Would Gathering Data from Nurses on Grant 6, Determine Important Information to Pass on During Shift Report that Can Lead to a Standardized SBAR Report Form?

Brittany Berthiaume, RN; Spencer Fowler, RN; Rebecca Leavitt, RN; Alexandra Lynch, BSN, RN; Gabriel Susen, RN; and Danielle Tower, RN
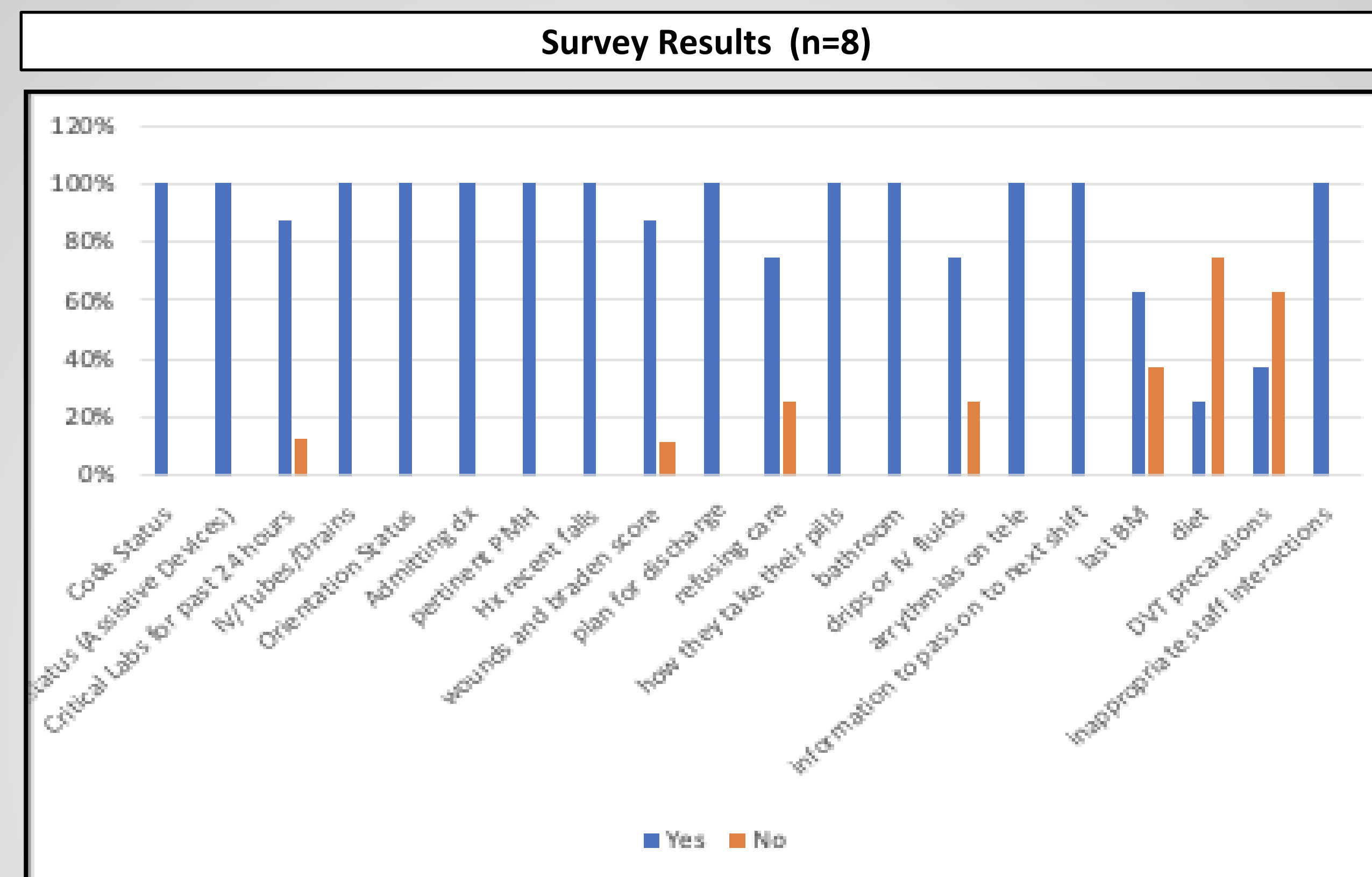
Background

- Miscommunication between caregivers during handoff contributes to 80% of serious errors in patient care
- The goal of patient handoff is to provide accurate and timely information about the patient in order to provide safe patient care.
- In an evaluation of more than 3,800 adverse patient events, TJC found that 65% were caused by communication problems and that at least half of these problems occurred during patient handoffs
- By gathering data about what nurses want to receive during patient handoff, could lead to a decrease in errors in providing patient care

Measures and Results

Survey Results (n=8)

Sample form following SBAR format

Practice Change

Standardized patient handoff to decrease errors in patient care.

Methods

- Immediately prior to survey distribution, verbal SBAR policy will be discussed to Grant 6 nursing staff
- Distribute a survey via Google Forms to Grant 6 RN staff (anticipated n=50) to gather data on what the nursing staff want to receive during handoff
- Gather data and prepare a presentation of the information Grant 6 nurses want to see on a standardized hand off form

Summary/Discussion

- **Next Steps:**
  - Create and implement a standardized SBAR report form to be utilized during patient handoff
  - Collaborate with IS to modify the current online handoff page that best fits the needs of the nurse
  - Evaluate the outcomes of patient safety.
- **Barriers of this Study:**
  - Lack of time to implement the collected data gathered on what nurses want to received during patient handoff
  - Human reliability and willingness to adapt a change

Conclusion

- 80% of patient care errors could be prevented during patient handoff
- The largest barriers of completing the project were having to change course of project due to global pandemic, time to complete survey due to business of the floor, and lack of responses
- Post survey handoff report sheet made and will be distributed to staff members on Grant 6 for RN use during bedside report

References

A. (n.d.). SBAR Nursing Report Sheet [Digital image]. Retrieved July 21, 2020, from https://store.nursejanx.com/downloads/sbar-nursing-report-sheet-fullsize/

A. (n.d.). Retrieved from https://www.jointcommission.org/en/standards/national-patient-safety-goals/

Streeter, A. R., Harrington, N. G., & Lane, D. R. (2015). Communication Behaviors Associated with the Competent Nursing Handoff. *Journal of Applied Communication Research, 43*(3), 294–314. doi: 10.1080/00909882.2015.1052828