A TECHNIQUE FOR COMMUNICATION

January 2009

Objectives

- Recalls the reasons for using S-BAR in the clinical setting
- Describe what S-BAR stands for and gives a clinical indication for its use
- Describes steps to take if patient’s need remains unmet after using S-BAR to communicate to a physician

JCAHO Patient Safety Goal

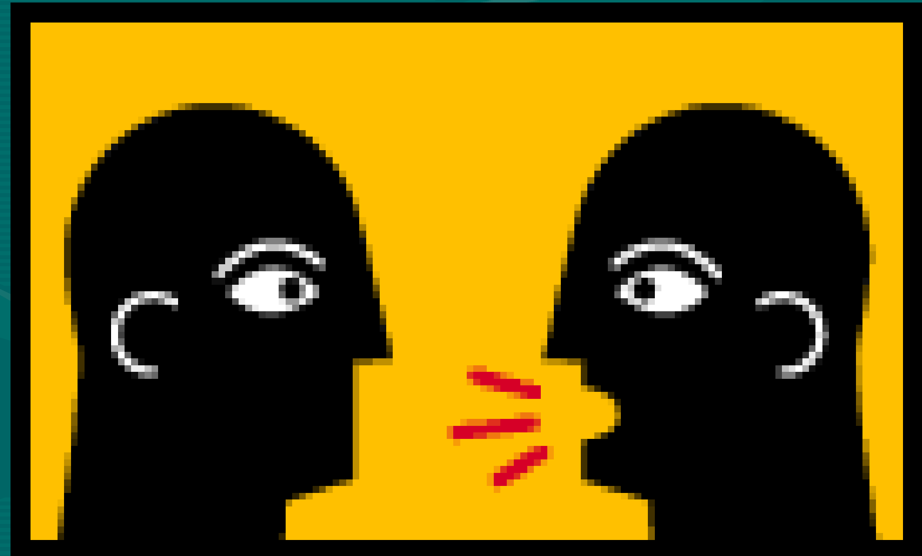
- IMPROVE COMMUNICATION AMONG CAREGIVERS
- SBAR is one method of meeting this Patient Safety goal by standardizing communication among caregivers.

SBAR STANDS FOR

- SITUATION
- BACKGROUND
- ASSESSMENT
- RECOMMENDATIONS

WHY SHOULD WE BE TALKING?

- The overwhelming majority of untoward and sentinel events involve communication failure between healthcare providers



COMMUNICATION IS EASIER IF:

- THERE IS A MODEL FOR COMMUNICATION
- EVERYONE IS AWARE OF THE MODEL
- EVERYONE USES THE MODEL TO COMMUNICATE PATIENT INFORMATION

Food for Thought

"The problem with communication ... is the *illusion* that it has been accomplished."

GEORGE BERNARD SHAW

S-BAR
Question 1

1. The majority of untoward and sentinel events occur as a result of poor communication among care givers.

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S-BAR
Question 2

2. Communication is easier if:

   a. There is a model for communication

   b. Everyone is aware of the model

   c. Everyone uses the model

   d. All of the above

Shift Report Guidelines

- MUHA has specific shift report guideline
- These guidelines are available in pocket-sized laminated cards
- Please request these guidelines from your preceptor

Sample Shift Report Guidelines

Nurses will refer to the following data elements to use for shift to shift report:

Kardex

Admission Database

24-Hour Nursing Notes

Plan of Care

Physician Orders

MARS

Sample Shift Report Guidelines

MUHA Recipe for Nurse to Nurse Shift Report

Patient Name/Age
Room Number
Attending/Service
Diagnosis
Past Medical History
Admit Date
Allergies
Activity
Isolation
Labs
Pain

Treatments/Procedures/Tests
Diet
IVF
High Alert Meds
Lines (CVP, etc.)
VS Frequency
VS Parameters
VS Trends
I&O
Drains
Oxygen/RT Needs

Resuscitation Status
Risks:
- Falls
- Restraints
- Suicide

Physical Assessment
Flu/Pneumonia Screen
Discharge Plan
Other Significant Data

When to Use SBAR Communication Technique at MUHA

- Transferring or “handing off” a patient from one caregiver or department to another
- Communicating a patient situation to a physician or other provider

"HANDING OFF" OR TRANSFERING A PATIENT TO ANOTHER DEPARTMENT OR CAREGIVER

- MUHA has an "SBAR HANDOFF REPORT GUIDE"
- This should always be used as the guide for handing off patients to another department or caregiver
- Please review this Guide on the next slide

SBAR HAND-OFF REPORT Guide

Introduce self and get name of person receiving report

SITUATION

This is the report on (patient name & room #)

- □ Code status
- □ Isolation/type
- □ Allergies, (band on)
- □ Diagnosis
- □ Current condition (include recent changes)
- □ Special needs (spiritual, cultural, learning, communication, social)
- □ Consults completed/planned
  - □ Admission Assessment complete

