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Implementing a Standardized Nursing Communication Tool to Improve Inpatient Nursing Communication

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Abstract

Problem: Patient handovers occur among nurses more than 4,000 times in a day at a typical teaching hospital. While common, failed patient handovers result due to the lack of standardization in nurse-to-nurse communication while handing over patient responsibility in the inpatient setting. The result of this is inadequate communication among nursing that has the potential to lead to adverse patient events.

Methods: This quality improvement (QI) project utilized a prospective, descriptive design with a post-intervention survey. A unit specific Situation, Background, Assessment, and Recommendation (SBAR) patient handover tool was created and implemented as the standardized method among a convenience sample of nurses following SBAR education. Quantitative data was collected via review of the number of SBAR patient handover tools used, total number of handovers completed, and post-intervention survey responses.

Results: Following the implementation of this QI project, a total of 141 tools were utilized out of 1,480 total patient handovers done resulting in a 10% compliance rate. The average demographic of nurses employed on this unit was females aged from 20 to 30 with less than two years of nursing experience.

Implications for Practice: Overall, the results of this QI project suggested positive results towards improving inpatient nursing communication and patient handover quality. Challenges to implementing a tool of this type include consistent encouragement and leadership presence to maintain better adherence to its use.

Implementing a Standardized Nursing Communication Tool to Improve Inpatient

Nursing Communication

Communication is at the core of healthcare. It is one of the most significant

contributors to providing high-quality patient care. Adequate communication within the

nursing field is a necessity for maintaining patient safety and quality of care. A successful

patient handover between nurses is one that entails excellent communication. The Joint

Commission (TJC) (2017) defines a patient handover as the transfer or acceptance of

patient care responsibilities via a real-time process of transferring patient-specific

information from nurse-to-nurse with the purpose of ensuring patient safety and

continuity of care. It is estimated that patient handovers among nurses occur more than

4,000 times in a day at a typical teaching hospital (TJC, 2017). For a single patient, this

occurs, on average, three times per day when considering shorter nursing shifts and the

frequency of transferring patients to different units (Smeulers et al., 2014). The problem

is that failed patient handovers are common in healthcare and are often due to

communication errors, misalignments in expectations, and the increasing complexity of a

high-quality patient handover (TJC, 2017). Despite the frequency of these occurrences,

there remains a lack of standardization in nurse-to-nurse communication while handing

over patient responsibility in the inpatient setting.

Miscommunication has been identified as a significant healthcare issue for

decades. In 2000, Kohn and Donaldson's "To Err is Human" identified communication as

the cause of about three out of four healthcare errors due to healthcare system failures.

Miscommunication during patient handover leads to potential patient harm. This occurs

when the oncoming nurse receives information that is incomplete, inaccurate,

misinterpreted, or not timely (TJC, 2017). Patient handover is recognized within research

as being an area vulnerable to common communication failures (Shahid & Thomas,

2018). According to a Sentinel Event Alert by TJC (2017), inadequate patient handovers

contribute to adverse events and many types of sentinel events, such as wrong-site

surgery, delayed treatment, falls, and medication errors. In the 2015 Annual Benchmark

Report on Malpractice Risks in Communication Failure, it was estimated that 30% of

medical malpractice claims were due to communication failures in the U.S. healthcare

system, resulting in 1,744 deaths and $1.7 billion in malpractice costs (CRICO Strategies,

2015). Nursing miscommunication accounted for 75% of the communication failure

cases. The result of this was almost half of the nursing miscommunication cases involved

a high severity injury and one-third resulted in patient death (CRICO Strategies, 2015).

Arora and Farnan (2021) recommend the use of standardized language during

patient handovers to aid in ensuring transmission of consistent information. This can

reduce the risk of miscommunication, misunderstanding, and omission of critical patient

information (Smeulers et al., 2014). Standardized language during patient handover

contributes to improving patient care and decreasing adverse events. Research supports

the idea that patient handovers should occur at the bedside with face-to-face

communication, promote patient involvement, use a structured communication tool, and

be supported with technology when necessary (Forde et al., 2018).

The Institute for Healthcare Improvement (IHI) identified the Situation,

Background, Assessment, and Recommendation (SBAR) Communication Tool as a

technique to provide a standardized framework for communication (IHI, 2017). Use of

this tool provides a clear structure for nursing handover communication and utilizes

relevant information in an organized and logical manner (Muller et al., 2018). SBAR is a gold standard that has been used within the healthcare setting since 2003 and is well known across healthcare disciplines (Shahid & Thomas, 2018).

