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IMPLEMENTATION OF SBAR REPORTING IN THE ED

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Statement of Determination

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Clinical Leadership Theme

Implementing SBAR (Appendix H) communication in the emergency department fulfills the CNL curriculum of Care Environment Management. Organization of a microsystem across the continuum of care to improve patient safety at a microsystem level, demonstrates the impact the CNL provides for continuous quality improvement, risk reduction and patient safety. Working with staff to implement my project fulfills the competencies put forth by the AACN for a CNL student.

Statement of the Problem

In our new, larger ED, nurses are giving rushed reports due to external and internal pressures to move patients out of the department or to less acute areas of the department. Important aspects of patient care are being lost and mistakes are being made. Staff are putting their license at risk and patients are subjected to unnecessary medical errors and/or consequences of miss communication.

The SBAR report is a frame work for effective briefing of oncoming team members to rapidly get everyone on the same page so that, they can efficiently move forward together in a coordinated fashion (Shalini and Castelino, 2015). With SBAR reporting important information is given. Patients are safer and there is a decrease in sentinel events.

Project overview

San Francisco General Hospital is a busy level one trauma center serving San Francisco and northern San Mateo county. With over 50 beds in our ED we are frequently at max capacity

and consistently short staffed. In a large department, it can be difficult for a limited amount of staff to continually monitor all the patients. We rely heavily on each other to watch each other's patients as well as central monitoring. The department is divided up into four different areas and each area requires a team leader that knows a little about every patient. In such a larger area with many patients the SBAR tool can be a quick way to give report to the pods team leader so they can understand the patients in their area.

Each pod has between four to six primary nurses and between one to two circulating nurses to help with tasks. The SBAR tool again is useful for staff to communicate amongst each other critical information.

The achieving the goal of integrating the SBAR communication tool into the culture of the department and seeing all nurses communicating in SBAR format would be a dream come true. SBAR has proven to increase patient safety and staff satisfaction. The biggest challenge is creating a change in practice and accepting SBAR into the departments culture. The aim statement of this project is to implement SBAR in the department to increase patient safety, increase staff satisfaction and decrease time spent on ambulance diversion.

Rationale

Being a nurse in the department, where I can apply my project, means I could choose something that I knew would be beneficial. After conducting many surveys and speaking with ED staff, I could determine the root causes for my project. The ED nurses were upset when receiving floor nurses asked too many questions that did not pertain to the patients admitting diagnosis. The results of a survey concluded floor staff felt they received an inadequate report

from ED nurses. A survey given to doctors revealed break coverage nurses were not always up to date in patients plans of care. Nurses in a different area receiving trauma patients did not always feel report was adequate and important information was often lost in hand off. Speaking with management and the nurse educators it was determined we have recently had an increase in falls since we have moved into our new department.

To initiate the project, I decided to get a group of ten nurses to volunteer. These nurses need training on the SBAR report sheet, take surveys and participate in interviews during the project. The management allowed for me to work with these ten nurses and visit them while they were working. This time is factored into the cost analysis. Printing of material and working with floor nurses are included as well (Appendix B).

Methodology

During the project, I will be interviewing the nurses in the ED three separate times to see how they are adapting to SBAR and if they feel it is helpful. I will take their input to improve the tool and methods. This approach is appropriate because a change in practice can require reinforcement, the staff may have questions and the staff may have suggestions on how to improve the reporting tool. The staff will also feel a sense of accountability because of their input and I want them to feel included in the process. This will help to change culture and develop nurses that support the change and help to get other nurses to change their reporting style.

During the project, I will be responsible for answering questions and collecting data from staff. I will also be surveying doctors for their opinions of how nurses are reporting to them. I will also be interview patients to see if they feel the nurses are more invested in their care.

I have been gathering data from nurses on the floor, nurses in the department, patients and doctors as well as nursing management on the overall quality and efficiency of reporting. Much of the reviewed literature regarding SBAR reporting was collected and presented in the same fashion as my study. If the data from my study compares like the reviewed literature, then I know the data I collected is accurate.

Data Source/Literature Review

San Francisco General hospital is a level one trauma center. It serves San Francisco and northern San Mateo county. The ED sees approximately 3,900 trauma activations a year. According to medicare.gov, only 69% of patients reported that nurses at SFGH always communicated well, the national average being 80%. The nurse interview in the ED stated that the current style of reporting was just fine the way it is, while most floor nurses felt reporting from ED nurses need to be improved.

