7-12-2023

Implementation of a Situation, Background, Assessment, Recommendation (SBAR) Patient Handoff Tool in the Electronic Medical Record (EMR)

Kristen L. Chandler
University of Missouri-St. Louis, kgaylord09@yahoo.com

Implementation of a Situation, Background, Assessment, Recommendation (SBAR) Patient Handoff Tool in the Electronic Medical Record (EMR)

Kristen L. Chandler

B.S. Nursing, University of Missouri- St. Louis, 2017

A Dissertation Submitted to The Graduate School at the University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree
Doctor of Nursing Practice with an emphasis in Pediatric Primary Care

August 2023

Advisory Committee

Dr. Elise Schaller, DNP, MHA, APRN, CPNP-PC
Chairperson

Dr. Roxanne Reid, DNP, MSNEd, RN

Jennifer Hoxsey, MSN, RN, CNE

Implementation of a Situation, Background, Assessment, Recommendation (SBAR) Patient Handoff Tool

In today's fast-paced world of health care, effective and efficient communication is vital. Ineffective communication results in poorly conducted patient handoffs (Commission The, 2017). Poor interaction, failure to convey accurate patient information, and lack of standardized procedures such as the use of evidence-based tools are all contributors to ineffective communication (Commission The, 2017). One of the demands of a nurse is good communication skills. Having valued communication skills is crucial for nurses to disseminate critical information amongst each other and other healthcare professionals; therefore, patient handoff should be performed with diligence using a standardized evidence-based tool to ensure quality of care and patient safety. Shift report between the incoming and outgoing nurse should be comprised of a patient's clinical status that is significant to their care and must be thoroughly communicated. The Joint Commission (TJC) has advocated for more effective communication in hospital settings to increase patient safety and quality of care (Trossman, 2019). TJC defined standardized handoff communication "as a process in which information about patient care is communicated consistently from one health care provider to another" (Trossman, 2019). Handoffs are one of the most integral parts of clinical practice. A study conducted in 2016 estimated that 30% of malpractice claims led to 1,744 deaths and $1.7 billion in malpractice expenditure over a five-year period. This was a result of substandard communication between healthcare providers (Commission The, 2017). Hospitalized patients are often passed between nurses an average of 42 times in any given week (O'Shea & Roney, 2021). When handoffs are performed inadequately, not only does it

affect the patients, but clinical decision-making is hindered, leading to potential harm, decreased quality of care, and poor health outcomes. Due to the increased rate of malpractice claims, The Joint Commission (TJC) recommends organizations implement an evidence-based standardized handoff approach into practice, aiding in streamlining the way handoff is given. The World Health Organization (WHO), The Joint Commission (TJC), and Agency for Healthcare Research and Quality (AHRQ) recommend the usage of Situation, Background, Assessment, Recommendation (SBAR) as an effective communication tool because it has been proven, when used in handoffs, communication between healthcare providers improves and adverse patient events are reduced (Wheeler, 2018). According to Ofori-Atta, Binienda, & Chalupka, (2018), in one 34-bed progressive care unit employing 55 nurses, use of SBAR reduced report time from approximately 40 minutes to 10 minutes, and the institution saved $8,000 in 2 months due to the reduction in overtime.

Using a standardized handoff tool and language during shift report helps ensure the transmission of information is consistent and allows for questioning. Nurses are essential in providing care and must participate in improving communication between colleagues and interdisciplinary teams. Poorly conducted handoffs are implication in 80% of preventable adverse events in healthcare facilities (Commission The, 2017). TJC also estimates that “65% of sentinel events such as falls, medication errors, and wrong site wrong patient surgical procedures are the result of communication breakdowns” (Commission The, 2017).

Many organizations including TJC, WHO, and The Institute of Medicine (IOM) estimated that 80% of all hospital adverse events are due to poor communication,

involving ineffective patient handoff reports that failed to disseminate pertinent patient information (Callaway, et al., 2018). “Between 210,000 and 440,000 patients, each year suffer some type of preventable harm that contributes to their death due to ineffective and inefficient communication among health care workers” (Rodziewicz, Houseman, & Hipskind, 2022). Thus, making medical errors one of the leading causes of death in hospitalized patients, costing approximately $20 billion a year (Rodziewicz, Houseman, & Hipskind, 2022). When change of shift is done effectively and is composed of structured, consistent, and concise communication, nurses need to understand by performing an efficient change of shift report, patient’s quality of care and safety will increase as well as the accountability between nurses.

The Institute for Healthcare Improvements Model for Change served as the framework for this quality improvement project involving a Plan Do Study Act (PSDA) cycle. This is widely accepted in nursing practice because it provides a structure for iterative testing of changes to improve the quality of healthcare (Taylor, et al., 2019). The purpose of this Doctor of Nursing Practice (DNP) quality improvement (QI) project is to implement a patient handoff tool into the electronic medical record (EMR) based on the Situation, Background, Assessment, and Recommendation (SBAR) method to help improve handoff communication and documentation. This project aimed to improve nurse-to-nurse communication with the use of a standardized shift report tool to increase the minimum staff documentation of bedside handoff compliance to 80%. The primary outcome measure was the number of SBARs completed by nursing staff. A secondary outcome measure was number of completions for each element in the SBAR. The question for the study was: In a pediatric rehabilitation facility, will implementation of a

standardized SBAR handoff tool in the EMR, increase documentation of shift-to-shift handoff communication?

Literature Review

A review of literature was initiated to utilize resources for the topic area. PubMed, Medline (EBSCO), and CINHAL were used to drive the search. The key search terms and phrases used were “handoff communication in nursing”, “development of standardized communication handoff”, “shift to shift report”, “handoff protocol”, and “implementation of SBAR in EMR”, with the use of Boolean operators AND and OR. The search initially resulted in 2,956 articles generated based on the key search terms and phrases. Inclusion criteria were studies from 2017 to 2022, published in the English language, and scholarly peer-reviewed journals. Exclusion criteria were publications that were published before 2017, not published in the English language, and were not scholarly or peer-reviewed journals. After inclusion and exclusion criteria were applied 154 articles were generated and 10 publications were selected for this review of the literature.

When discussing patient handoff communication challenges, the use of the SBAR tool has been shown to improve the efficiency, quality, and efficacy of communication between nurses and other healthcare providers, as well as improving patient quality of care, patient safety, patient satisfaction, and accountability (Cornell, 2018, Ruhomauly et al., 2019). This literature review was conducted to synthesize the evidence supporting the documentation and use of SBAR as a standardized patient handoff tool to improve the quality of nurse communication and improve patient care outcomes.