The purpose of this project was to implement a SBAR-themed standardized communication method among nursing staff to improve nursing communication. The overall aim was to increase compliance with a standardized SBAR patient handover tool among nursing staff by 15% in two months and improve the nursing staff's perception of communication. This topic was chosen to be implemented on this hospital unit because it lacked any type of standardization for patient handover among nursing. To guide the research conducted for this project, the Population, Intervention, Comparison, Outcome, and Time (PICOT) question of, "Among inpatient nursing staff, what is the effect of a standardized SBAR communication method on the nursing staff's compliance and perception of communication within 2 months?" was developed.

Review of Literature

The search engines of the Cumulative Index of Nursing and Allied Health Literature (CINHAL), Cochrane Library, Wiley Online Library, and PubMed were utilized. Key search terms used included *structured nursing handover, handoff, care transfer, shift report, clinical handover in nursing, SBAR, compliance, nursing communication*, and *communication* with Boolean operators AND and OR. The inclusion criteria consisted of the following: published date 2014 to 2021, English language, adult patients aged 18-years and older, nursing-based handovers, SBAR method, and inpatient admission. The exclusion criteria consisted of the following: patient age less than 18 years old, non-English language, outpatient settings, and non-nursing-based handovers.

The number of articles produced after this refined search was 18, of which nine were

selected for this review of literature. All studies in this literature review were peer-

reviewed and include a QI project, cross-sectional online survey, clinical practice

guideline, systemic reviews, pilot studies, and a summary of available research. Common

themes from these studies included the need for standardizing nursing handovers and

successful outcomes associated with SBAR handover interventions.

Background

The SBAR tool is recognized by TJC, IHI, Agency for Healthcare Research and

Quality (AHRQ), and the World Health Organization (WHO) as an efficient and effective

tool for patient handover communication (Shahid & Thomas, 2018). It is a reliable and

validated communication tool that is associated with minimal communication errors,

which substantially improves patient safety and outcomes, quality of care, and

satisfaction among healthcare providers (Shahid & Thomas, 2018). Healthcare staff, such

as nurses, may have first encountered SBAR as a student. Because the SBAR model has

been around so long, it is recommended that a refresher for SBAR education be

implemented and followed by annual education among nursing staff (Shahid & Thomas,

2018).

The SBAR communication tool was first developed to improve nurse-to-

physician communication. It was later used for nurse-to-nurse communication as a patient

handover method. Smeulers et al. (2014) recognized the need for further research on a

standardized nursing handover tool after conducting a systematic review that resulted in

no eligible studies for inclusion of the review. This systematic review aimed to determine

the effectiveness of interventions that were designed to improve nursing handover

(Smeulers et al., 2014). The authors searched seven databases with the selection criteria

of randomized controlled trials evaluating nursing handover. Specifically, information

regarding the association between patient handover and prevention of adverse events, or

optimizing transfer of patient information required for continuity of care, was being

sought (Smeulers et al., 2014). At the time of inquiry, there was no available evidence to

support the effectiveness of any nursing handover tool.

Pilot Studies

Cornell et al. (2014) conducted one of the first successful studies on SBAR

patient handover among nursing and found positive outcomes. This study aimed to

measure the impact of both SBAR and interdisciplinary rounds on nurse-to-nurse

communication during patient handover. The hypothesis for the SBAR intervention was

that it would ideally lead to shorter patient handover times, a reduction in the use of paper

forms, increased consistency of patient handovers, and improved quality of information

relayed (Cornell et al., 2014). After Institutional Review Board (IRB) approval was

received at a suburban hospital in the mid-South, a team of managerial and staff nurses

developed a SBAR protocol to be implemented on a 48-bed medical-surgical unit. This

protocol consisted of an electronic version of a SBAR patient handover tool that was

implemented with 36 staff nurses on the unit. To observe compliance, direct observation

of shift reports was employed. Results of observations were compiled and assessed

statistically using box plots, histograms, and ANOVA. The results included decreased

time to complete patient handover, decrease in time spent handling paper documents,

increased computer use during patient handover, and decreased use of other handover

methods, which suggests that nurses were more focused when using SBAR (Cornell et

al., 2014). This study found that more information was exchanged with greater

visualization and discussion, which improved consistency and quality of information

being communicated between nurses (Cornell et al., 2014). Thus, this study supports the

idea that SBAR for nursing handover improves communication, is successful as a

standardized tool, and leads to statistically significant outcome measures.

Since the initial study, the literature contains multiple primary studies supporting

SBAR nursing handover implementation. A prospective study by Achrekar et al. (2016)

found significant improvement to SBAR use during patient handover after the

implementation of an educational module. Data for this study was drawn from a larger

research study (Achrekar et al., 2016). After approval was granted by the IRB, 20 nurses

were selected by simple random sampling for auditing. The setting was an unnamed

tertiary care cancer center in India. The intervention was a self-instructional educational

module on clinical communication skills for nursing and incorporating the SBAR tool for

patient handover communication (Achrekar et al., 2016). Compliance with the tool was

audited at the first and 16th week after the intervention. Then, nurses' opinions about the

SBAR form were obtained using a multiple item Likert scale (Achrekar et al., 2016).