Improved reporting can increase patient safety, decrease sentinel events and increase patient and staff satisfaction.

During my research, I developed my PICO statement to help discover and explore related articles to support my study and the findings during the project. By implementing the SBAR communication tool, can the culture of unorganized, insufficient reporting by ED nurses to other nurses and physicians be improved? Will nurses and physicians learn to adopt this new style of

reporting and initiate a change of culture? Determining a PICO statement helped me to sufficiently research necessary data needed to thoroughly cover my topic.

1. *The Impact of SBAR on Nurse Shift Reports and Staff Rounding* (2014). The authors found that SBAR is recommended for improving communication, and is considered essential to achieving efficiency. Communication skills of all nurses improved with use of SBAR, and fostered a high level of performance regardless of nurse experience

2. *An Interprofessional Simulation Using the SBAR Communication Tool* (2016). In this study, pharmacy students worked with nursing students on multiple patient cases in various settings using the SBAR communication tool. The results of the SBAR communication tool study improved pharmacy students' self-perception of interprofessional competence and attitudes toward interprofessional collaboration.

3. *The Situation, Background, Assessment and Recommendation (SBAR) Model for Communication Between Health Care Professionals: A Clinical Intervention Pilot Study* (2015). The authors of this study evaluated hospital based health care professionals' experiences from using the SBAR communication tool. The study included a pre- and post-intervention questionnaire before and after the implementation of SBAR at surgical hospitals wards. The authors determined that the introduction of SBAR increased the experience of having a well-functioning structure for oral communication among health care professionals regarding patients' conditions.

4. *The 'Go-Between' Study: A Simulation Study Comparing the 'Traffic Lights' and 'SBAR' Tools as a Means of Communication Between Anesthetic Staff* (2016). In this particular study, the authors decided to test two different models in the OR to see what worked best

for them. There were several episodes of miscommunication and the authors decided to develop a new communication tool. The aim was to compare the SBAR with their tool and assess how they performed in communicating a request for assistance from one anesthetist to another in a simulated setting. The results proved SBAR was not of better use than their developed tool. The use of SBAR was variable, ranging from no benefit, to modest improvements in safety culture or communication. This study also yield plentiful useful data.

5. *Effectiveness of Protocol on Situation, Background, Assessment, Recommendation (SBAR) Technique of Communication Among Nurses During Patients' Handoff in a Tertiary Care Hospital* (2015). In this study, the author determined that communication problems are the leading cause of sentinel event. Staff may not realize that hand-off communication is a high-risk process. The goal was to find the effectiveness of SBAR protocol in terms of difference in knowledge and practice among control and experimental group. The study concluded that the SBAR protocol during hand-off among nurses was effective and determined the need for imparting the protocol in practice

6. *The Effect of an Electronic SBAR Communication Tool on Documentation of Acute Events in the Pediatric Intensive Care Unit* (2016). The authors of this study were part of a research team that hypothesized that an electronic SBAR template would improve documentation and communication between nurses and physicians. After completion of the project it was determined that the implementation of an electronic SBAR note is associated with more complete documentation and increased frequency of documentation of communication among nurses and physicians.

Timeline

To begin the process of SBAR reporting I will first need to find a group of nurses willing to commit to using the SBAR report tool for a 3-month period (Appendix C). Once the group is established, I will conduct a pre-project (Appendix D, E, F, G) survey on the nurses' style of reporting and their preconceived notions of the SBAR tool. Once the survey is done I will spend the rest of the time explaining the tool. Once their questions are answered the nurses will be asked to use the SBAR reporting tool for all reports given to nurse, doctors and management. During the 3 months, I will periodically visit each nurse for ten minutes to evaluate the process and ask for suggestions as well as answering questions. Once the three months is up I will have a final meeting with the nurse, gather a post-project survey and talk with the nurses about their experience. Aside from the ED nurse, I will speak with 5 floor nurses to evaluate pre-project and post-project, I will also speak with doctors about their opinions of SBAR reporting from nursing staff. I will also speak with management about overall staff satisfaction and patients with their feelings of the nurse giving report.

Expected Results

So far I have gathered that it will be extremely difficult to change practice. The nurses I have interviewed so far have been helpful and want to see me succeed but their overall feeling is that the SBAR tool does not cover everything they would like to give in report. They are feeling the report can be inefficient. When I meet with doctors, patients and management the general sense is that reports are coming off clearer and unnecessary details are being left out. I am

hoping that nurses will begin to see the importance of a cleaner reporting style that covers basics and not necessarily every piece of information that may not be relevant.

