SBAR Communication
Objectives

• Discuss why SBAR is needed

• Describe the meaning of SBAR

• Apply a communication technique using case scenarios
Communication Can Be a Problem

• From 1995 – 2005 JCAHO reviewed over 2537 sentinel events in General Hospitals and Emergency Departments

• Communication issues identified as being the root cause and the major contributor in these events

• In 2005 nearly 70% of sentinel events, the root cause was communication.
Causes of Communication Breakdown

- Different communication styles
- High level of activity
- Frequent interruptions
- No standardization in organizing essential information
- Loss of information
Focus on Hand-offs: Background

• Hand-offs
  • Definition

• The transfer of care from one provider to another provider

• A mechanism for transferring information, responsibility, and authority from one set of caregivers to another
Background

• Principles of error-free hand-offs
  • Communicate interactively – allow and promote questions
  • Communicate up-to-date information regarding care, treatment, services, condition
  • Limit interruptions to avoid losing or skewing information
  • Allow sufficient time to complete hand-off
  • Require a verification process – repeat-backs or read-backs
  • Ensure the receiver of the information has the opportunity to review relevant data, including previous care treatment services
Who Participates in Hand-Offs?

• Any one involved in Healthcare
  • Hand-offs
    • Medical Student to physician
    • Medical Student to Resident/Fellow
    • Medical Student to clinician
    • Medical Student to Medical Student
SBAR

- **Situation**
- **Background**
- **Assessment**
- **Recommendation**
Why SBAR?

• Similar to the SOAP model
• Provides answers to physicians’ three main questions
  • What is the problem?
  • What do you need me to do?
  • When do I have to respond?
• Standardized approach that promotes efficient transfer of key information
• Helps create an environment that allows clinicians to express their concerns
SBAR Guidelines: Step 1

Have all the patient’s information available before you contact the physician.

- Name
- Medical record number
- Age
- Diagnosis
- Medication list
- Allergies
- Vital signs
- Lab results
- Advance Directive
SBAR Guidelines: Step 2

A physical assessment has been conducted

- Have I seen and assessed the patient myself before calling?
- Review the chart/labs/tests
- Frame your communication before you communicate.
SBAR Guidelines: Step 3

(S) Situation

What is the situation you are calling about?

- Identify self, level of education/title, location
- Patient name, gender/age, location

- What is going on with the patient that is a cause for concern. A concise statement of the problem
SBAR Guidelines: Step 3 (cont.)

(B) Background

What is the clinical background information that is pertinent to the situation?

- Admitting diagnosis and date of admission
- List of current medications, allergies, IV fluids, etc.
- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Medical history
- Recent clinical findings
- Advance Directive/code status
SBAR Guidelines: Step 3 (cont.)

(A) Assessment

Share the results of your clinical assessment

- What are the clinical findings?
- What is the analysis and consideration of options?
- Is this problem severe or life threatening?
SBAR Guidelines: Step 3 (cont.)

(R) Recommendation

What do you want to happen and by when?

- What action/recommendation is needed to correct the problem?
- What solution can you offer the physician?
- What do you need from the physician to improve the patient’s condition?
- In what time frame do you expect this action to take place?
Summary

• SBAR provides a method of clearly communicating the pertinent information from a clinical encounter
• Empowers all members of the healthcare team to provide their input into the patient situation including recommendations
• Assessment and recommendation phases provide an opportunity for discussion among the members of the health care team
• May not be comfortable at first for either senders or receivers of information
http://youtu.be/jvlmokllIOQ

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Scenario 1

- Joey is a 10 year old male with a history of asthma who has been admitted to the intermediate care unit this afternoon after receiving 2 hours continuous albuterol in the ER. He arrived to the floor 1 hour ago and was doing well at that time. The nurse calls you to let you know that Joey has become more tachypneic. You ask for his current vitals, she tells you his HR is 152, RR is 35, BP is 84/62, pulse ox is 87% on room air.