Stewart (2017) conducted a systematic review of 21 studies across three databases. The purpose of this review was to synthesize existing evidence of the usage of SBAR during patient handoff and its impact on provider communication and patient safety (Stewart, 2017). Results unveiled in all 21 studies, the use of SBAR was highly effective in improving patient handoff communication by facilitating a common language for communication between healthcare providers, increasing providers' confidence and their perception of effective communication (Stewart, 2017). In addition, SBAR was found to improve the quality of handoff reports by improving accuracy, efficacy, and efficiency (Stewart, 2017). Muller et al. (2018) conducted a systematic review of 5 databases and found the implementation of an SBAR communication tool improved patient safety, especially when used to guide communication between providers and nurses. Healthcare providers involved in transferring patient information may be distracted, to avoid preventable distractions it is recommended that nurses share patient information in designated areas away from distraction to improve the accuracy and thoroughness of nurse-to-nurse communication (Shahid & Thomas, 2018). The above studies concluded the effect of an SBAR tool improves healthcare provider communication, improves patient safety, and provided the nurses with a standardized way of providing effective communication. Recommendations among studies included further research due to the lack of existence of enough high-quality studies.

The use of the SBAR patient handoff tool has been shown to improve patient care outcomes (Devereaux, 2017; Muller et al., 2018, Stewart, 2017). According to Callaway et al., 2018, bedside handoffs among healthcare providers have been shown to facilitate communication of pertinent information between nurses, optimizing healthcare and

outcomes. By not having a standardized shift report tool in place, patient outcomes are jeopardized. It is estimated by The Joint Commission Center for Transforming Health Care, that 80% of serious medical errors or sentinel events involve ineffective patient handoff reports which do not transmit pertinent information and recommend the use of standardized, structured patient handoffs (Callaway et al., 2018). Poor communication results in misdiagnoses and other medical mistakes that can easily lead to avoidable health complications and the death of patients (Journal, 2022). In the study published by HIPAA Journal 2022, 23,000 medical malpractice lawsuits were investigated, and found more than 7,000 of those lawsuits could be attributed to communication failures. Miscommunication of important information about a patient's symptoms or condition can lead to incorrect decisions being made about treatment when the severity of the patient's condition is misunderstood (Journal, 2022). Another study reviewed incident reports filed. Of the 211 communication failures, errors of omission were the most common (27%) and more than half of the conceptual failures were the transfer of information failures (58.4%) while 20.1% were physical harm (Umberfield, Ghaferi, Krein, & Manojlovich, 2019). Muller et al. (2018) conducted a systematic review of 11 studies, which were selected to meet the criteria of having primary outcomes related to patient outcomes. The purpose of the review was to analyze the impact of SBAR on patient safety patient outcomes (Muller et al., 2018). Eight of the studies included explored the impact on specific adverse patient outcomes or events, such as unplanned transfers to another hospital. At the same time, the remaining three focused on adverse patient outcomes such as drug events (Muller et al., 2018). It was revealed that eight out of 26 patient care outcomes improved with the use of SBAR (Muller et al., 2018). Eleven

outcomes were described as improved (though not significant), six had no change, and one was reported as worsened (Muller et al., 2018). Throughout the studies implementation of a standardized SBAR tool during shift reports significantly increased improved outcomes for patients. Recommendations included searching for a standardized universal tool to be used in all in-patient hospital settings and establishing a way to measure improved patient outcomes related to the implementation of an SBAR tool. To ensure the quality of care of patients it is detrimental for nurses to communicate using a standardized tool.

The Institute for Healthcare Improvements Model for Change is one of the most common reliable quality improvement methods for implementing and solidifying change in health care systems (McGowan & Reid, 2018). Change in an organization may be guided by Deming's Plan-Do-Study-Act (PDSA) cycle. Implementing and solidifying change is relevant for an ongoing problem such as inconsistencies in the shift-to-shift report. Implementation of a standardized handoff tool in the electronic medical record (EMR) can be supported by the PDSA cycle due to its aim to improve patient safety, quality of care, and quality of nurse communication.

In summary, it is unclear what the best tools and methods are to measure handoffs but implementing a standardized shift to shift handoff is recommended by numerous accrediting agencies (Trossman, 2019). Shift report is vital because it includes the passing of accountability and responsibility to the oncoming nurse. A lack of thorough shift-to-shift report can compromise the quality of care and safety of patients. Some organizations do not have a standardized shift report tool. After literature review, the SBAR handoff report tool is one of the most frequently used when initiated into shift

report between nurses. This tool has the advantage of promoting critical thinking, improving situational awareness and collaboration between physicians and nurses. Further investigation, creation, and implementation of a standardized shift-to-shift process needs to be done and further research may need to be conducted regarding the handoff of patients who are involved in multidisciplinary teams (Trossman, 2019). By streamlining the way, the shift-to-shift handoff is performed nurse-to-nurse communication will improve, leading to safer patient outcomes.

Methods

Design

This quality improvement (QI) project is an observational study. Data was collected from prospective survey responses starting on nurses' satisfaction of bedside shift report prior to implementation and after implementation of the SBAR tool within the EMR. Data was also collected from prospective chart reviews of documentation of the SBAR tool adapted into the electronic medical record for 3 months after the acknowledgment it received. The data was analyzed using inferential and descriptive statistics. Inferential statistics was used to analyze data collection in regard to the survey pre and post-implementation. The data being collected on SBAR implementation was analyzed using descriptive statistics. The data from the nursing surveys is anonymous and data from the chart review EMR collected is in aggregated form and was anonymous. The IT department collected the number of SBARs completed and collected how many elements were documented on every bedside shift report completed. The data collected was sent in the form of an excel sheet in an email weekly. The findings from the QI project was provided

to the pediatric service line to help determine the next steps in improving nurse-to-nurse handoff.

Setting

This project occurred in a Pediatric Rehabilitation Facility in Maryland Heights, Missouri with 60 patient beds. This hospital is the first and only specialized pediatric bridge hospital in Missouri and one of only a few in the country. As a pediatric bridge hospital, it supports kids from birth to 21 who are well enough to leave a traditional hospital but still need help before they go home. Specializing in caring for children and families with the most complex conditions, illness, and injuries; bridge the gap between hospital and home.

Sample

This project used a convenience sample of registered nurses currently employed at the project site on the East Unit and West Unit engaged in patient care and documentation of SBAR data and its elements. A nurse is assigned to a group of patients (based on nurse-patient staffing ratios) for one of two twelve-hour shifts, requiring patient handoffs on average twice a day. Any staff not employed on the East Unit or West Unit, not providing direct patient care, and shifts less than twelve hours (7a-7p or 7p-7a) was excluded as well as any other documentation outside of the SBAR tool and elements.

Data Collection/Analysis

A prospective record review containing quantitative, descriptive data regarding the number of SBARs documented and what elements of the SBAR were documented on from January 30, 2023, through April 23, 2023, was generated weekly (Monday through Sunday) (See Appendix B). The SBAR elements that were collected from the record review

include orders, meds, clinical data, social summary (behavior plan, restrictions, caregiver training, other (free text)). All SBARs documented in the EMR utilized by nursing staff during handoff became part of the patient's medical record and required dual signoff. This was a cosigned procedure which will decrease inaccurate results and increase accountability. A schedule of day shift and night shift nurses was provided to compare how many SBARs were documented on vs how many staff members were working on that given shift to compare how many SBARs were completed in that given shift vs not completed (See Appendix C).

