It appeared that, before SBAR was introduced, nursing staff had different perceptions on what should be included in the handover. They were also using some of 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


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**Fig 1. Model for Improvement**

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will we know that a change is an improvement?</td>
</tr>
<tr>
<td>What changes can we make that will result in improvement?</td>
</tr>
</tbody>
</table>

**Act**

**Plan**

**Study**

**Do**