Inter-rater reliability of the audit was established using the kappa statistic, and data was

analyzed using both descriptive and inferential statistics (Achrekar et al., 2016).

Significant improvement in adherence was seen post intervention, along with

sustained continued adherence at the 16-week point (Achrekar et al., 2016). Most of the

nurses that participated (79%) found the SBAR tool used during patient handover to be

useful for helping organize their thinking and streamlining data (Achrekar et al., 2016).

Limitations of the study included possible difficulty understanding the self-reporting tool,

content analysis of all forms was not completed, and a small sample size (Achrekar et al., 2016). This study recommended that a SBAR tool modified to organizational requirements should be regularly used to standardize nursing handover, bring about positive patient outcomes, and for ensuring patient safety (Achrekar et al., 2016).

       Padgett (2018) conducted a prospective pilot study to assess if educating nurses on patient handover expectations, the use of a SBAR form, and its documentation positively affected nurses' perception of communication. The study utilized a quasi-experimental pretest-posttest design with a comparison group (Padgett, 2018). After receiving IRB approval, nurses from three units at an unnamed hospital were emailed a link to a voluntary, anonymous survey evaluating their perception of the handover process in place at the time (Padgett, 2018). After responses were received, one unit was chosen by convenience sampling to participate in an educational module based on the IHI's SBAR guidelines for communication that included the expected handover process and SBAR use (Padgett, 2018). One month after the education was given, the same survey was sent to the same nurses in the same manner (Padgett, 2018). While comparing pre and post surveys, the score on communication effectiveness during patient handover increased from less than 50% to 66%, good communication increased from 48% to 85%, and poor communication decreased from 40% to 29% on the experiment unit (Padgett, 2018). The post intervention survey done by the treatment group showed a significant improvement in the nurses' perception of their own communication (Padgett, 2018). If being replicated, it was recommended that making the education on SBAR mandatory would increase the effectiveness of the project (Padgett, 2018). Limitations of the study included a small sample size, unknown of whether all shifts were represented equally,

sample was subject to volunteer bias, and only 65% of staff completed the education. An

education model intervention such as this one can be effective in increasing nursing

perception of communication effectiveness.

A QI initiative by Usher et al. (2018) found that the intervention of using a

slightly modified SBAR for patient handover created an improvement in nursing staffs'

perception of communication and increased their preparedness to care for patients. The

tool used in this study was a standardized Situation, Background, Assessment,

Recommendation, and Thank (SBAR [T]) form. The sample included all the nurses

working on an unnamed institution's 38-bed medical-surgical unit. Before the

intervention, 32 nurses completed a Medical Intensive Care Unit Shift Report (MSR)

Communication Scale. In addition, the project lead observed the nurse participants and

completed a SBAR (T) competency checklist to assess communication, handover quality,

and general information of handover style currently being used (Usher et al., 2018).

Following the hospital's QI process model, a required educational module on

standardized SBAR (T) patient handover, communication, and accountability was

implemented (Usher et al., 2018). Each nurse was also supplied with a pocket card

containing the expected patient handover components as a reference tool. After module

completion, 25 out of the 32 nurses completed the post-project scale. Independent t tests

were used to compare pre-post scale results and pre-post implementation SBAR

competency scores. The results of this study were an improved perception of patient

handover and communication for nursing and a reduction in the length of patient

handover time after the intervention (Usher et al., 2018). Limitations of this study

included a small sample size and lack of full participation due to other projects being

implemented on the unit at the same time. This study is one of many that shows success in nurses adhering to the SBAR tool with improved perceptions of communication.

Preferred Tool

SBAR is often the self-selected preference for nursing to use as a patient handover tool in areas without a standardized handover. A cross-sectional online survey on best and worst patient handover experiences among nurses found that the most frequently mentioned tool used in the best patient handover scenarios was the SBAR Tool (Streeter & Harrington, 2017). Similarly, an integrative review identifying factors considered when reviewing the process of nursing handover found that the most frequently self-selected tool used for patient handover was SBAR (Forde et al., 2018). Whole entities, such as the German Society of Anesthesiology and Intensive Care Medicine, have created clinical practice recommendations of using SBAR as the standardized patient handover across the board (Dossow & Zwissler, 2016). Not only are nurses choosing this method independently, but healthcare facilities are implementing clinical practice guidelines to encourage the use of SBAR during patient handover. SBAR is recognized by TJC, IHI, AHRQ, and WHO as an efficient and effective tool for patient handover communication (Shahid & Thomas, 2018).