To examine nurses' overall satisfaction with beside shift report pre and post-implementation, prior to the implementation of the electronic SBAR tool, a survey was distributed to nurses at the Nursing Shared Leadership meeting where education on the SBAR tool was provided and a copy of the survey was placed in each nurse's mailbox. There was then an email sent stating a survey had been placed in their mailboxes and to return completed surveys to the Manilla envelope placed in the nurse manager's office. Nurses were educated about the intent of this survey at the Nursing Shared Leadership meeting and in the email that was sent out. The exact same survey was distributed post-implementation by placing a copy in the nurses' mailbox. (See Appendix D).

To better understand the outcomes of implementation of SBAR documentation in the EMR and nurse hand off communication inferential and descriptive statistics including an independent sample t-test was employed via Statistical Package for the Social Sciences (SPSS). Data collected has been displayed in the form of tables and bar charts. Conclusions have been drawn from the analysis.

Approval Process

Formal approval was attained from the project site's Clinical Nurse Manager and Clinical Nurse Educators on August 30, 2022. Limitations include documentation of completion of SBAR during handoff is self-reported, causing the results to potentially be skewed. Benefits include improving shift-to-shift communication, improved documentation, and improved communication among collaborating medical staff teams. The University of Missouri-St. Louis (UMSL) Institutional Review Board (IRB) determined the project to be quality improvement activity not requiring IRB review.

Procedure

This quality improvement project was led by the Doctor of Nursing Practice (DNP) candidate. All nursing staff was provided with education (See Appendix A) about the SBAR tool placed in the EMR during the January Nursing Shared Leadership meeting and this same education was placed in the project site's learning data base labeled as "Mandatory Education" to be completed by all nursing staff one week prior to implementation. All nursing staff had the SBAR tool documentation available to them in Cerner. The expectation is that nursing staff will document on all elements of the SBAR discussed including orders, meds, clinical data, social summary (behavior plan, restrictions, caregiver training, other (free text)) and a dual sign off will be required. A schedule of day shift and night shift nursing staff was collected to determine how many nurses worked each shift compared to how many SBARs were completed (Appendix C). The nursing staff were given a survey prior to implementation and post implementation of the SBAR tool in the EMR to collect data on nurses' satisfaction of SBAR pre and post implementation (Appendix D). This is a 15-item survey that is scored on a Likert scale from 1-5 (1= strongly disagree, 2= disagree, 3= neither disagree nor agree, 4= agree, 5=

strongly agree). This survey was completed anonymously prior to implementation and again at the end of the 12-week implementation period.

With the report audit, the number of SBARs completed and elements documented on data was recorded in the appropriate template weekly. At the conclusion of the implementation on April 23, 2023, the primary investigator collected final SBARs completed vs not completed and elements documented on and analysis will occur using inferential and descriptive statistics.

Results

During the implementation period of January 30, 2023, through April 23, 2023, between day shift and night shift it was expected 8,241 bedside shift reports were documented. In the 12-week time frame 8,188 were documented (See Figure 2). There were 84-day shifts and night shifts included (n=84) in this data set. The mean for day shift was 99.35% and for night shift it was 99.37%. Meaning that there was only a 1.43 standard deviation for day shift and a 1.29 standard deviation for night shift. Analysis of weekly run chart data showed that 99% for day shift and night shift nurses were compliant with use of the SBAR Patient Handoff Tool intervention. The goal of increasing the minimum staff compliance to 80% with the use of the standardized shift report tool in the EMR was met.

Information Technology (IT) was not able to run the report of what elements were documented on and data was not collected on the specific elements of orders, meds, clinical data, social summary (behavior plan, restrictions, caregiver training, other (free text)).

The pre and post implementation survey provided data on nurse satisfaction of the handoff process before and after the implementation of the intervention tool. Analysis and comparison of the mean pre and post implementation responses from the 15-items showed improvements post-implementation ranging from -2.1 to +1.3 (See Figure 1). There were 22 pre-implementation surveys (n=22) anonymously completed and 23 post-implementation surveys (n=23) completed. Among the 15 questions (Q1, Q2, Q3…) there was significant improvement among questions 1, 2, 3, and 5. All of which specifically addressed use of an SBAR tool during handoff (See Appendix D).

Discussion

Implementation of the documentation of bedside shift report during the QI timeframe for day shift and night shift exceeded 99%, achieving the stated goal of increasing the minimum staff documentation of bedside handoff compliance to 80%. Prospective data was collected during QI implementation. Prospective survey responses starting on nurses' satisfaction of bedside shift report prior to implementation and after implementation of the SBAR tool showed that there was increased satisfaction of bedside shift report overall. Results of this QI project concur with evidence that use of the SBAR tool during patient handoff improves the quality, efficacy of communication and efficiency (Cornell et al., 2018; Stewart, 2017). The greatest improvement was seen in questions related to the SBAR tool (questions 1, 2, 3, and 5). There was a decrease in satisfaction related to the time it took to give handoff (question 9). Most of the responses were congruent with it taking more time by implementing the SBAR tool. While literature points to evidence that SBAR reduces adverse patient events and improves patient care outcomes, this was beyond the scope of this QI project, which focused on

implementing and evaluating the impact of the SBAR tool intervention in improving nurse communication during handoff and documentation compliance.

Limitations of this QI project included resistance from nursing staff during the implementation phase due to shift-to-shift handoff being too “time consuming.” Staff verbalized that it was taking them longer to perform handoff due to the requirement of cosigning at the completion of handoff, hindering the oncoming shift to begin looking up orders for their daily patient list. Another limitation was that IT was not able to generate or run the reports of the specific elements that were documented within the SBAR tool.

Recommendations for future endeavors include not requiring a nurse to cosign as this placed an increased time in giving bedside shift report and a delay in the oncoming nurse getting their shift started as there were not enough computers available for the oncoming shift to begin looking at orders. Revision of the elements documented on needs to be considered as based on the nurse survey post implementation the elements chosen to be documented did give the nurses the feeling that all important information was given during bedside shift report. Findings from this novel effort may guide future PDSA cycles, and revamping what information nurses at this project site would like to implement into their bedside shift report.

Conclusion

SBAR tool improves nurse-to-nurse communication when used during patient handoffs. A strength of this QI project is that the service line and leadership were highly supportive of this quality improvement project to improve nurse-to-nurse communication,

compliance with documentation, and to meet the long-term goal of keeping the SBAR tool implemented into the electronic medical record.

Implications for practice include incorporating SBAR as an integral part of patient handoff communication. Research has shown that when SBAR is used it is effective in facilitating a standardized language for communication between nurses and other healthcare providers. SBAR is therefore useful not only during handoff communication between nurses, but also among physicians to improve communication and patient care outcomes.

