SBAR Handoff at Bedside Report

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Background

- A leading cause of sentinel events evaluate by The Joint Commission is communication failure during handoffs
- The Agency for Healthcare Research and Quality has identified improving handoffs as a priority in US nationwide efforts to improve patient safety
- Benefits include: better **communication** among nurses and other health care providers, **increased visibility** of nursing interventions, **improved patient care**, **enhanced data collection** to evaluate nursing care outcomes, greater **adherence to standards of care**, and **facilitated assessment** of nursing competency
- Giving new staff the tools to continue to build long term stability and confidence

Practice Change

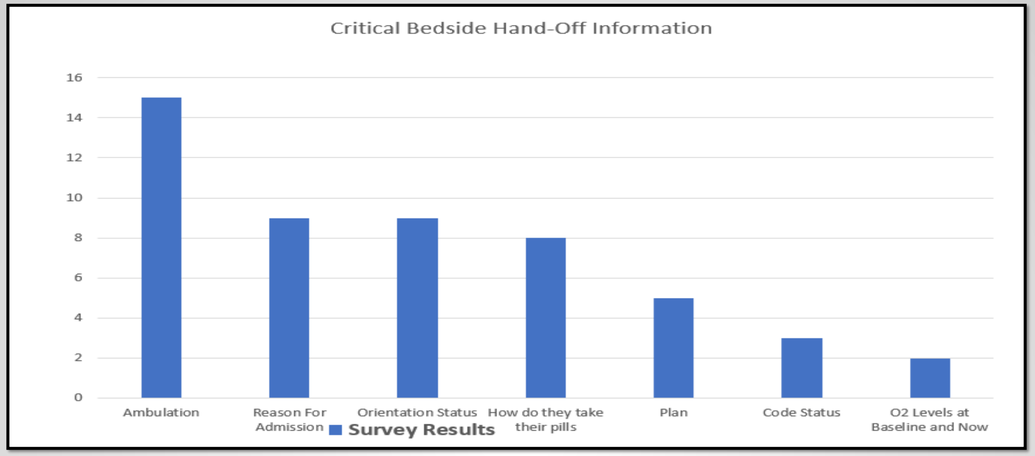
Improved SBAR Handoff during Bedside report between registered nurses using a formulated tool, **designed by nurses for nurses**

Methods

- Distributed paper pre-surveys to RNs
- Formulated a tool that included criteria pertinent to the SBAR policy PCD 04-001
- Utilized handoff tool during bedside report and revised it to fit patient and unit specific criteria

Measures and Results

Pre-Survey Results (n=15)



SBAR Handoff

Northern Light Eastern Maine Medical Center

Title: Patient Handoff	
Policy/Procedure #: PCD 04-001	**Date Posted: 08/21/2019**
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Author: Kim Demers, Associate Vice President, Patient Care Services	
Leadership Sponsor: Kim Demers, Associate Vice President, Patient Care Services	Final Approver: Deb Sanford, Vice President, Nursing & Patient Care Services
Supersedes: PCD 04-001	Dated: 08/13/2014

SCOPE
All healthcare staff.

RELATED POLICIES/PROCEDURES
None.

DEFINITIONS
SBAR is a situational briefing tool that logically organizes information so that it can be transferred to others in an accurate and efficient manner

A. **S – Situation**: may include patient name, room number, admission date, pending transfer/discharge date, physician, code status, isolation, fall risk score and braden score
B. **B – Background**: may include admission diagnosis, surgical procedure, SIGNIFICANT past medical history, allergies, procedures completed within the past 24 hours including results/outcomes, and/or where stand with post procedure vitals/assessment, any falls, assaults, high risk activities or pressure injuries identified in the past 24 hours.,
C. **A – Assessment**: may include abnormal assessment(s), abnormal vital signs, change in dressing condition, NG/drain output, IV fluids/drips/site and when site is to be changed, current pain score, what has been done to manage pain, rhythm (if on cardiac monitoring), protocols (i.e. where at with replacement medications/lab work), pressure injury prevention interventions and fall prevention interventions
D. **R – Recommendation**: may include identification of need to change plan of care, concerns, transfer/discharge planning needs, pending labs/x-rays etc., change in diet, activity, and/or medications.

Summary/Discussion

- **Next Steps:**
  - Create and implement a Hand Off in SBAR format that would be helpful to narrow in on the key points
  - Follow and track patient care and information making sure that all pertinent information is being relayed
  - Continue to provide the best handoff possible to aid in the continuity of care
- **Barriers of this Study:**
  - Lack of participation due to resistance of change
  - Lack of seasoned nurses wanting to adapt to new ways
  - The requirement to follow the SBAR format

Conclusion

- Patient continuity of care and patient satisfaction were greatly improved
- Communication was greatly improved, making sure patients were cared for to highest standard during their stay
- Specific care of patients was greatly improved, less items were missed
- Post education results pending

References

- Rutherford, M., (Jan. 31, 2008) "Standardized Nursing Language: What Does it Mean for Nursing Practice? "OJIN: The Online Journal of Issues in Nursing, Vol. 13 No. 1. Available: www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/Mp1Jan08/A
- Zou, X.-J., & Zhang, Y.-P. (2016). Rates of Nursing Errors and Handoffs-Related Errors in a Medical Unit Following Implementation of a Standardized Nursing Handoff Form. *Journal of Nursing Care Quality*, *31*(1), 61–67. doi: 10.1097/ncq.0000000000000133