The Plan-Do-Study-Act (PDSA) Cycle framework was chosen as the evidence-based practice framework to guide the implementation and evaluation of this intervention. This method is one of the most familiar and commonly used approaches to rapid cycle performance improvements (White et al., 2021). This framework was selected because it has a well-known benefit to contributing to small-scale change and it is associated with sustainable improvements (White et al., 2021). This cycle begins with the

"Plan" stage, which includes the process of recruiting a team, drafting an aim statement,

describing the current context and processes, describing the problem, and identifying the

causes and alternatives (Minnesota Department of Health, n.d.). The second, or "Do"

stage, begins the implementation of the action plan which includes collecting of data

along the way (Minnesota Department of Health, n.d.). The third, or "Study" stage,

utilizes the data gathered thus far and determines if the plan resulted in improvements,

assesses if it is worth the investment, and reviews unintended side effects (Minnesota

Department of Health, n.d.). The last stage is the "Act" stage, where the team reflects on

the plan and its outcomes, reviews lessons learned, and standardizes the intervention if

the results were successful (Minnesota Department of Health, n.d.).

This QI project focused on the need for improved nursing communication via a

standardized SBAR patient handover tool. The literature reviewed on this topic included

a cross-sectional online survey, clinical practice guideline, systemic reviews, and primary

studies implementing the SBAR tool during patient handover. Overall, these studies

revealed an improvement in the overall quality of patient handovers, increased nursing

satisfaction with communication, and long-term adherence to SBAR patient handovers

with this intervention. The literature recommends a unit modified standardized SBAR

form to be used among nursing during patient handover after initial education followed

by annual review. This QI project utilized the PDSA Cycle as a framework to implement

and evaluate this process to improve nursing communication on a neurology specific unit

at a large teaching hospital in Missouri.

Methods

Design

This QI project was a prospective, descriptive pilot study with a post-intervention survey. Quantitative, descriptive data was collected during implementation via review of the number of SBAR patient handover tools used, total number of handovers completed, and post-intervention survey responses. Post implementation data was abstracted biweekly assessing the frequency of the tool's use from February 1 to March 29, 2022.

Setting

This QI project took place on a 21-bed neurology specialty unit at a 1,266-bed urban teaching hospital in the Midwest. This hospital is part of a large nonprofit health care organization consisting of 15 hospitals totaling 3,026 staff beds with 30,647 employees.

Sample

This QI project used a convenience sample of staff nurses employed on the unit. The unit had 39 nurses employed at the start and 33 nurses at the end of the project that served as participants. Nurses working temporarily on the unit from other areas and those who had not received the education were not included. The desired sample size was the participation of approximately 25 nurses. The actual sample size was 10 nurses that participated in the post-intervention survey.

Procedures

This QI project was led by the Doctor of Nursing Practice (DNP) candidate as the primary investigator (PI). The nursing staff received education on SBAR using the IHI's SBAR Tool, review of the patient handover process, and unit expectations via email one

week prior to implementation. This was reviewed with staff every weekday morning

during a unit huddle until project implementation on February 1. The paper tool based on

this education was provided to staff to use during each patient handover (See Appendix

A, Figure 1). The staff was then instructed to place their used sheets in a completed

folder. A designated tray was placed at the nursing station with new sheets and a folder

for used sheets. Update emails were sent to staff nurses biweekly, with information on

current compliance rates and reinforcement of education. Three charge nurses were

identified as super users as a reference for staff. On April 2, after the intervention was

implemented for eight weeks, a five-point Likert scale survey was sent to the nursing

staff via Qualtrics to assess perceptions of improvements in communication, opinions on

the handover tool, and to gather basic demographics of the nursing staff. Survey response

reminders were sent via Qualtrics every two days for one week.

Data Collection and Analysis

The number of standardized SBAR patient handover tools used by nursing and the

total number of handovers completed was collected by the PI on a biweekly basis. This

data was entered into a data collection tool. The data collection tool was maintained by

the PI on a password protected computer. At the conclusion of the project, the data was

transferred into an Excel spreadsheet and analyzed using descriptive statistics (See

Appendix B, Table 1). Data and variables of compliance rate was analyzed for possible

relationships. The nursing staff's experience level, age, and gender was assessed via

Qualtrics survey.

Approval Processes

Formal, written approval was sought and obtained from the participating unit's

Patient Care Manager on September 22, 2021. The project was assessed and determined

not to be human subject's research. Further approval was sought and obtained from the

University of Missouri–St. Louis IRB prior to the implementation of this intervention.

Results

Demographics

The sample included 10 staff nurses that responded to the survey. There were

eight female (80%) and two (20%) male participants. The age of participants included

eight in the 20-30 age range (80%), one in the 30-40 age range (10%), and one in the 40+

age range (10%). The experience level of participants included seven with 0-2 years

(70%), two with 2-4 years (20%), and one with 5+ years (10%) (See Appendix B, Figure

2).

