INSPIRING CHANGE

Improve handoff communication with SBAR

By Stacey Eberhardt, BSN, RN

EFFECTIVE AND EFFICIENT communication is vital in the fast-paced world of healthcare. Good communication skills are particularly important for nurses who regularly convey critical patient information to other healthcare professionals. Nowhere is this more evident than in the patient handoff report.

In our facility, the handoff procedure and documentation between the medical-surgical units and the OR lacked consistency and structure. We believed a change in practice would benefit both patients and nurses. This article describes how we achieved our primary objective to improve patient handoff by implementing an evidence-based handoff tool in Situation Background Assessment Recommendation (SBAR) format.

Whisper down the lane
It's widely recognized that information degrades with each patient transfer. This leads to communication errors, which are a key component of adverse patient safety events such as medication errors and patient falls. Standardization of patient handoff procedures is an important first step in increasing meaningful communication, positive patient outcomes, and optimal working relationships between healthcare professionals.

A multidisciplinary team of healthcare providers at Kaiser Permanente, an integrated managed-care consortium, was the first to recognize the tool's potential to effectively transmit information within the clinical setting. After SBAR was implemented to conduct patient handoff at its facilities, it rapidly spread to other organizations.

Standardization of communication practices is also required by many national agencies and organizations, including The Joint Commission and the Department of Defense. Standardization is supported by our current hospital policy and the existing nursing care model, the Patient CaringTouch System.

SBAR in action
The project initiated at our facility was conducted according to the Iowa Model of Evidence-Based Practice to Promote Quality Care. This model presents specific steps to implement a change in practice and evaluate its impact. Nurses first identify a practice question within their workplace. It's then determined if the practice question is a priority for the organization. If so, a team is selected to develop, implement, and evaluate a practice change. The team collects and critiques pertinent research evidence. If sufficient evidence is unavailable, the team can either conduct research or continue with the practice change using lower levels of evidence. The practice change is then implemented on a small scale. If positive outcomes are achieved, the practice change is applied organization-wide. Leadership support, staff education, and dissemination of positive outcomes are crucial to a successful implementation process.

Time to focus
The Iowa Model begins with identification of the problem, via problem-focused triggers and/or knowledge-focused triggers. Inconsistent handoff between the medical-surgical units and the OR was first identified as a problem through the experiences of new nurses on the medical-surgical units (problem-focused trigger). The process was disorganized and confusing, leading to frustration among the new staff. This sentiment was echoed in our organization's Joint Commission survey findings and in the results of a questionnaire distributed among the staff (knowledge-focused triggers).

We investigated the standards for patient handoff in national agencies and organizations. We found that a structured patient handoff process, such as SBAR, is supported by The Joint Commission and the Department of Defense Patient Safety Program. Additionally, it's supported by the U.S. Army Nurse Corps Patient CaringTouch System, and current hospital policy for patient handoff procedures. The culmination of these factors led to the decision that correcting inconsistent handoff was a priority for the hospital. A team of six nurses was formed to explore viable evidence-based solutions.

Any questions?
A population, intervention, comparison, and outcome (PICO) question is a method used in evidence-based nursing to frame and answer clinical questions. The team's PICO question was: For the medical-surgical and OR nurses at our hospital, could the implementation of a standardized
documentation form, the SBAR transfer note, result in greater than 75% of unit transfer documentation in comparison with current documentation practice?

The team established that improved documentation of patient handoff was the desired outcome of the practice change. The short-term goal was that greater than 75% of patients being transferred from a medical-surgical unit to the OR would have a SBAR handoff within the first month of implementation. The handoff would be recorded in the hospital’s inpatient computer documentation system.

The long-term goal was that 100% of inpatient transfers would be conducted in SBAR format and documented in the inpatient computer documentation system. Hospital policy would be updated if the change proved effective.

He said, she said

The baseline data included how many patient handoff procedures were documented and what attitudes the nursing staff had about current handoff procedures. The team collected baseline data through random medical record audits of patients transferred from a medical-surgical unit to the OR for a 1-month period. We found that the location, content, and occurrence of the documentation were inconsistent. A clinical note, in varying styles, was written documenting a patient transfer 32% of the time. An annotation of a patient transfer to the OR was made in the vital signs flow sheet of the patient’s medical record 42% of the time. SBAR format was not used at all, nor was there any indication of a nurse-to-nurse handoff.

We distributed questionnaires regarding current practices and attitudes toward patient handoff to medical-surgical and OR nurses; the response rate was 28% and 31%, respectively. Although 81% of the medical-surgical nurses were aware of hospital policy to give handoff report in SBAR format, 93% indicated that they gave report to an OR nurse less than 25% of the time, and 86% stated that handoff was in SBAR format less than 25% of the time. The results from the OR nurse questionnaires corroborated these findings.

