COMMUNICATION

My name is Venisa Morgan. I’m a registered nurse. I work at Texas Tech Health Sciences Center School of Nursing. Today, I want to talk to you about “SBAR Communication.”

Communication in the healthcare work environment is crucial, so this information can be used not only by nurses but by other employees.

Today’s healthcare is a complex network of practice settings, providers, and available treatments. The work environment is usually hectic and noisy, and the workflow is often interrupted due to unexpected events. Given the complexities of the healthcare workplace and the nature of the work, it is understandable that there are ample opportunities for potential failures in communication and inadvertent patient harm.

In 2004, The Joint Commission reported that more than 60% of Sentinel Events involved inadequate communication. With patients’ lives on the line, it is imperative that we, as healthcare professionals, master the art of communication, particularly in translating patient conditions. Now, more than ever, effective communication between clinicians is essential to patient care, and improving patient outcomes.
Ineffective communication is often why patients are harmed. Ineffective communication is the most frequently cited root cause category of Sentinel Events. Simple system failures combined with omission of clear interdisciplinary communication caused most cases of serious patient harm.

PREVENTABLE MEDICAL ERRORS

Communication issues among team members was the single most important factor identified in The Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) 2004 “Root Cause Analysis of Naturally Reported Cases of Infant Death and Permanent Disability.”

Dunsford (2009) reported that, in 1999 the Institute of Medicine (IOM) estimated that as many as 98,000 people died in United States hospitals each year due to preventable medical errors.

The Joint Commission in 2004 reported that 72% of root causes identified during reviews of Sentinel Events related to infant deaths and injury during delivery were attributed to communication failures.

The implications of missed or ineffective communication can be severe. A patient’s clinical condition can deteriorate very quickly, and the ability to communicate assessment data rapidly and effectively can literally mean the difference between life and death.

Communication is very complex. Communication patterns between healthcare workers are variable and influenced by multiple factors, and these factors are often the cause of errors. Pattern factors include individual style differences in communication. Gender plays a role, education plays a role, cultural backgrounds, stress and fatigue (I’m sure we have all experienced that in the healthcare workplace), and established hierarchies and social structures all play a role. These structures can be power gradients, non-linear workplace interactions, workplace cultural environments, the climate of the workplace, and
relationships with the healthcare team can all play a role in the complexities of communication. The variables in communication patterns and workplace factors can lead to unpredictable dynamics in the sending and receiving of information.

GAPS IN LANGUAGE

Miller, Riley, and Davis (2009) stated, “The Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ) report that ‘the nature, characteristics, and communication patterns of healthcare teams, while important, remain poorly understood.’” The IOM indicated that “the quality of communication amongst healthcare team members varies significantly, and that this variability has important consequences for patient safety.”

We speak different languages. As healthcare professionals, we are all trained in separate disciplines, these are known as “silos.”

Nurses often are using descriptive language, while physicians are trained to communicate quite differently.

Other healthcare professionals are also trained within their disciplines and may have great variability in the way they communicate with one another and other healthcare team members.

Miller, Riley, and Davis report that healthcare professionals are predominately educated and trained separately within their disciplines; and Dr. Michael Leonard of Kaiser-Permanente Colorado believes that nurses and physicians, because they are educated differently, are basically speaking different languages.
We want to understand that the differences in communication styles among practitioners, disciplines, genders, cultures, etc., are the basis for effective communication.

TRAINING MAKES A DIFFERENCE

Nurses, as I mentioned, frequently use descriptive narratives when communicating patient information, while physicians commonly communicate in “headlines,” with a concentration on action. They want to know what they need to do to treat the patient to improve their condition.

Nurses are trained to communicate in broad narrative patterns; physicians tend to speak in those headlines — they want to know what it is that they need to do to make a timely clinical judgment or diagnosis, so that a treatment plan is effective.

While the nurse is speaking on the phone, frequently, the physician is impatiently waiting for him or her to get to the point.

FOR EXAMPLE

Let’s take a look at a case study.

This is a scenario; it is not a real patient, but it may give you an idea of how you can use SBAR in any type of patient situation where you have a change in patient condition that concerns you, and that may need to be communicated to another healthcare team member, or to the provider.