I hope to see more nurses begin to use SBAR but at this point I have seen very few nurses show interest in the project. Which is disappointing.

Nursing Relevance

This project shows me that even great ideas can be difficult to implement. Culture is extremely difficult to change. I hope that when I meet again with the floor nurses that their experience will change the perception that the ED nurses are getting. If nurses understand the value of the SBAR we can change the department and create uniformity in our handoffs.

Summary Report

In our ED, nurses giving report to the floor nurse, a transfer of care between ED nurses and when a nurse reports to the physician are all given in different formats with no base or continuity. Leaving room for errors. It has been reported that 1,744 deaths and $1.7 billion in hospital costs related to miscommunications (CRICO Strategies, 2015). With the implementation of the SBAR reporting tool, the goal is to decrease miscommunications and improve patient and staff satisfaction. The SBAR framework not only enhances the clarity and efficiency of communication between team members but also assures that each person involved knows what is going on when they come to assist in a critical situation. The SBAR technique can help to get all information related to a patient in a same page and moving together (Shalini and Castelino, 2015)

San Francisco General Hospital is a Level One Trauma Center that provides trauma care, stroke and heart attack care to San Francisco and northern San Mateo county. The hospital sees approximately 3900 trauma patients annually. The hospital is also one of the few remaining safety net hospitals that is part of a city wide integrated health care system, providing primary, specialty and hospital care for the city's vulnerable populations, (sfdph.org, 2017)

Implementation of my project required the creation of a team of volunteer nurses that would report to doctors, other nurses and the admitting floors in the SBAR format over the course of a few months. When reports were given, the nurses used the SBAR tool and throughout the study would complete surveys on how well the process was going. Nurses in the ED and on the floor, were also given a pre and post study survey on their perception of the tool and how well the SBAR tool actually worked in their setting.

Of the 10 ED nurses, 8 say they will continue to format their reports in SBAR format many stating it has changed their practice for the better. One nurse stated they would not use it, the other nurse stated that "SBAR was helpful in certain cases, in others, not so much". Out of the 5 nurses accepting patients from the ED onto the floor, all 5 felt that SBAR was a much easier and concise format of reporting that fit their required admitting forms.

The form that I used to adapt the tool we used was the SBAR reporting and handoff tool. It is a generic form that can be found on the internet. It is the SBAR Clinical Communications Format (Appendix H). All other forms were created by myself in order to specifically collect relevant data related to our department and hospital. The questionnaires were created with our staff and volunteers input.

The initial evaluation required a survey of the nurses asking their understanding of the SBAR tool, their willingness to participate and any experience with evidenced based practice. In conclusion, I found that the nurses participating had an overall positive experience with the SBAR and would either continue to use it, incorporate parts of it into their practice and/or would prefer that all nurses use the SBAR tool. Recommendations would be to expand the sample size, create leaders from the group who would be willing to encourage, teach and recruit new nurses. I found the tool was effective and appreciated by the nurses who participated. I will continue to champion for this tool to be used in our department and I wish I had more nurses to help change our culture.

The group of volunteer nurses yield 8 nurses who say they will continue to use SBAR reporting in their practice. Of these 8 nurses, I have identified three who state they will help me to create an SBAR document more suited for our patients and ED reporting in general. We are hoping to create a team that will begin to initiate teaching SBAR reporting to the staff. We will continue to have meetings and incorporate small teaching sessions during the daily talking points. We have already begun working on these tools and scheduled dates for talking points and the initial roll out of the new form.