Standardized Tool

During the implementation period of February 1 through March 29, 2022, 141

(10%) tools were used, and 1,480 total patient handovers were completed. The days the

PI was present resulted in higher compliance rates (25%), followed by weekdays with

management present (11%), and the lowest compliance was seen on weekend days (6%)

(See Appendix B, Table 1). Although daily compliance varied, the overall use of the tool

increased throughout the project (See Appendix B, Figure 3).

Review of descriptive statistics revealed an overall increase in use from February

to March. Results of the independent samples t-test showed that the number of SBAR

handovers completed increased from February ($M = 2.25$, $SD = 3.471$, n = 63) to March

($M = 2.96$, $SD = 3.00$, n = 83) but was not statistically significant at the 0.5 level of significance ($t = -0.824$, $df = 54$, $p = 0.414$). Additionally, the total number of handovers completed increased from February ($M = 25.04$, $SD = 5.330$, n = 701) to March ($M = 27.82$, $SD = 5.938$, n = 779) but also was not statistically significant at the 0.5 level of significance ($t = 1.847$, $df = 54$, $p = 0.70$). The daily percentages of compliance also increased from February ($M = 0.09$, $SD = 0.123$, n = 241) to March ($M = 0.11$, $SD = 0.121$, n = 330) but this was not statistically significant at the 0.5 level of significance ($t = -0.878$, $df = 54$, $p = 0.384$). Simple line mean graphs of these results can be reviewed in Appendix B, Figure 4.

The five-point Likert scale survey resulted in findings supporting that the tool improved nursing communication and overall quality of patient handovers (See Appendix B, Figure 5). Field one "The standardized SBAR patient handover tool meets expectations for a successful patient handover" resulted in a mean of 3.80 and highest score of the answer Somewhat Agree (40%). Field two "I prefer to use the standardized SBAR patient handover tool over other patient handover methods" resulted in a mean of 3.00 and highest scores of Somewhat Disagree (30%) and Somewhat Agree (30%). Field three "The implementation of the standardized SBAR patient handover tool has improved nursing communication on the unit" resulted in a mean of 3.50 and highest score of Somewhat Agree (50%). Field four "I feel as if patient handover quality has improved since the implementation of the standardized SBAR patient handover tool" resulted in a mean of 3.50 and highest score of Somewhat Agree (60%). Field five "I will continue to use the standardized SBAR patient handover tool after the completion of this study" resulted in a mean of 2.80 and highest score of Somewhat Disagree (40%).

Discussion

Implementation of this QI effort points to the improvement of nursing communication, as well as patient handover quality, using a standardized patient handover tool and answered the study question for this QI project. Participation relied heavily on continued encouragement and reinforcements. Daily compliance with the tool's use varied based on the presence of the PI and management, but overall, gradually improved throughout the project. This low compliance may be in relation to the demographics of nurses employed on this unit which was predominately females aged from 20 to 30 with less than two years of nursing experience.

Recommendations for future PDSA cycles include creating a stronger environment for change, obtaining nursing feedback prior to implementing change, and ensuring consistent presence of the PI. The environment for change created in this project could have been improved by creating super users earlier in the process, sending more frequent updates on compliance rates, and including staff in change talk before the start of the implementation. Some of the feedback obtained from staff during the implementation was dislike for characteristics of the tool. This project had obtained approval from management with review of the tool but did not include a large amount of nursing feedback prior to use. This could have been improved by obtaining staff nurse feedback prior to use. Based on the higher compliance rates with PI presence, overall compliance could have been improved with more consistent presence.

The main limitation of this study was burnout of staff nurses due to the strain of the COVID-19 Pandemic. The increased workload and subsequent stress and fear that have accompanied the pandemic created an environment that was difficult to influence.

Other limitations included a small sample size, sample that was subject to volunteer bias, compliance with the education was not measured therefore unknown, and the possibility that all the tools used were not included in the data as there were multiple occasions of nurses forgetting to turn in used sheets.

Conclusion

In this QI project, implementation of a SBAR standardized patient handover tool seems to have improved nursing perception of communication and patient handover quality. Due to the many limitations of this study, further PDSA cycles are required for more definitive and reliable results. The skill set and knowledge required to implement this QI project was obtained primarily through DNP level education. This experience, with guidance from DNP educators' expertise, has contributed greatly to my personal preparation within the DNP role. The process of reviewing available literature, implementing a PDSA cycle, and statistically evaluating results show cases the education of a DNP level educated nurse.