In this QI effort, implementation of documentation of bedside shift report was achieved. Future PDSA cycles and data collection should take place for ongoing quality improvement and analysis.

References

Ashcraft, A., & Owen, D. (2017). Comparison of standardized and customized SBAR communication tools to prevent nursing home resident transfer. *Applied Nursing Research, 38,* 64-69. doi:10.1016.2017.09.015

Callaway, C., Cunningham, C., Grover, S., Steele, K., McGlynn, A., & Sribanditmongkol, V. (2018). Patient handoff process: Implementation and effects of bedside handoffs, the teach-back method, and discharge bundles on an inpatient oncology unit. *Clinical Journal of Oncology Nursing, 22*(4), 421-428. doi:10.1188/18.CJON.421-428

Commission, T. J. (2017). Sentinel event alert: Inadequate hand-off communication. *The Joint Commission*(58). Retrieved from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_(1).pdf

Cornell, P., Gervis, M., Lauren, Y., & Vardaman. (2018, October). Impact of SBAR on nurse shift reports and staff rounding. *Medsurg Nursing*, 334-342.

Devereaux, T., Marchetti, G., Zionts, N., Engberg, S., Watzlaf, V., Bonenberger, S., & Perry, A. (2017). Condition-specific SBAR effect on transfers, hospitalizations, and 30-day readmissions from long-term care to acute-care. *Journal of the American Medical Directors Association, 17*(3). doi:10.1016/j.jamda.2015.12.078

Field, T., Tija, J., Mazor, K., Donovan, J., Kanaan, A., Harrold, L., . . . Gurwitz, J. (2018). Randomized trial of a warfarin communication protocol for nursing

homes: an SBAR-based approach. *The American Journal of Medicine,* 179e1-179e7. doi:10.1016/j.amjmed.2018.09.017

Journal, H. (2022). Effects of poor communication in healthcare. *HIPAA Journal*, 1-6.

McGowan, M., & Reid, B. (2018). Using the plan, do, study, act cycle to enhance patient feedback system for older adults. *British Journal of Nursing, 27*(16), 936-941. doi:10. 12968/bjon.2018.27.16.936

Muller, M., Jurgens, J., Redaelli, M., Klingberg, K., Hautz, W., & Stock, S. (2018). Impact of the communication and patient hand-off tool SBAR on patient safety: a systemic review. *BMJ Open*. doi::10.1136/bmjopen-2018-022202

Ofori-Atta, J., Binienda, M., & Chalupka, S. (2017). Bedside shift report: Implications for patient safety and quality of care. *Nursing, 45*(8), 1-4. doi:10.1097/01.NURSE.0000469252.96846.1a

O'Shea, E., & Roney, L. (2021). SBAR: not just for patient handoffs. *Nurse Education, 46*(1), 48. doi:10.1097/NNE.0000000000000887

Rodziewicz, T., Houseman, B., & Hipskind, J. (2022). *Medical error reduction and prevention.* StatPearls.

Ruhomauly, Z., Betts, K., Coupe, K., Szekely, M., Relwani, A., McCay, J., & Jaffry, Z. (2019). Improving the quality of handover: implementing SBAR. *Future Healthcare Journal, 6*(2), 54. doi: https://doi.org/10.7861/futurehealth.6-2-s54

Ruhomauly, Z., Betts, K., Jayne-Coupe, K., Karanfilian, L., Szekely, M., Relwani, A., . . . Jaffry, Z. (2019). Improving the quality of handover: implementing SBAR. *Future Healthcare Journal*, 6-22. doi:10.7861/futurehosp.6-2s-s54

Shahid, S., & Thomas, S. (2018). Situation, background, assessment, recommendation (SBAR) communication tool for handoff in health care- a narrative review. *Safety in Health, 4*(7). doi:10.1186/s40886-018-0073-1

Shahid, S., & Thomas, S. (2018). Situation, background, assessment, recommendation (SBAR) communication tool for handoff in healthcare- a narrative review. *Safety in Health, 7*(2), 1-9. doi:https://doi.org/10.1186/s40886-018-0073-1

Stewart, K. (2017). SBAR, communication, and patient safety: an integrated literature review. *Medsurg Nursing, 26*(5), 297-305.

Taylor, M., McNicholas, C., Nicolay, C., Darzi, A., Bell, D., & Reed, J. (2019). Systematic review of the application of the plan-so-study-act method to improve quality in healthcare. *BMJ Quality & Safety, 23*(4), 290-298. doi: 10.1136/bmjqs-2019-001862

Trossman, S. (2019). Consistent, quality communication: nurses help lead efforts on safe patient handoffs and transfers. *American Nurse Today, 14*(1), 28.

Umberfield, E., Ghaferi, A., Krein, S., & Manojlovich, M. (2019). Using incident reports to assess communication failures and patient outcomes. *Joint Commission Quality and Patient Safety, 45*(6), 406-413. doi:10.1016.j.jcjq.2019.02.006

Wheeler, K. (2018). Effective handoff communication. *OR Nurse, 8*(1), 22-26. doi:10.1097/01.ORN.0000438472.00326.1a

Tables

Table 1

Percentage of SBARs Completed

Group Statistics

	Shift: AM or PM	N	Mean	Std. Deviation	Std. Error Mean
Percentage completed	AM	84	99.352	1.4233	.1553
	PM	84	99.373	1.2914	.1409

Table 2

Independent Samples T Test of Percentage of SBARs Completed

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Percentage completed	Equal variances assumed	.051	.822	-.099	166	.921	-.0208	.2097	-.4348	.3932
	Equal variances not assumed			-.099	164.455	.921	-.0208	.2097	-.4348	.3932

Table 3

Group Statistics of Pre and Post Implementation Survey Means

Group Statistics

	Pre vs. Post	N	Mean	Std. Deviation	Std. Error Mean
Q1	Pre	22	3.23	1.510	.322
	Post	23	4.39	.722	.151
Q2	Pre	22	3.41	1.333	.284
	Post	23	4.48	.665	.139
Q3	Pre	22	3.50	1.263	.269
	Post	23	4.00	.798	.166
Q4	Pre	22	3.91	.811	.173
	Post	23	4.22	.671	.140
Q5	Pre	22	3.77	.922	.197
	Post	23	4.35	.647	.135
Q6	Pre	22	2.77	1.152	.246
	Post	23	2.52	.898	.187
Q7	Pre	22	3.59	.908	.194
	Post	23	3.39	.783	.163
Q8	Pre	22	4.14	.640	.136
	Post	23	4.74	.449	.094
Q9	Pre	22	2.18	.733	.156
	Post	23	4.30	.703	.147
Q10	Pre	22	3.82	.664	.142
	Post	23	4.39	.583	.122
Q11	Pre	22	3.32	1.129	.241
	Post	23	2.61	.891	.186
Q12	Pre	22	3.86	.990	.211
	Post	23	2.57	.896	.187
Q13	Pre	22	3.59	1.260	.269
	Post	23	2.87	1.058	.221
Q14	Pre	22	3.64	.848	.181
	Post	23	4.00	.953	.199
Q15	Pre	22	3.77	.869	.185
	Post	23	3.22	1.043	.217

