Using a communication framework at handover to boost patient outcomes

A trust introduced a structure for presenting critical information at handover. This has aided communication between team members and benefited care.

INTRODUCTION

It is well recognised that the increased acuity and complexity of patients’ needs in a busy surgical or medical ward presents challenges to both nursing and medical staff. The National Patient Safety Agency (2007) suggested that effective communication is an important factor in improving clinical practice and patient outcome. Some of the main comments in this report from both nursing and medical staff on the difficulties with communication were:

- Unclear documentation;
- Nurses not communicating clearly;
- If nurses are not confident and articulate on the telephone, they do not get the response they need;
- Doctors finding it difficult to prioritise because of inadequate verbal handovers from nursing staff;
- Doctors not always telling other staff about changes to patient management.

NICE (2007) supported these findings and recommended that both nursing and medical staff should use a formal structured handover supported by a written plan. Unfortunately, these recommendations are not always followed in training. In our experience, nurse education has not prepared practitioners in the art of effective verbal communication. This is usually developed through observing peers and reflective clinical practice.

EXPERIENCE IN SOUTH DEVON

In 2006, the South Devon Healthcare Foundation Trust joined phase two of the Safer Patients Initiative (SPI), which is supported by The Health Foundation. The main outcomes of this national initiative were:

- A 15% reduction in hospital mortality;
- A 30% reduction in adverse events;
- A 30% reduction in cardiac arrests;
- A 50% reduction in MRSA bacteraemias.

AUTHORS Peggy Christie, BSc, RGN, is modern matron, critical care; Hazel Robinson, BSc, RGN, is critical care outreach lead; both at South Devon Healthcare Foundation Trust, Torbay.


This article provides nurses with a simple structure to aid effective communication. It explains how one trust implemented the situation-background-assessment-recommendation (SBAR) structure to improve patient handover, and outlines the benefits for nurses and patients.

<table>
<thead>
<tr>
<th>TABLE 1. USING THE SBAR STRUCTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
</tr>
<tr>
<td>Where you are telephoning from</td>
</tr>
<tr>
<td><strong>Background</strong></td>
</tr>
<tr>
<td>Relevant past medical history and treatment to date — it is imperative that this is brief, succinct and relevant</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>Be specific about your request and the time frame</td>
</tr>
<tr>
<td>Ask if there is anything you can do before the other staff member arrives</td>
</tr>
<tr>
<td>Document the call including date, time and who you spoke to</td>
</tr>
<tr>
<td>If you are worried and do not receive the response you need, you may need to escalate to a more senior clinician</td>
</tr>
</tbody>
</table>
SBAR was advocated as the structure for communication for the project. Published by the Institute for Healthcare Improvement (2004), this tool can be used at any part of the patient journey and it lends itself particularly well when used to hand over critical information. SBAR stands for:
- Situation;
- Background;
- Assessment;
- Recommendation.

HOW TO USE SBAR
The key to effective communication is preparation. Before picking up the telephone, nurses should gather the necessary information. Then they should use the structure in Table 1 to present the information gathered.

The benefits of using a communication tool such as SBAR are that it encourages and promotes:
- Sharing of accurate and relevant information;
- Better patient experience;
- Credibility of nursing handover;
- Better decision making by medical staff;
- Appropriate prioritisation of patients;
- Improved time management;

- Active listening.
- Compare the two handovers in Table 2 and consider the following points:
  - Credible nursing practice;
  - Information for effective decision making and prioritisation;
  - Time management;
  - Patient experience.

Which structure would you choose to use from Table 2?

INTRODUCING THE SBAR TOOL IN SOUTH DEVON
The mechanism for change used was the small tests of change or plan, do, study, act (PDSA) cycle. This is incorporated into the model for improvement, which examines where you are and where you could be (Langley et al, 1996) (Fig 1).

The cycle is based on the principle that learning requires action and study of the outcomes. Therefore, the benefit of using PDSA is that, following the initial trials of adopting the tool, we were able to evaluate the results and act quickly on what we had learnt. This method of change is recommended by the Institute for Healthcare Improvement and Patient Safety First, the patient safety campaign in England to which 96% of acute trusts are signed up.

PDSA CYCLE METHODOLOGY
The cycle consists of four phases that are continuous and is usually illustrated as shown in Fig 1. This approach to change and improvement should be a continuous cycle until optimal performance is achieved.

A PDSA CYCLE FOR INTRODUCING A COMMUNICATION TOOL
Plan
Main considerations:
- Acceptance that communication was an issue within the organisation;
- Acknowledgement that a communication tool was needed;
- Key questions:
  - Who is best placed to roll it out?
  - How can we roll this out multiprofessionally?
  - What teaching methods and aids might be suitable?
  - How might we audit the change and ensure it is embedded?
  - How can we ensure the change is positive?
  - When and where shall we start?
  - Regular evaluation by the project team.

Do
At the trust, the SBAR tool was rolled out to one ward first with the aim of well placed posters, stickers on telephones (compliant with infection control policy), supported with 10–15 minute teaching sessions at ward level and simulated scenarios.