Implementing the transfer note

A new documentation form titled SBAR Transfer Note was created for the inpatient computer documentation program. The goal of the new note was to document the entire patient handoff process in SBAR format. Although in the pilot phase the note was used solely for medical-surgical unit-to-OR transfers, the team created the note with the intent of eventually capturing every transfer between all inpatient units in our hospital.

In accordance with its title, the note is formatted into the four sections of SBAR. The nurse handing off the patient is responsible for initiating the note. The patient’s identifying information, including allergies and code status, is at the top of the document. The situation section contains the patient’s diagnosis. A brief description of the patient’s current condition, medical history, and surgical history is listed in the background section. The information can be transcribed from the patient’s history and physical assessment findings, which is a separate document in the patient’s medical record.

The assessment portion contains the patient’s latest vital signs, pain intensity rating score, and IV access. This is autpopulated from other areas in the computer medical record. The nurse enters the patient’s current medications, time of last pain medication, time of last antibiotic, and invasive devices, such as drains, urinary catheters, and vascular access devices. At the end of the note in the recommendation section, the nurse notes pending labs, procedures, treatments, and diagnostic tests.

The movement of a patient transferring from the medical-surgical unit/ambulatory procedure unit (APU), to the OR, to the postanesthesia care unit (PACU), and finally back to the medical-surgical unit/ APU is also documented. A section titled APU/OR/PACU appears after the recommendation portion. Clicking on this section reveals the pre-op worksheet and checklist. The medical-surgical nurse records pre-op vital signs, pre-op medications, last void time, and N.P.O. status here. Items in this section were identified as crucial information by OR nurses who completed our survey.

The medical-surgical or APU nurse and the accepting OR nurse then both sign at the bottom of the section. A signature indicates that SBAR handoff has been given and received for the patient. The note is used to document the patient’s intraoperative and postanesthesia assessment.

At every point of transfer, the signature block is signed by the two nurses responsible for the transfer to document the chain of responsibility. The note ends with the transfer of the patient back to the APU or medical-surgical unit, where the receiving unit will complete a separate postassessment note.

Understanding the note

The team presented the note and pilot project to the nurse leaders of the OR, PACU, and medical-surgical units. We designated unit champions to educate staff on the note and gather feedback. The team conducted a pilot test of the note on one medical-surgical unit during December 2012 to refine the process and make adjustments where needed. For example, the team
originally intended for the medical-surgical nurse to complete the SBAR note and give a face-to-face verbal handoff with the OR nurse. However, during the pilot test, feedback from medical-surgical and OR nurses indicated that a telephone handoff would be equally efficient.

The note was then implemented on all medical-surgical units in January 2013. At this point, documentation of patient transfers was done solely by using the SBAR transfer note on these units.

Although the original focus of the team was to document medical-surgical to OR transfers, the success of the note has led it to be used throughout the hospital. Assessment criteria specific to the neonatal ICU, labor and delivery unit, and pediatric unit were included. The note can be used for patients transferring from the ICU to the medical-surgical unit, and vice versa.

As the innovation was disseminated throughout the hospital, unit champions from the ICU, mother/baby, neonatal ICU, and pediatrics were selected and educated on using the note and baseline data were collected. The unit champions educated their staff on the note over the next month, and it was implemented on these additional units in February 2013.

**Writing it all down**
The team resurveyed medical-surgical and OR staff at 1 and 4 months post-implementation. Sustaining the gain will be measured by another survey after 8 months of implementation. Reassessment of other units will follow a similar schedule.

On the medical-surgical unit selected for the pilot phase, 50% of transfers to the OR were documented using the SBAR transfer note after 1 month. After 4 months, 100% of patient transfers from the medical-surgical unit to the OR and 90% percent of transfers from the PACU to the medical-surgical unit were documented using the SBAR transfer note. (See Nursing2014 iPad app for supplemental content.) The nursing staff, especially on the medical-surgical units, received the note positively and adopted the change in practice.
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The success of the SBAR transfer note has encouraged nurses throughout the hospital to seek out new ways to implement best practices in their work environment.

Handoff success reached
Patient handoff remains one of the most important aspects of patient care. Effective and efficient communication must be incorporated into any handoff system for optimal and safe patient care. Using evidence-based practice, our organization identified a problem and implemented a solution that established consistent and contemporary communication procedures. The SBAR transfer note standardized the patient handoff method and increased nursing adherence and satisfaction with the new practice. We hope that the SBAR transfer note continues to promote and enhance communication at our hospital for current and future patients.

REFERENCES

Stacey Eberhardt was a clinical nurse at Landstuhl Regional Medical Center in Landstuhl, Germany. She’s now a clinical nurse at San Antonio Military Medical Center in San Antonio, Tex.

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