Table 4

Independent Samples T Test of Pre and Post Implementation Survey

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Q1	Equal variances assumed	19.058	<.001	-3.323	43	.002	-1.164	.350	-1.871	-.458
	Equal variances not assumed			-3.276	29.838	.003	-1.164	.355	-1.890	-.438
Q2	Equal variances assumed	13.566	<.001	-3.427	43	.001	-1.069	.312	-1.698	-.440
	Equal variances not assumed			-3.381	30.545	.002	-1.069	.316	-1.715	-.424
Q3	Equal variances assumed	6.177	.017	-1.595	43	.118	-.500	.313	-1.132	.132
	Equal variances not assumed			-1.580	35.192	.123	-.500	.317	-1.142	.142
Q4	Equal variances assumed	.045	.834	-1.392	43	.171	-.308	.222	-.755	.138
	Equal variances not assumed			-1.386	40.808	.173	-.308	.222	-.758	.141
Q5	Equal variances assumed	2.009	.164	-2.430	43	.019	-.575	.237	-1.052	-.098
	Equal variances not assumed			-2.411	37.503	.021	-.575	.238	-1.058	-.092
Q6	Equal variances assumed	1.966	.168	.817	43	.418	.251	.307	-.368	.870
	Equal variances not assumed			.813	39.704	.421	.251	.309	-.373	.875
Q7	Equal variances assumed	.639	.429	.791	43	.433	.200	.252	-.309	.709
	Equal variances not assumed			.788	41.464	.435	.200	.253	-.312	.711
Q8	Equal variances assumed	.747	.392	-3.672	43	<.001	-.603	.164	-.934	-.272
	Equal variances not assumed			-3.644	37.507	<.001	-.603	.165	-.938	-.268
Q9	Equal variances assumed	.301	.586	-9.918	43	<.001	-2.123	.214	-2.554	-1.691
	Equal variances not assumed			-9.909	42.678	<.001	-2.123	.214	-2.555	-1.690
Q10	Equal variances assumed	.382	.540	-3.079	43	.004	-.573	.186	-.948	-.198
	Equal variances not assumed			-3.070	41.720	.004	-.573	.187	-.950	-.196
Q11	Equal variances assumed	1.256	.269	2.345	43	.024	.709	.303	.099	1.320
	Equal variances not assumed			2.333	39.948	.025	.709	.304	.095	1.324
Q12	Equal variances assumed	.015	.903	4.617	43	<.001	1.298	.281	.731	1.866
	Equal variances not assumed			4.606	42.113	<.001	1.298	.282	.730	1.867
Q13	Equal variances assumed	.573	.453	2.084	43	.043	.721	.346	.023	1.419
	Equal variances not assumed			2.076	41.053	.044	.721	.347	.020	1.423
Q14	Equal variances assumed	.085	.772	-1.350	43	.184	-.364	.269	-.907	.180
	Equal variances not assumed			-1.353	42.779	.183	-.364	.269	-.906	.178
Q15	Equal variances assumed	2.036	.161	1.936	43	.059	.555	.287	-.023	1.134
	Equal variances not assumed			1.944	42.229	.059	.555	.286	-.021	1.132

Figures

Figure 1

Pre/Post Implementation Survey Responses

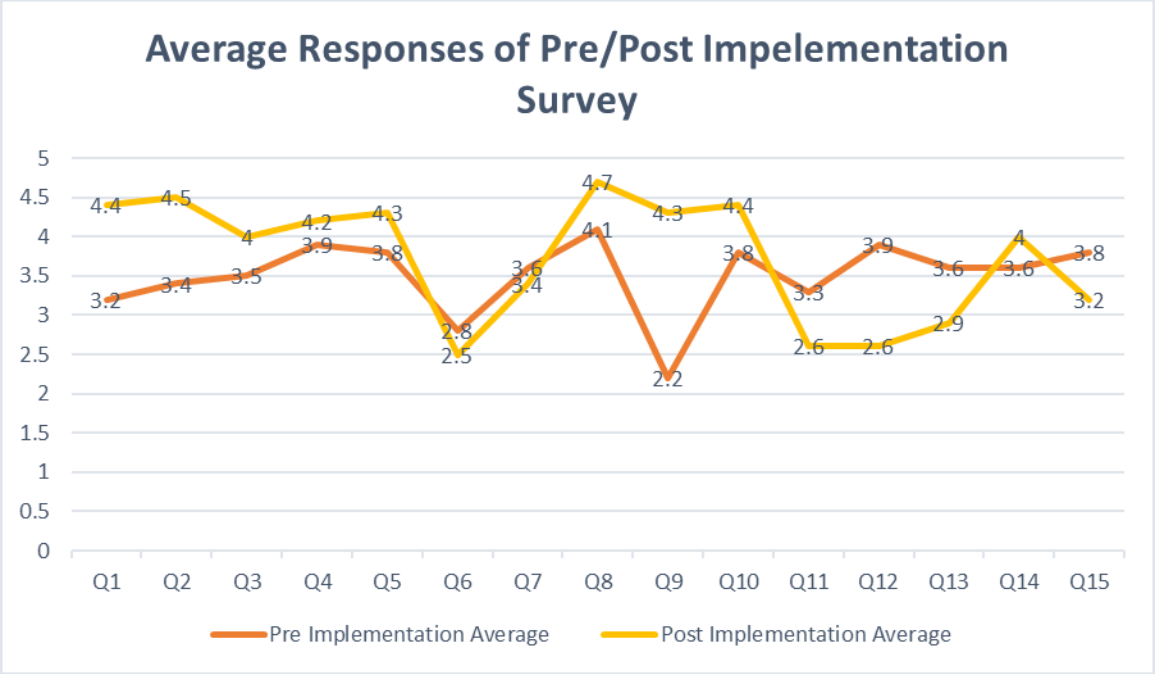
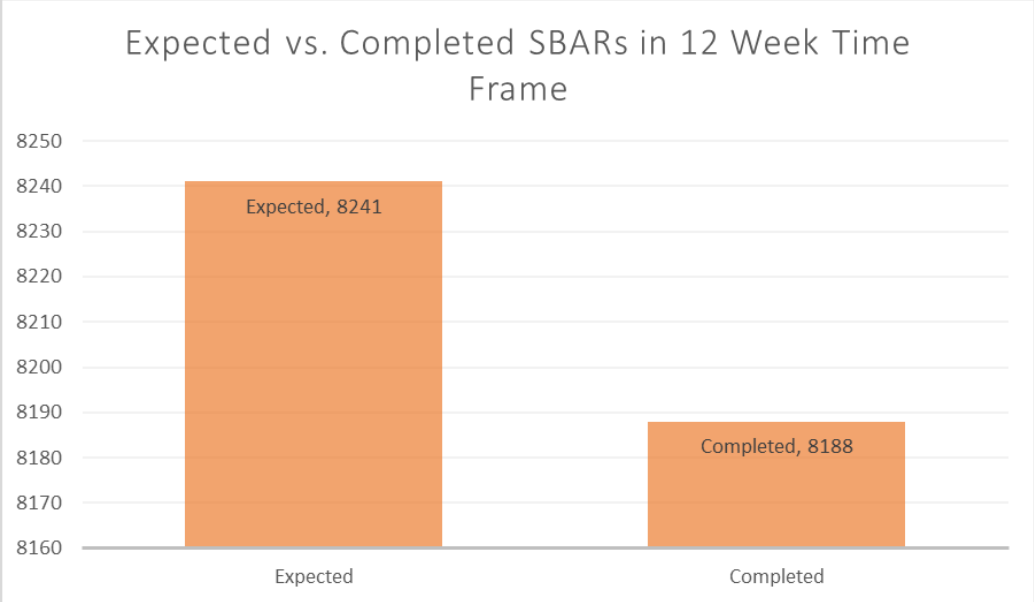