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Appendix A

Figure 1. Standardized SBAR Handover Tool

Today's date:

SBAR Patient Handover Sheet
(Situation, Background, Assessment, Recommendation)

S ITUATION	Name: Age: Gender: Code Status: Allergies:		Admitting Date: Chief Complaint: Admission Diagnosis:
			Team: Consults:
B ACKGROUND	Past Medical History:		Course of Stay Info:
	Surgical History:		Isolation: Precautions:
A SSESSMENT	Vital Signs: Pain:		I&O: Diet: Fluid Restriction: Voiding: BP BSC BR Foley FCD BM:
	Neuro Exam: A&Ox Pupils: Facial: Strengths: RU /5 LU /5 RL /5 LL /5 Sensation: Neglect: Vision:	Respiratory: O2 Requirements: RA NC Trach: Cardiac: Rhythm: BP Goal:	IVs: PICC: Fluids: Tubes/Drains: JP Hemovac LD
			Activity: Up w/ Turn:
			Skin/Wounds: Fall Precautions:
	Significant Labs: Accu Checks:		Restraints:
R ECOMMENDATION	Goals: Planned Procedures: Post Procedure Monitoring: Reminders:		Nursing Orders: Discharge Planning:

Patient Sticker:

Don't Forget! Turn in to Folder when Finished!

Appendix B

Table 1. Data Collection

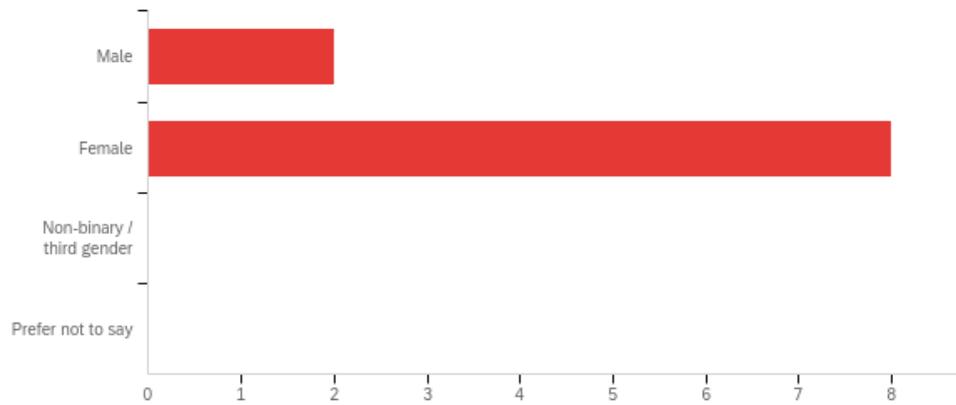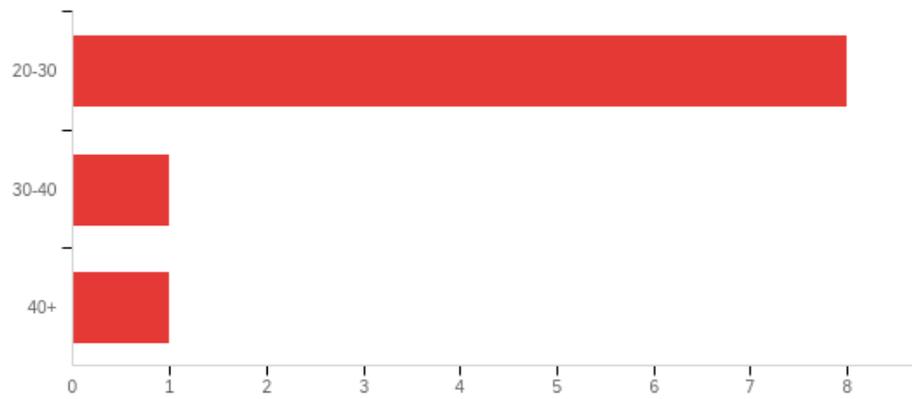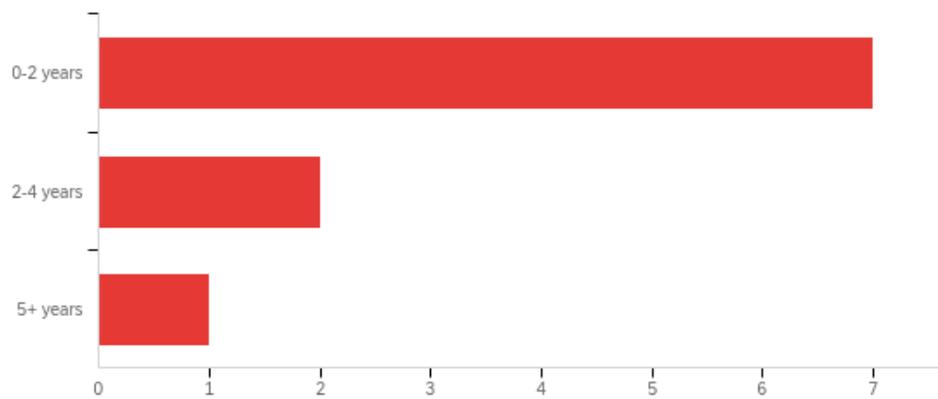| February		
# of SBAR Handovers Completed	# of Handovers Completed	Daily Compliance
5	26	19%
3	25	12%
1	20	5%
2	20	10%
0	18	0%
0	15	0%
3	22	14%
0	23	0%
4	29	14%
0	33	0%
0	30	0%
0	30	0%
0	31	0%
0	32	0%
0	27	0%
16	31	52%
6	34	18%
0	26	0%
8	21	38%
2	28	7%
3	29	10%
4	28	14%
0	24	0%
1	17	6%
0	17	0%
4	23	17%
0	20	0%
1	22	5%
March		
# of SBAR Handovers Completed2	# of Handovers Completed2	Daily Compliance2
10	26	38%
5	31	16%
0	28	0%
4	16	25%
4	11	36%
0	16	0%
3	21	14%
6	27	22%
8	28	29%
7	31	23%
0	28	0%
0	30	0%
0	30	0%
3	32	9%
7	27	26%
0	35	0%
0	32	0%
4	36	11%
0	31	0%
4	35	11%
6	35	17%
4	32	13%
4	27	15%
0	24	0%
4	27	15%
0	27	0%
0	26	0%
0	30	0%
83	779	10%
10%		

