergreen, along with colleagues Doug Bonacum and Suzanne Graham, this model has been implemented widely at health systems nationwide.14

The four components of the SBAR model allow the caregiver to organize his or her thoughts in a systematic manner to send a specific message to the recipient. The communication is meant to be a brief, concise picture of what is happening at the moment and what the sender wants the recipient to address. The entire SBAR is always communicated in the same sequence, allowing the recipient to anticipate the interaction.

The situation

This step relays the circumstances of the call to the recipient. During this moment, the caller identifies him or herself as well as the patient. Information such as code status and allergies are relayed in this part of the conversation.

- My name and credentials are ...
- The patient’s name is ...
- The patient’s code status is ...
The background
This step gives the recipient of the information the context of the communication.
Background may include:

- Pertinent physical assessments
- Recent surgery
- Recent lab results
- Recent medications
- Length of stay and diagnosis

The assessment
This step is the communicator’s assessment of the situation. It can be as simple as saying, “Something is wrong” or “The patient is deteriorating,” or it can be a more definitive assessment, such as “I think the patient may have a pulmonary embolus.”
Assessment includes statements such as:

- I think the patient has a ...
- I am concerned about ...
- The patient seems to be getting worse. I think we need to do something different.
Chapter 1

The recommendation

This step conveys what the communicator wants to receive in response to this message.

- I want you to come and examine the patient
- I would like an order for ...
- I suggest that we ...

Figure 1.2 demonstrates how SBAR communication can be used when a nurse questions what a physician is doing. Compare the interactions between the nurse and physician in Figure 1.1 to those in Figure 1.2. SBAR provides the information clearly, and it specifically asks the surgeon to step back rather than simply dropping hints and hoping that the surgeon will respond. In this scenario, the use of SBAR will prevent a wrong-site surgery.

The SBAR approach to communicating addresses all the issues identified in the literature cited in this chapter. The tool can be used between physician specialties to determine what components should be required to create an effective handoff. The format is standard, and the content within each step of the model can be standardized for different scenarios. SBAR can eliminate fragmented communication.

As hospitals’ workforces diversify, more and more communication about patients will take place between clinicians of different backgrounds. Thus, clear communication and a unified mental model are more important than ever. Planned communication helps staff members organize their thoughts and relay the pertinent facts to the next caregiver or to a physician in a standard way.
SBAR Basics

The SBAR model is a methodology for such structured communication. This type of communication helps clinicians focus, and it contributes to a shared mental model. When done correctly, SBAR communication is clear, factual, and concise. A consistent format ensures that important facts are always communicated. In addition, specific, important data points, such as allergies or last dose information, can be embedded into the structure so that they are consistently and correctly passed on.

SBAR is especially helpful in situations that require immediate attention and action, such as patient transfers between departments, or in situations that require the communication of critical information, such as reporting about a patient’s condition to a
rapid response team (RRT). For this reason, SBAR efforts often begin with handoffs and situations in which an RRT is called.

Conclusions

- Communication among caregivers must be clear in order to ensure the best patient care possible. Although clear communication might sound like a simple endeavor, many hospitals—if not most—struggle to improve the key interactions that enable doctors and nurses to give and receive the facts that are vital to patient care.

- Different caregivers may have different mental models, or maps for behavior that are based on each person’s experiences, background, and cultural norms. These mental models define how we perceive and react to situations. Getting all members of the team to function using the same mental model, so that they’re not “actors in different movies,” goes a long way toward improving communication.

- The Joint Commission has attempted to address communication breakdowns with an NPSG, which calls on hospitals to adopt a standardized approach to communicating critical information during handoffs. Although The Joint Commission does not require hospitals to use SBAR, this method is an effective way of conveying vital information during handoffs and in other situations. In addition, it can be documented, and it can ensure that all caregivers are working with the same mental model.
Getting Started—Making the Case for SBAR

However, before SBAR can be pilot-tested and rolled out, all departments must commit to its success. This chapter has made the case for SBAR, both as an important way to ensure patient safety and as a way to demonstrate regulatory compliance.

Chapter 2 will offer tips for bringing leaders, caregivers, and others on board.

Downloadable versions of the following figures are included on the accompanying CD-ROM:

- Figure 1.1: Players in different movies
- Figure 1.2: SBAR communication

To download and customize these figures, see the instructions at the back of the book.

REFERENCES

6. Ibid.
Chapter 1


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