John Doe is a 70-year-old Caucasian male admitted under the care of Dr. Fixit. He is in Room 315 of Three North Medical/Surgical Unit at General Hospital. His admission diagnosis is UTI (urinary tract infection). He has a past medical history of recurrent UTI, rheumatoid arthritis, hyperlipidemia,
hypertension, and osteoporosis. He takes several home medications including Caltrate®, Lipitor®, metoprolol, Rheumatrex®, and acetaminophen (as needed for pain).

His weight is 165 pounds and his height is 5 feet, 7 inches. His date of birth is 5/5/35. He has no known drug allergies.

Now, take a minute and pretend that you are the nurse who’s caring for this patient, John Doe. You have just gotten a handoff report.

This handoff report indicates that John Doe was admitted to the hospital yesterday from his nursing home after having presented to the ED (emergency department) with fever, lower abdominal pain, and decreased GCS (Glasgow Coma Scale). He has an existing Foley catheter in place from the nursing home, a left forearm 18-gauge and a right AC (antecubital vein) 20-gauge started by EMS. The current time is 0700 (7:00 a.m.). Mr. Doe complained of lower abdominal discomfort throughout the night.

Upon assessment, the patient is lethargic but arousable, and oriented to date and time only. Mr. Doe is complaining of some nausea, but no vomiting reported. Bowel sounds are hypoactive times 4 quadrants. The lower abdomen is tender to pressure. No distention noted. His skin is warm and flushed. S1 and S2 are auscultated without murmur, but the heart rate is elevated. The lung sounds are clear to all lobes, but the respiratory rate is elevated. Pulses are 1+ to all extremities. Mild edema is noted to the lower extremities. The left forearm 18-gauge has normal saline infusing at 50 mL/hr.

The Foley catheter is to gravity, the total shift intake (liquid) was 1100 mL and the total (urine) output was 600 mL. His urine is amber-colored, cloudy, and with sediment noted. The nursing home reported that his last BM was yesterday morning. The 0600 vital signs included a heart rate of 104, blood
pressure was 86/52, a respiratory rate of 26, a temperature of 101° F, and an O₂ saturation of 90% on room air.

Also, the labs are altered in many areas. The patient has an elevated white count; his bands are significantly elevated. His glucose is beginning to elevate. His BUN and creatinine are showing signs of kidney dysfunction. He has elevated clotting times and his ABG (arterial blood gas) is showing compensated metabolic acidosis with an elevated lactate level.

Now, take a few minutes and try to formulate what may be happening with Mr. Doe. You may want to grab a notepad and write down some of the problem areas that you are seeing and identify maybe the main problem, or several problems that you can see that, in your discipline, you need to address.

Mr. Doe has multiple complications, as you can see, but what these signs and symptoms are really pointing toward is sepsis. Now, sepsis is systemic inflammatory response syndrome (SIRS) in the presence of a confirmed or suspected infection.

This patient has a known urinary tract infection — that was the purpose for admission — but now, this patient is exhibiting signs of systemic inflammatory response syndrome, defined as requiring two or more of the following symptoms in adults:

A temperature of 36°C and 98.6°F is normal, of course, but a temperature of greater than 38°C, or 100.4°F, is a cause for concern. Also, if you have an elevated heart rate greater than 90 beats per minute, and if you have a respiratory rate greater than 20 per minute, or a PaCO₂ of 32 mmHg or higher, those are causes for concern which could point toward systemic inflammatory response syndrome.
And if you have a white count of less than 4000 cells per mm3, or greater than 12,000 cells per mm3, or greater than 10% increase in bands forming, those signs point towards SIRS.

If you have two or more of any of those clinical signs or symptoms, more than likely, they are pointing towards systemic inflammatory response syndrome.

THE PROBLEM OF COMMUNICATING CLEARLY

Now, imagine that you have to communicate these concerns to the provider and you might wonder, “How am I going to communicate? As a nurse, I don’t want to diagnose, but I do have concerns that this patient has sepsis.”

Keep in mind that your communication pattern needs to be direct and effective so that the provider is able to identify clearly that this patient does have this identified problem, and that we can formulate a plan of care that is going to improve this patient’s condition.