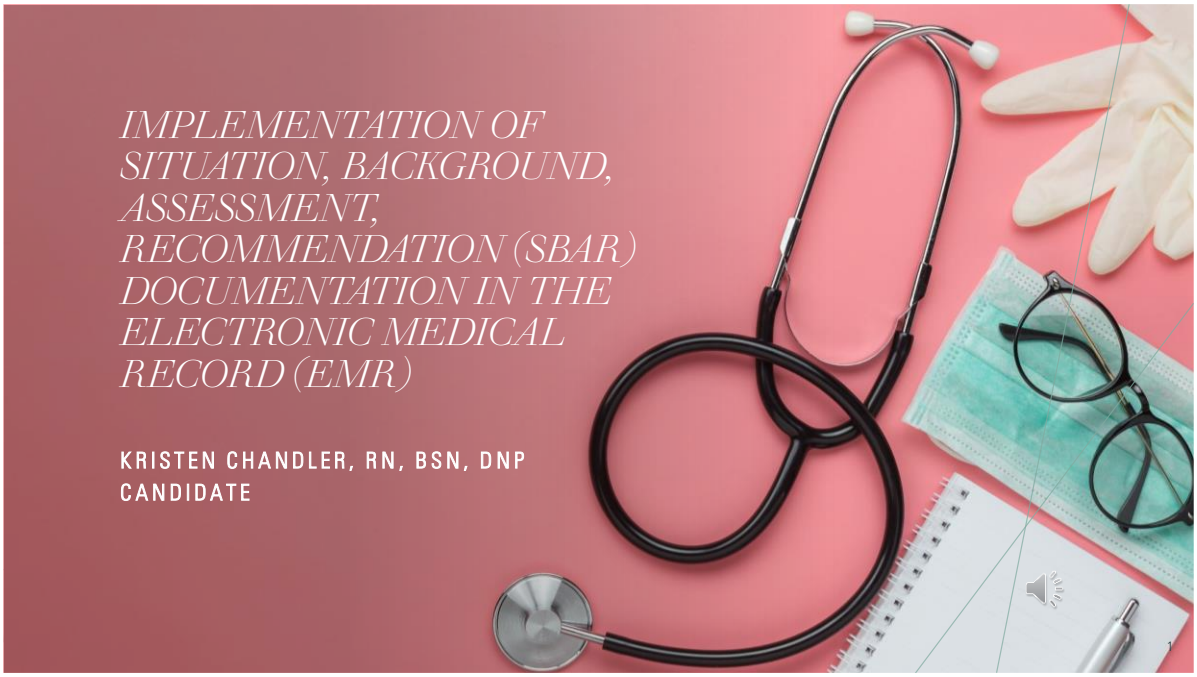
Figure 2



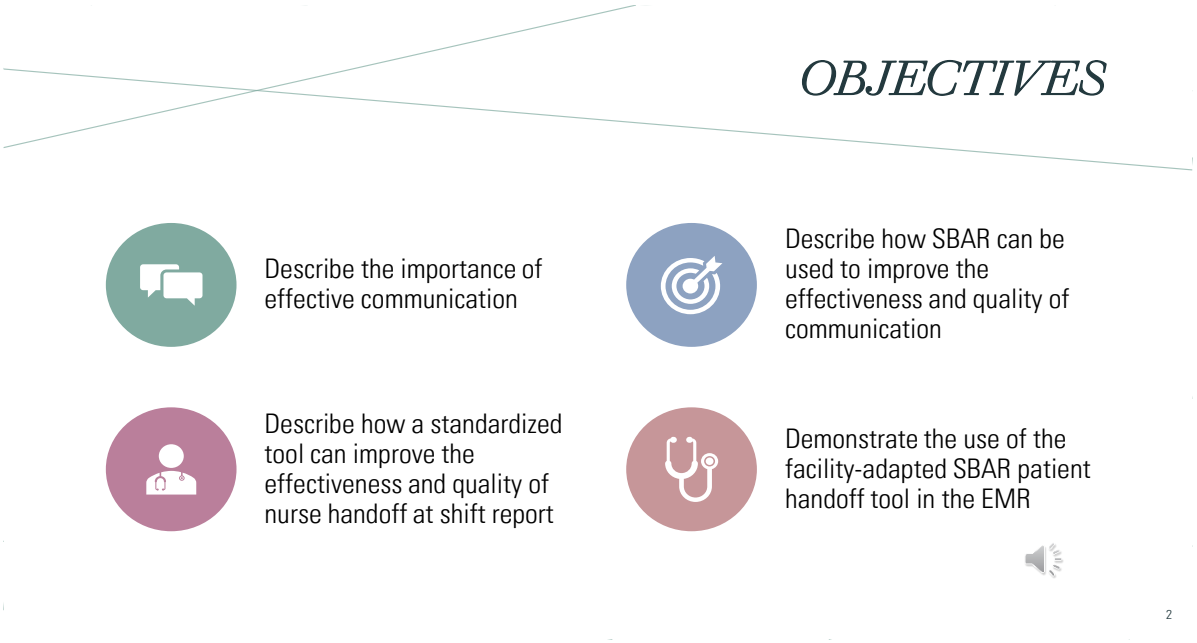
Appendix A

SBAR Education Slide Handouts

SBAR Education Slide 1



SBAR Education Slide 2



SBAR Education Slide 3

IMPORTANCE OF EFFECTIVE COMMUNICATION

- Risk for adverse patient outcomes **increases** with missed, ineffective or poor communication
- Poorly conducted handoffs implicated in 80% of preventable adverse events
- An ineffective handoff is the first point of safety failure
- It is recommended that an evidence-based handoff communication approach is used (SBAR).