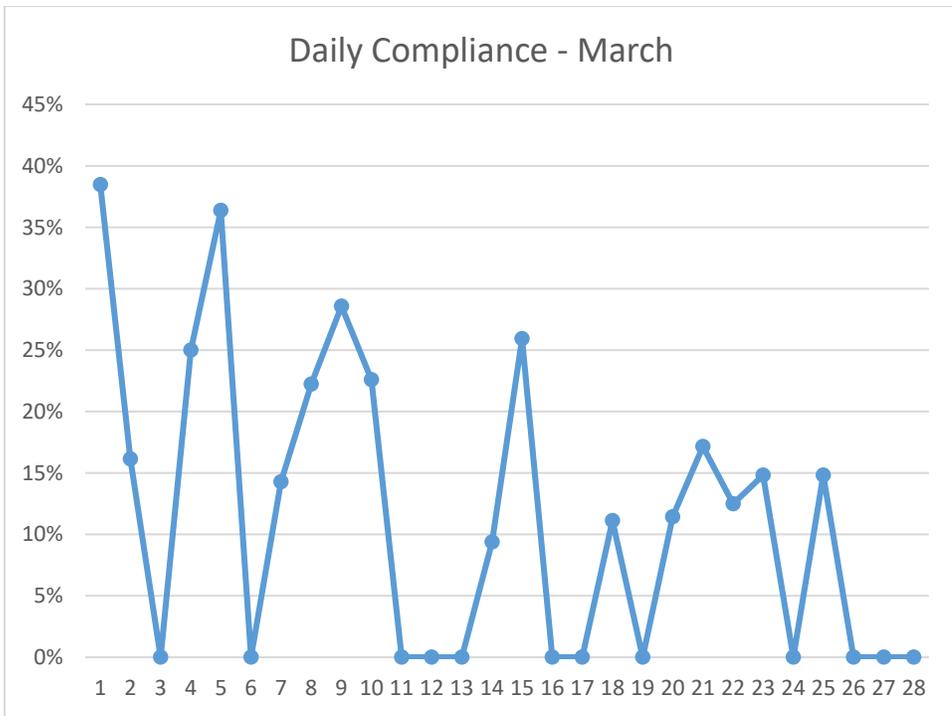*Figure 2. Demographic Characteristics of Participants*