Clinical staff were actively encouraged to cascade the tool to their peers, which required active monitoring by ward managers and the project team.

The tool was then rolled out to all ward areas and multiprofessional teams. As mentioned above, the SBAR communication tool can be used at any stage of the patient journey. Communication between wards was formalised by using specific handover sheets and receiver sheets using SBAR.

This format has also been used to structure trust meetings, with positive results. Formal education was delivered at trust clinical induction and all other appropriate forums.

Study
Auditing this change proved challenging for the project team as, initially, it was unclear which was the most effective audit tool.

One of the measurements that worked well was for nurses receiving a patient transfer to document the information received and comment on the handover sheet if the information was robust. This data was then

---

Table 2: Communication Structures

<table>
<thead>
<tr>
<th>Structure 1</th>
<th>Structure 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor: Hi, this is Matt, the surgical F1, you are bleeping me. Nurse: Hello, this is staff nurse on Rose Ward. Can you come and review a patient of mine please? Doctor: What is the problem? Nurse: His blood pressure is low. Doctor: What is it? Nurse: 88/45. Doctor: What was it before? Nurse: Not sure, let me go and get his charts. It was 135/70. Doctor: What did the patient come in with? Nurse: Hold on, let me get my handover sheet – he had a small bowel resection three days ago. Doctor: What are his other vital signs? Nurse: Hold on, I will just have a look – his temperature is 38.6°C, pulse is 122/min, respirations 26/min, SpO₂ 93% on air. Doctor: What is his urine output? Nurse: Not sure, let me go and get his fluid balance charts. Sorry, can’t find it. Doctor: What medications is he on? Nurse: Let me go and get his prescription chart. Doctor: Don’t worry, I will wander up later and review him.</td>
<td>Doctor: Hi, this is Matt, the surgical F1, you are bleeping me. Nurse: Situation: Hi, this is Sue, staff nurse on Rose Ward. I am contacting you regarding a Mr Smith who has suddenly become hypotensive. BP is 88/45. Background: He had a small bowel resection three days ago and is receiving IV fluids at 125ml/hr. This man is normally fit and well with no relevant past medical history. Assessment: His airway is patent, respirations 26/min. SpO₂ 93% on air. I have started him on 6l oxygen and his SpO₂ has come up to 98%. Pulse is regular, rate 120/min, BP was 135/70 earlier, now 90/40. He is cool peripherally with a capillary refill of four seconds. His urine output has also dropped, over the past three hours 35ml, 20ml, 10ml. At the moment, he is alert and complaining of abdominal pain. He has also been vomiting. Temperature is 38.7°C. I think he is septic, possibly abdominal. Recommendation: I need you to come and see this patient now. Doctor: OK, I am on my way. Nurse: Is there anything I can do before you get here? Doctor: Can you give stat bolus of 500ml normal saline and monitor his BP. Nurse: OK, see you in a minute.</td>
</tr>
</tbody>
</table>
It appeared that, before SBAR was approximately 45 minutes to seven minutes. The time taken was dramatically reduced from this time to catch up socially. SBAR offers a clear structure to the handover and has had a positive impact on the quality of information given.

It was recognised that the information for specialised areas had to be tailored to provide what was relevant to them.

**Act**
Tests of implemented change were performed regularly and new ideas on improvement readily put into practice where appropriate. These planned changes to the process were informed by issues identified at the fortnightly project team meetings.

One change that improved patient handover between wards was for the accepting ward to lead the process. It was unclear why this should have had such an impact, possibly because the admitting ward had a clear view of the information needed to prepare for a patient admission.

Further education was given to wards that did not appear to be adapting to the change. The importance of cascading any SBAR education received was reiterated to staff.

**CONCLUSION**
The use of a communication tool such as SBAR addresses the main concerns identified by the NPSA and NICE. Introducing it to South Devon ensures that, as a trust, we comply with NICE guidance and, more importantly, it helps to ensure a positive patient experience/outcome.

SBAR has also helped the trust to meet Safer Patients Initiative requirements. By July 2009, we had achieved:

- An 11% reduction in hospital mortality;
- A 65% reduction in adverse events;
- An 8% reduction in cardiac arrests;
- An 83% reduction in MRSA bacteraemias.

Results showed clear time management improvements, as time was freed up to complete other nursing duties.

A main component in the project’s success was the support of the trust executive team, as well as strong ownership by ward staff. Nursing staff were initially concerned that using the SBAR tool would lead to a delay in escalation and response during an emergency; however, this has not been the case. In emergency situations, such as when the cardiac arrest team has to be called, staff follow local policies.

One of the main lessons for the organisation was to ensure that a core group of trainers from all disciplines was identified.

For sustained action, the concept should be part of continued education and championed by clinical staff throughout the organisation.

Box 1 has details for more information for trusts wishing to implement SBAR.

**For further information, please contact hazel.robinson1@nhs.net**

**REFERENCES**


Never miss a thing
Get Nursing Times content delivered direct to your inbox. From our daily news round-up to bespoke content for your clinical specialty, register at www.nursingtimes.net and choose your free newsletters today.