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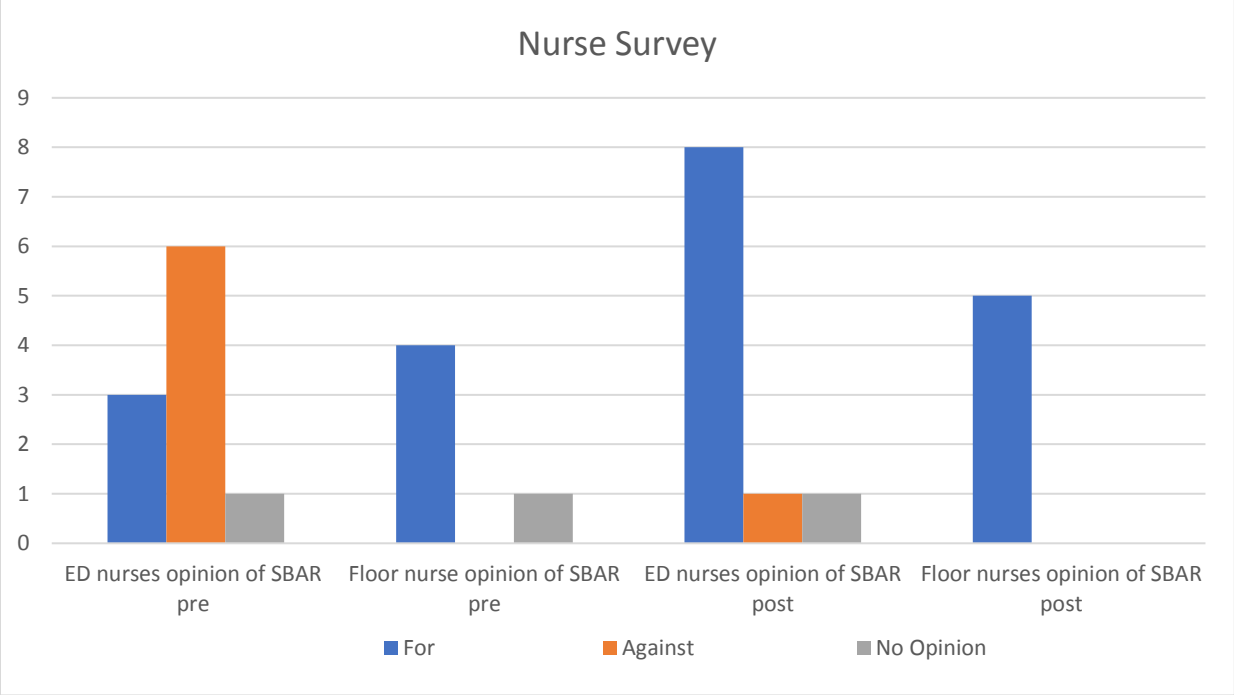
Appendix A


Nurse Survey
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ED nurses opinion of SBAR pre
Floor nurse opinion of SBAR pre
ED nurses opinion of SBAR post
Floor nurses opinion of SBAR post
For
Against
No Opinion

Appendix B

	Initial 30 minute meeting/survey	1st 10 minute interview	2nd 10 minute interview	3rd 10 minute interview	Exit survey and final interview 30 minutes	Average $/hour	Total
10 ED Nurses	$35 x 10	$11.67 x 10	$11.67 x 10	$11.67 x 10	$35 x 10	$70	$1,050.1
5 Floor Nurses	$35 x 5	x	x	x	$35 x 5	$70	$350
Supplies	x	x	x	x	x	x	$150
							$1550.1

Appendix C

	February 3rd	February 20	March 17	March 25	April 29th
0800	Meeting with ED staff	Interview ED staff	Interview ED staff	Interview ED staff	Meeting with ED staff
0900	Meeting with Floor staff	Interview RN's patients	Interview RN's patients	Interview RN's patients	Meeting with Floor staff
1000	xx	Met with management	Met with management	Met with management	xx
1200	xx	Met with MD	Met with MD	Met with MD	xx

Appendix D

Pre SBAR ED survey

1. What is your understanding of SBAR?
2. How do you currently give report?
3. How willing are you to accept another style of reporting?
4. Do you think SBAR reporting will change how patient handoffs?
5. What is your experience with evidence based practice?

Appendix E

Post SBAR ED survey

1. What is your understand of SBAR?
2. Will you continue to use SBAR to give report?
3. Will you recommend SBAR to your fellow nurses?
4. Has SBAR changed what you find relevant in giving report?
5. Did you enjoy this experience?