Gender

Age

Experience
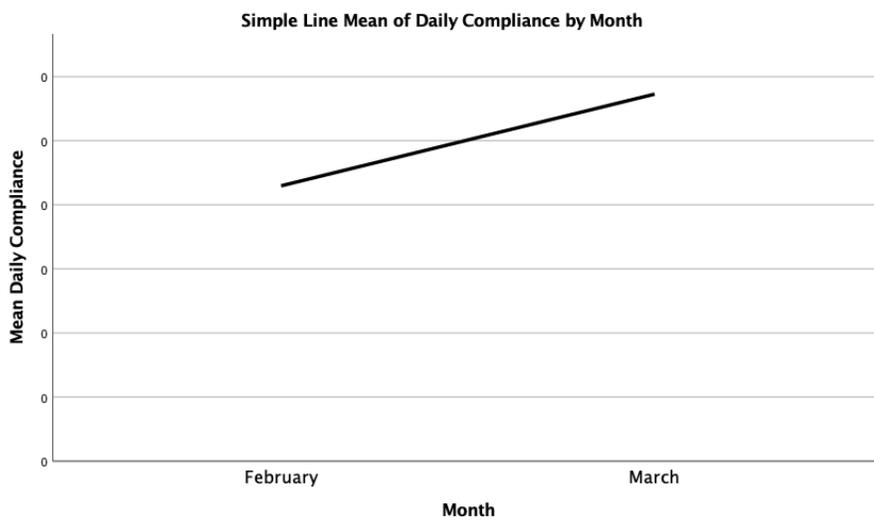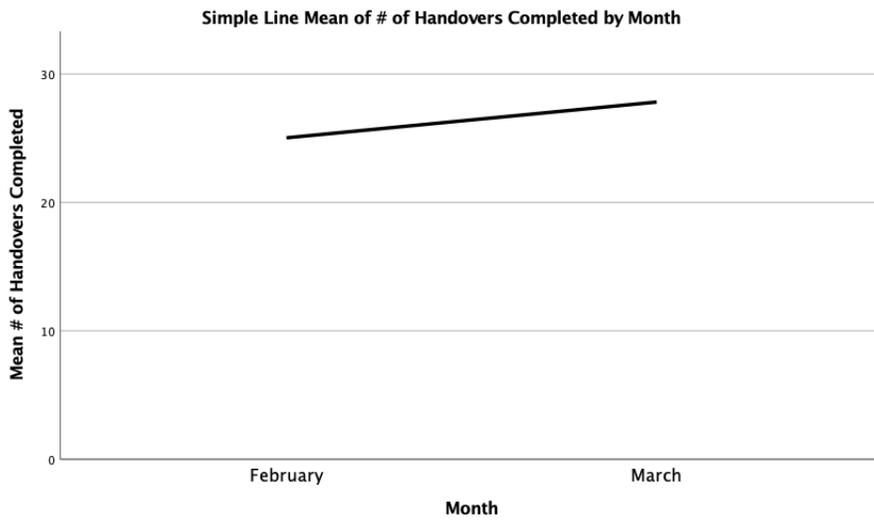
Figure 3. Daily Compliance
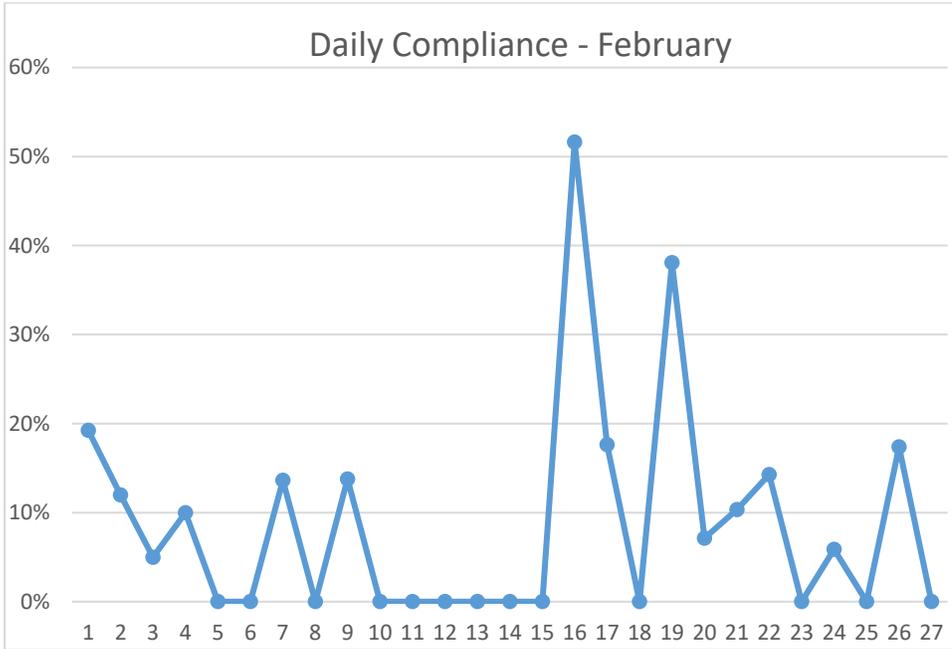
Figure 4. Mean Line Charts

Simple Line Mean of # of SBAR Handovers Completed by Month

Simple Line Mean of # of Handovers Completed by Month

Simple Line Mean of Daily Compliance by Month

Figure 5. Survey Results

- The standardized SBAR patient handover tool meets expectations for a succes...
- I prefer to use the standardized SBAR patient handover tool over other pati...
- The implementation of the standardized SBAR patient handover tool has impro...
- I feel as if patient handover quality has improved since the implementation...
- I will continue to use the standardized SBAR patient handover tool after th...