BACKGROUND

- □ Key tests/critical results
- □ Current treatments
- □ Plan of care
- □ Significant patient complaints/problems (patient/family concerns/communication with physician)
- □ Medication review due
- □ Disposition of patient belongings

ASSESSMENT

Abnormal Findings/Outcomes or Significant Results/Changes/Problems, Issues

- □ Vital Signs (temp/pulse/respiration/BP/N/V)
- □ Cardiovascular changes: Heart sounds/rhythm
- □ Respiratory changes: Breath sounds/cough
- □ Pain
- □ Medications
- □ Antibiotics (DC time if appropriate
- □ Other
- □ Pneumonia vaccine given/needed
- □ Influenza vaccine given/needed
- □ Wound (type, location, dressing/site, condition/drainage, time last changed)
- □ IVs (type, amount, problems, location)
- □ Intake (diet, diet status, fluid intake)

SBAR HAND-OFF REPORT Guide (cont.)

ASSESSMENT (CONTINUED)

□ Output □ Fluids/urine/emesis □ Other (drains, tubes…)

□ Elimination

- □ Catheter
- □ Urine color
- □ Bowel sounds
- □ Stools

□ Cognitive/Mental status issues/changes

□ Safety (restraints, fall risk, aspiration, suicide)

□ Restraints (type, physician order status, assessment)

□ Skin temperature/condition

- □ Temperature/color/edema/hematoma
- □ Evidence of skin breakdown/site/treatments in place

□ Activity

□ Mobility status/use of assistive devices

RECOMMENDATIONS

- □ Anticipated changes
- □ Tests/treatments needed, □ Pending results
- □ Information to give physician/other members of healthcare team
- □ Provide patient/family following information

ANY OTHER INFORMATION NEEDED??

Remember!

- Always use the SBAR Handoff Report Guide when transferring a patient from one department or caregiver to another

S-BAR FRAMEWORK FOR COMMUNICATION TO AN MD

S – situation: what is the present situation

B - background: how did we get here?

A - assessment: what do I think the problem is?

R – recommendation: what are we going to do to fix it?

ASSERTION IN COMMUNICATION

- "Individuals speak up and state their information with appropriate persistence until there is a clear resolution"

KEY IS BEING PREPARED

- Have I assessed this patient myself before I call?
- Do I have on hand?
  - The chart?
  - List of meds, IV fluids, labs?
  - Most recent vital signs?
- Have I read the most recent progress notes?
- What do I want to happen as a result of this call?

S-BAR Steps for Communication with an MD

- S – SITUATION
  - State your name and unit
  - I am calling about (pt name and room #)
  - The problem I am calling about is:

S-BAR

- B–BACKGROUND
  - Admission diagnosis and date of admission
  - ***Pertinent*** medical history
  - A ***brief*** synopsis of the treatment to date
  - Code status

S-BAR

- A-ASSESSMENT
  - Most recent vital signs
  - ***Significant*** assessment findings
  - ***Significant*** labs or other results

S-BAR

- R – RECOMMENDATION

  State what you would like to see done:

  - Transfer the patient to the ICU?
  - Come see the patient ASAP?
  - Talk to patient and family about the code status?
  - Ask for a consultant to see the patient now
  - State treatment, i.e., fluids, chest tubes, pain medication

S-BAR
Question 3

3. S-BAR is a method of communication among caregivers and stands for:

a. Subject, background, assessment, recommendation
b. Situation, background, assessment, recommendation
c. Subject, baseline data, action, results
d. Situation, background, action, results

A CLINICAL EXAMPLE

- S – Situation - Dr. Jones, I'm Paul, an RN on 8East. Mr. Jones in 810 is in respiratory distress.
- B – Background – He was admitted for COPD exacerbation this morning, has been stable on 3L nasal cannula, but is now acutely worse.
- A – Assessment – VS 98/62, HR 108, RR40, O2 sat 74% with a nonrebreather at 10L. His breath sounds are decreased on the right side. I think he may have a pneumothorax.
- R – Recommendation – I need your to come see him immediately. Can we get some ABGs and a STAT portable chest x-ray?

CHECK LIST WHEN COMMUNICATING with an MD

- Get person’s attention/make eye contact
- Use the person’s name
  - Express concern
  - **S - State the problem**
  - **B - Background**
  - **A - Assessment**
  - **R – Recommendation**
- Reassert if necessary
- *Go up the chain of command if necessary*

S-BAR
Question 4

4. **You have used the S-BAR method to communicate your patient's need for immediate attention and has not received it. You best response would be to:**

a. Keep calling the same practitioner until you get results
b. Hope the practitioner will act soon
c. Go up the chain of command
d. Ask the next shift to follow-up

Congratulations!

- You have completed the module on SBAR.