- You go see the patient. You note that he has sub/intercostal retractions, is tachypneic, and unable to speak full sentences. He has diffuse wheezing both during inspiration and expiration which is prolonged. The parents tell you he has been hospitalized in the ICU before due to asthma. You review the CXR done earlier which demonstrates hyperinflation.

- How would you communicate with the senior resident/attending about your concerns regarding Joey in SBAR format?
Scenario 2

- Lucila is a 3 month female in ER for congestion, cough, difficulty breathing. Congestion and cough started 3 days ago, and parents noticed difficulty breathing this morning. +posttussive emesis 2-3 times per day. Emesis is nonbloody, nonbilious, and looks like formula. She has been taking 1 ½-2 oz every 3-4 hours, a decrease from her usual 3oz every 2-3hrs. She has slightly decreased urine output, with 5 wet diapers in last 24 hours. Two year old sister has been ill with an upper respiratory infection. No fever at home.

- In the Emergency Room, Lucila had increased work of breathing that improved after suctioning. She was noted to have an oxygen saturation of 88% was placed on 1/2L NC. Chest x-ray shows hyperinflation with a viral picture. There is no focal pneumonia. RSV PCR is pending.

- PMHx: 37 wk spontaneous vaginal delivery. Mother serologies neg. No complications

VITAL SIGNS:  T 36.4  RR 64  HR 140  BP 84/47  Sat 95% on 1/2LNC  Wt 4.5 kg
GENERAL:  sleeping but alerts with exam. Moderate subcostal retractions noted. No nasal flaring.
SKIN:  No rashes.
HEENT:  AFOSF. positive red reflex. TMs are clear b/l. OP is clear. (+) clear discharge bilaterally.
RESPIRATORY:  Coarse breath sounds but good aeration bilaterally. No crackles.
CARDIOVASCULAR:  RRR, no murmurs. Pulses are 2+ bilaterally in UE and LE. Cap refill < 2 sec
ABDOMEN:  Soft and nontender, nondistended with no masses and no organomegaly.
EXTREMITIES:  No cyanosis or edema.
NEUROLOGIC:  Good suck, vigorous cry and positive Moro. There are no focal deficits. MAEE

Use SBAR to admit this baby to the intern on the pediatric floor
Scenario 3

- Davey is a full term 21 day male admitted with fever. He was more fussy but feeding well. 8 wet diapers per day. No URI sx, V/D. Full septic work up was done in the ER with blood, urine and CSF. Ampicillin and cefotaxime given.

- PMHx: VD at 38 weeks with no complications. Maternal serologies were negative, including GBS and HSV.

Vitals:  T 37.9, HR 140, RR 48, BP 84/50. Sat 99% on RA.

General: Well appearing, vigorous infant in no acute distress.

Skin:  No rashes.

HEENT: AFOSF.  PERRL, MMM with a small amount of thrush on the tongue.  TM clear b/l

Neck:  supple with no lymphadenopathy.

Resp:  Clear to auscultation bilaterally.

CV:  RRR with normal S1 and S2, no murmurs.  Pulses 2+ brachial/femoral bilaterally.

Abdomen:  Soft, nontender, nondistended, no HSM.

GU:  Uncircumcised male with testes descended bilaterally.

Extremities:  He moves all extremities equally and well. No tenderness to palpation of extremities.

Neuro:  Positive Moro, vigorous suck, positive grasp.

- Labs: Urinalysis significant for moderate blood, large leukocyte esterase, 100 protein. Microscopic: 20-50 WBC, 3-8 RBC and moderate bacteria, nitrites are negative.

- CBC: WBC of 14, H&H 15/45, platelets 325; differential: 31% segs, 15% bands, 40% lymphs.

- CSF: 6 WBC, 51 RBC; 28% lymphocytes, 72% monocytes, glucose 54 protein 84.

- Blood, urine and CSF cultures are pending. HSV PCR pending.

- Sign out using SBAR to your co-medical student working nights.