You might overhear a nurse who calls, and it might sound something like this:

“Dr. Smith, I’m taking care of Mr. Doe. He has vital signs of... he has a heart rate of... oh, my gosh, it’s so high – it’s 104. His blood pressure is 86/52. His respiratory rate is 26. His temp is 101 and his sat is 90% at room air. Oh, shoot! I need to go do something about that and try to get that above 95; but in the meantime, his assessment is... he doesn’t look well this morning. He is a little flushed. He is showing some edema. His Foley catheter is draining some sediment. He’s having some abdominal pain and discomfort. He has quite a few problems and I really don’t know what is going on, but can you come and look at this patient? I need some help here and he just doesn’t look good to me.”
PUZZLE TO PICTURE

You can see that, with something like that presentation, where you just start off giving a lot of bits of information, the listener may not quite understand the purpose of your call or where you are going with the information.

The way I like to present information regarding a change in a patient’s condition — you could think about it as if you are writing a formal paper — you have an introductory sentence, it’s going to introduce the listener to what you’re about to talk about.

Then you are going to have the center of the paragraph — that body of information that is going to support your topic sentence. Then you are going to have your conclusion, and in this case, it’s going to be a recommendation for care.

So, we want to take a look at how we can reformulate the scenario that we just presented in a clearer manner, so that the listener, or the provider who is going to have to make appropriate care plan decisions, is going to be able to make those decisions with the most informative information, so that the patient has an optimal outcome.

We will revisit this issue after we talk a little bit more about some effective ways to communicate.

A REVOLVING ISSUE

First of all, year after year The Joint Commission has created National Patient Safety Goals in an effort to improve patient safety and patient outcomes. And year after year, communication amongst healthcare providers is on the list. In 2006, as well as in 2009, the commission had the goal of, “improving effectiveness of communication” amongst caregivers.
In 2013, yet again, we wanted to “improve staff communication in getting important labs to the right person on time.”

You can see that communication is an ongoing issue.

The National Patient Safety Goals are created when there are significant problems seen in particular areas. Obviously, communication continues to be a problem in the healthcare workplace that affects patient outcomes, so it is always landing on the National Patient Safety Goals list.

Effective communication between nurses and patients during shift changes, and during telephone communications with providers, is critical to patient safety and their outcomes.

The importance of effective communication is obvious.

“Effective communication, which is timely, accurate, complete, and unambiguous and understood by the recipient, reduces errors and results in improved patient safety,” stated The Joint Commission (2006). “Acutely-ill patients’ outcomes correlate with the quality of communication between the clinicians involved. One of the most important factors in determining the outcome of an acutely-ill patient is the quality of the communication between the clinicians involved.”

SBAR: STANDARDIZED, STRUCTURED COMMUNICATION

We want to bridge the gap. We want to standardize and structure communication so that we are communicating effectively between disciplines whose practitioners may have been educated and trained in different ‘silos,’ and who have a different format for their communication.
The Institute for Healthcare Improvement (IHI), The Joint Commission, and the World Health Organization (WHO) support a standardized communication tool known as SBAR, a form of structured communication.

SBAR stands for: Situation, background, assessment, and recommendation. We’re going to talk further about exactly what that means and what information falls under each of those categories.

SBAR serves as a template for structured nursing and interdisciplinary communication. Many organizations are considering SBAR as a method for standardizing handoffs to comply with The Joint Commission’s National Patient Safety Goals, so a standardized approach such as the SBAR format can provide potential solutions to improve the quality of clinical communication, and prevent medical errors due to poor communication.

SBAR can help bridge the interdisciplinary gap, facilitate more mutually satisfying communication and, more importantly, assure that the other provider hears critical information.

The structure allows practitioners with different communication styles to communicate more effectively by improving the ability to encode and decode verbal messages. This reduces the risk for errors or misinterpretation, and improves patient safety.