(Callaway, 2018, Rodziewicz, Houseman & Hipskind, 2022)

3

SBAR Education Slide 4

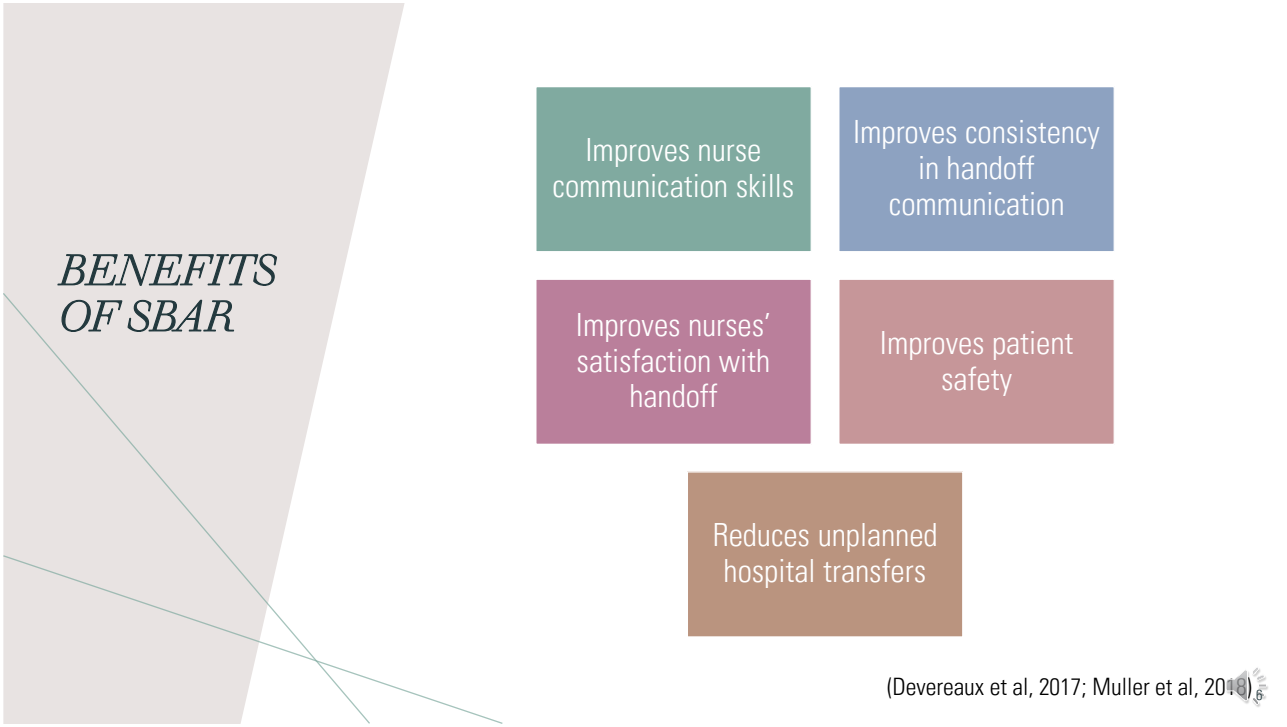
WHAT IS SBAR?

- S = situation
  - Room #, Name, Age, Gender, Admit date, Admitting diagnosis
- B = background
  - Past medical history, Labs, Medications, Allergies, Treatments
- A = assessment
  - Status during last shift, New Orders, Change of
- R = recommendation
  - Plan for next shift, Lab results pending

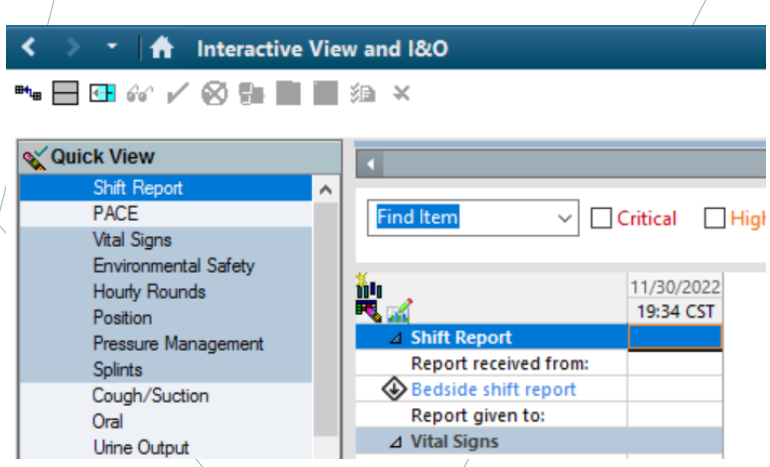
4

SBAR Education Slide 5

SBAR Education Slide 6



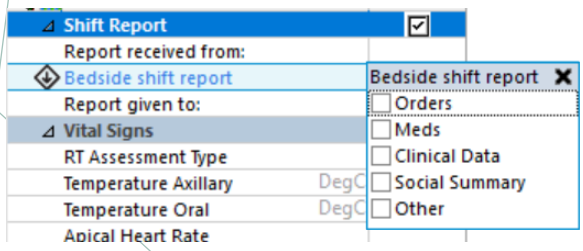
SBAR Education Slide 7



SBAR IMPLEMENTATION

WHERE IS THIS LOCATED?

SBAR Education Slide 8

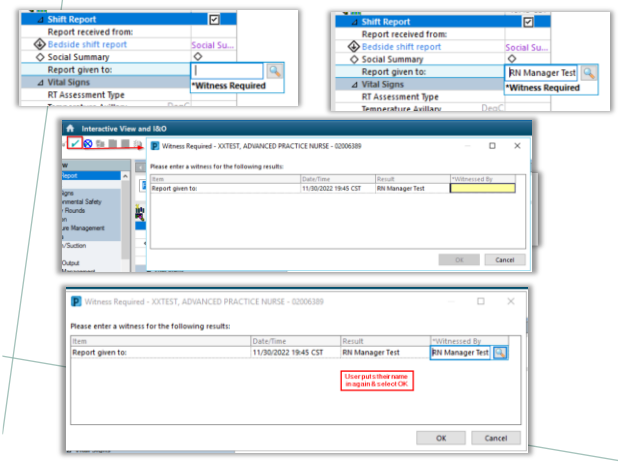


SBAR IMPLEMENTATION

- What is the expectation?
  - Orders
  - Meds
  - Clinical Data
  - Social Summary
    - Behavior Plan
    - Restrictions
    - CG Training
    - Other
  - Other
  - All of the above is to be discussed during bedside shift report.

