

Team Communication about Serious Events

The SBAR Model

The Joint Commission, which accredits the majority of hospitals in the United States, analyzes the root causes of sentinel or critical events. Poor communication is the most common cause of patient injury or death in the clinical setting. **SBAR** (Pronounced S-Bar), developed by Kaiser Permanente of Colorado, is a formalized method of communicating with other healthcare providers that is being adopted by many hospitals.

SBAR promotes patient safety by helping physicians and nurses communicate with each other. Staff and physicians can use SBAR to share what information is important about a patient. It improves efficiency by way of a standardized form of communication that helps caregivers speak about patients in a concise and complete way. SBAR is an acronym for:

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

SBAR is used to report to a healthcare provider a situation that requires immediate action, and to define the elements of a hand off of a patient from one caregiver to another (for example, during transfers from one unit to another or during shift report, and in quality improvement reports).

Liability issues may surround the communication that occurred in any clinical situation, particularly when unexpected changes in a patient's condition occur. It is often difficult to determine what the healthcare prescriber (physician, physician assistant, nurse practitioner) was told. An inexperienced or fatigued nurse may omit specific important information. One of the goals of SBAR is to provide a structure for such communication. The elements of SBAR are explained below and applied to contacting a healthcare prescriber.

Consider the following scenario with regard to SBAR:

Situation: When calling a healthcare provider to report a change in the patient's condition, the nurse identifies his or her name and unit, the name and room number of the patient, and the problem. The nurse describes what is happening at the present time that has warranted the SBAR communication.

Situation Example: "Dr. Jones, this is Jane Smith, RN, of 5-West. I am to notify you that your patient, Scott Kelly, in Room 4017-2, fell on the floor today while being transferred out of bed."

Background: The nurse includes relevant background information specific to the situation. For example, this could include the patient's diagnosis, his mental status, current vital signs, complaints, pain level, and physical assessment findings.

Background vignette: "As you know, Mr. Kelly had a laminectomy and bone fusion on January 17. His legs have been weak since surgery. He fell when our aide was helping him get up with a walker. His current vital signs are 145/90, pulse of 88 and respirations of 20. He is able to move all of his extremities, although he is complaining of pain at his incision of 7 on a scale from 1-10."

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Assessment: This step of the communication provides the nurse with the opportunity to offer an analysis of the problem. If the situation is unclear, the nurse tries to isolate the problem to the body system that might be involved and describes the seriousness of the problem.

Assessment vignette (continued): "I see no changes in his neurological status since he fell; neither of his legs is shortened and externally rotated. He is quite anxious now and also worried something in his neck has been injured."

Recommendation: The nurse states what he or she thinks would help resolve the situation or what is the desired response. This might be phrased in the form of a question: "Do you think we should give him a medication, perform lab work, do an xray, perform cardiac monitoring, or transfer to another unit? Will you come to evaluate him?"

Recommendation vignette (continued): "I believe it would reassure Mr. Kelly if you would examine him. When can we expect you to come?"

Here is another yet more concise example...

Dr. White, this is Sue Black, RN, I am calling from ABC Hospital about your patient Sophie Brown.

Situation: Here's the situation: Mrs. Brown is having increasing dyspnea and is complaining of chest pain.

Background: The supporting background information is that she had a total knee replacement two days ago. About two hours ago she began complaining of chest pain. Her pulse is 120 and her blood pressure is 128/54. She is restless and short of breath.

Assessment: My assessment of the situation is that she may be having a cardiac event or a pulmonary embolism.

Recommendation: I recommend that you see her immediately and that we start her on O₂ stat.

The safe and effective care of patients depends on consistent, flawless communication between caregivers. End of shift report, hand-offs or the process of passing on specific information about patients from one caregiver team to another, is an area where the breakdown of communication between caregivers often leads to episodes of avoidable harm to a patient.

End of Team Communication about Serious Events, the SBAR Model Lesson