Appendix F

Floor pre SBAR survey

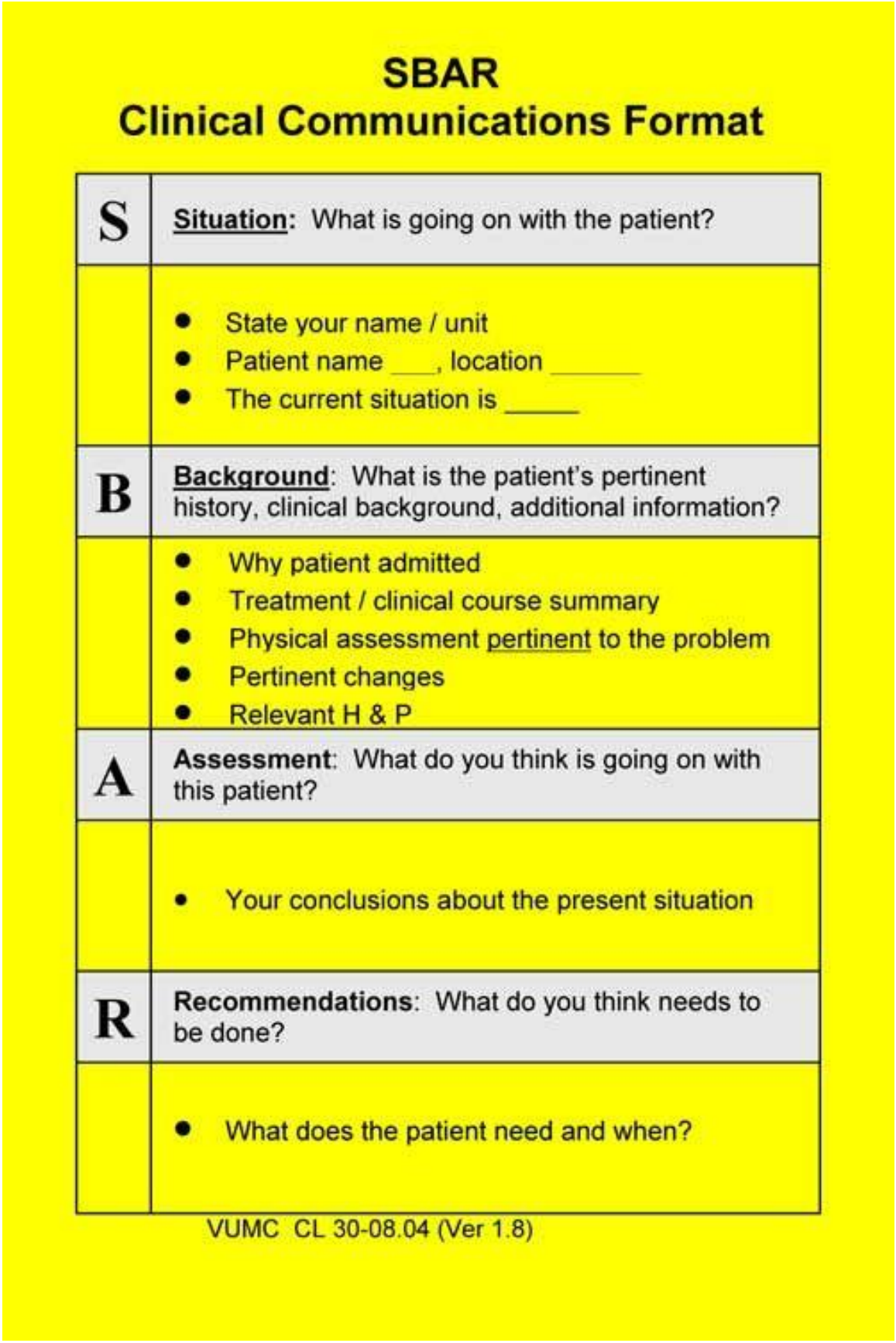
1. What is your feeling when receiving report from the ED
2. What is important to you when receiving report
3. What is your understanding of SBAR
4. Would you appreciate a uniform style of reporting you would receive from the ED
5. What is your experience with evidence based practice?

Appendix G

Floor post SBAR survey

1. Do you think the reporting style changed in the ED
2. If it did, was it better or worse?
3. Was the pertinent patient information given to you?
4. Do you think this style of reporting would work in your unit?
5. Did you enjoy this experience?

Appendix H



SBAR
Clinical Communications Format

S	**Situation**: What is going on with the patient?
	• State your name / unit • Patient name ___, location _____ • The current situation is _____
B	**Background**: What is the patient's pertinent history, clinical background, additional information?
	• Why patient admitted • Treatment / clinical course summary • Physical assessment pertinent to the problem • Pertinent changes • Relevant H & P
A	**Assessment**: What do you think is going on with this patient?
	• Your conclusions about the present situation
R	**Recommendations**: What do you think needs to be done?
	• What does the patient need and when?

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