SBAR Education Slide 9

SBAR IMPLEMENTATION



- This will require dual nurse sign off
- When signing documentation, the prompts for the Oncoming RN to witness documentation will fire

9

SBAR Education Slide 10

RankenJordan.
PEDIATRIC BRIDGE HOSPITAL

Transitioning kids from hospital to home

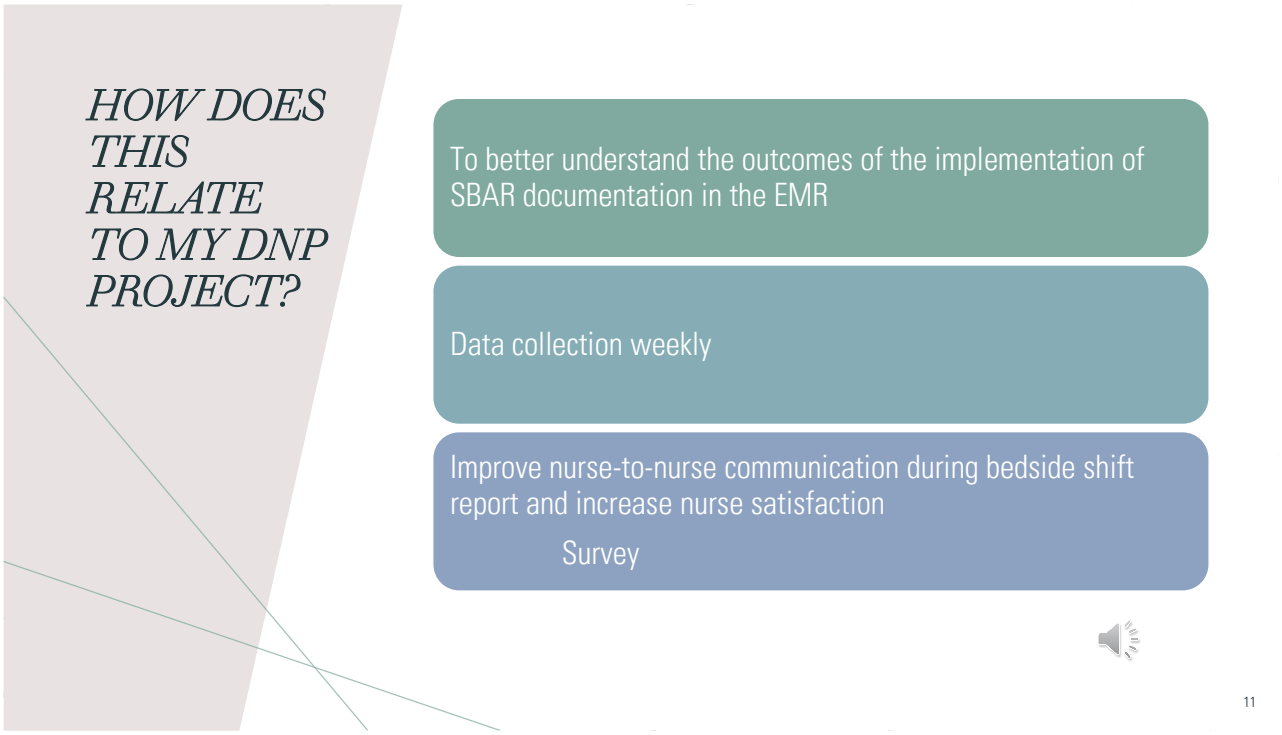
Bedside Shift Report Checklist

- ❑ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ❑ Open the medical record or access the electronic work station in the patient's room together.
- ❑ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.
  - **S** = **Situation**. What is going on with the patient? What are the current vital signs?
  - **B** = **Background**. What is the pertinent patient history?
  - **A** = **Assessment**. What is the patient's problem now? Brief review of systems (head-to-toe)
  - **R** = **Recommendation**. What does the patient need?
  - **T** = **Thank you.** Thank the patient and family.
- ❑ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubing, catheters, etc.
  - Visually sweep the room for any safety concerns.
- ❑ Review:
  - Orders
  - Medications
  - Clinical Data
  - Social Summary (e.g., behavior plans, restrictions, caregiver training, etc.)
- ❑ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - *"Do you have any concerns about safety?"*
    - *"Do you have any questions or worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - *"What do you want to happen during the next 12 hours?"*
    - Communicate patient schedule for the day.

- Bedside Shift Report Checklist will be posted on each computer for reference.

10

SBAR Education Slide 11



SBAR Education Slide 12

Appendix B

Prospective Data Collection (January 30, 2023- April 23, 2023)

Date:			
		Documented	Not Documented
Bedside Shift Report:	Orders		
	Meds		
	Clinical Data		
	Social Summary		
	Other		
Social Summary:	Behavior Plan		
	Restrictions		
	Caregiver Training		
	Other (free text)		

Appendix C

Data Collection on SBARs Completed vs Not Completed

Day Shift			
Week of	# Of Nurses On	Patient Census (expected # of SBARs completed)	# Of SBARs Completed
Week 1: 1/30/23-2/5/23			
Week 2: 2/6/23-2/12/23			
Week 3: 2/13/23-2/19/23			
Week 4: 2/20/23-2/26/23			
Week 5: 2/27/23-3/5/23			
Week 6: 3/6/23-3/12/23			
Week 7: 3/13/23-3/19/23			
Week 8: 3/20/23-3/26/23			
Week 9: 3/27/23-4/2/23			
Week 10: 4/3/23-4/9/23			
Week 11: 4/10/23-4/16/23			
Week 12: 4/17/23-4/23/23			

Night Shift			
Week of	# Of Nurses On	Patient Census (expected # of SBARs completed)	# Of SBARs Completed
Week 1: 1/30/23-2/5/23			
Week 2: 2/6/23-2/12/23			
Week 3: 2/13/23-2/19/23			
Week 4: 2/20/23-2/26/23			
Week 5: 2/27/23-3/5/23			
Week 6: 3/6/23-3/12/23			
Week 7: 3/13/23-3/19/23			
Week 8: 3/20/23-3/26/23			
Week 9: 3/27/23-4/2/23			
Week 10: 4/3/23-4/9/23			
Week 11: 4/10/23-4/16/23			
Week 12: 4/17/23-4/23/23			

Appendix D

Satisfaction survey given to nurses pre and post SBAR tool implementation

Question	Strongly Disagree (1)	Disagree (2)	Neither Disagree nor Agree (3)	Agree (4)	Strongly Agree (5)
1. I always use a patient handoff tool for shift report					
2. Patient handoff report tool is easily accessible					
3. Patient handoff tool captures all critical information necessary for transfer at shift change					
4. I use SBAR (Situation, Background, Assessment, Recommendation) method for handoff shift report					
5. Shift report contains sufficient information about patients					
6. I am often given information during handoff that is not relevant to patient care					
7. The way information is given to me is easy to follow					
8. I am able to clarify/ask questions about information that has been provided to me					
9. I find shift handoff takes too much time					
10. The information I receive is up to date					
11. I feel that important information is not always given to me					
12. I have been asked “do you know this patient,” then not given a background					
13. I have been told “no changes” to patient status when I’ve answered “yes” to having patient previously					
14. I feel like I have enough information about my patient after handoff					
15. I am satisfied with the process currently in place for patient handoff report					