To reconcile communication differences, SBAR can be used as a predictable structure for communication that promotes critical thinking. Standardizing the structure of communication by using formats, such as SBAR, can help the speaker organize their thoughts and be prepared with critical information. It allows the receiver to focus on the important parts of the message, because less important aspects have already been eliminated.
Now, what is SBAR? The Institute of Healthcare Improvement’s definition states: “SBAR stands for ‘situation, background, assessment, and recommendation.’” It is a communication format that was initially developed by the military and refined by the aviation industry and, adopted in the healthcare setting by Kaiser-Permanente to reduce risks associated with the transmission of inaccurate or incomplete information. The Institute for Healthcare Improvement (IHI) recommends the SBAR technique because it provides a framework for communication between members of the healthcare team about patients’ conditions.

It is easy to remember, it is a concrete mechanism useful for framing any conversation, especially the ones that translate information about a patient’s condition that needs immediate attention. SBAR allows for an easy and focused way to set expectations for what will be communicated, and how it will be communicated between members of the healthcare team, and it is essential for developing teamwork and fostering a culture of patient safety.

SBAR VARIATIONS

There are variations in SBAR. For example, we talked about it meaning “situation, background, assessment, and recommendation,” but you might see it as ISBAR, and that means “introduce or identify yourself” first, and then go to the “situation, background, assessment, and recommendation.”

You might also see it as SBARR. The additional “R” means “repeat back.” Maybe the physician has given you an order, and you want to repeat back to the provider what that order is, for instance.

Going back to the “I” in ISBAR, it does stand for “introduce” so, you want to initially say your name. “Hi, my name is Venisa Morgan. I’m the nurse caring for John Doe.”
In the previous illustration, the person talking did not introduce themselves. They could have been the unit secretary, they could have been the nurse’s aide on the unit, they could have been the charge nurse, they could have been the primary nurse — they could have been anybody. So, it is very important that you introduce who you are, and how you are involved in the patient’s care so that the listener is better able to identify where you are coming from, and where you are going with the conversation.

Once again, the “R” in “SBARR” stands for “repeat back,” which is essential because it helps to close the loop for the communication; it helps to indicate that you, the listener, has heard the information correctly, and any information you have gotten from the provider or other person on the line, knows that the exchange was heard and clearly understood by both parties.

BREAKING IT DOWN

Let’s give an example of what information you might find under each of these different areas. In “situation” you are presenting the situation that you’re calling about — it’s what is going on with the patient. Keep in mind that, even though we aren’t using the “ISBAR” here, it is just expected that you have introduced yourself and you’ve clearly identified the patient. Of course, there are many patients with the same first or last names in the same hospital unit, so you need to clearly identify the patient as well — including when they were admitted, their diagnosis, and so forth, so that the provider on the line or the person in front of you is able to clearly identify which patient you are talking about.

Then you want to talk about the situation. Why you are calling. Use that introductory sentence. It prepares them for other information that you’re going to give that supports the topic.
So, once again, you are identifying yourself, the unit, the patient, the room number, and then you are briefly stating the problem — what happened, when it started, how severe it is. It could sound something like this:

Nurse: “My name is Venisa Morgan. I’m the RN taking care of John Doe. He is in room 350 of Three West of the Medical/Surgical Unit, General Hospital. He was admitted yesterday with a urinary tract infection.”

Then the doctor or the provider might say, “Oh, yes. I remember this patient. I know who you are talking about.”

Nurse: I’m calling because I have a few concerns that I’m worried about.” Maybe you would say, “I need to talk to you about an urgent safety issue regarding Mr. Doe” or “I need about (so many minutes) to talk to you about some changes in the patient’s condition, treatment plan, procedures, protocols, environmental or organizational issues related to the patient” — whatever it is that you’re calling about. Introduce that problem or the reason you are calling right up front, so that the listener isn’t trying to put pieces together as you are communicating.

Then you want to go into the background: “Are you aware of…” specific problems. Maybe it’s about their age or about their diagnosis; maybe it’s more about their admission or maybe it’s about the discharge plans, or their treatment plans, and any issues in and around their treatment plans. It could be a number of things that are falling into that background, but you want to tie it back to the problem.

We’ll go back to that case scenario in a little bit to tie that information in, and indicate what background information is important to support the problem that you’re calling about. It could include the admitting
diagnosis, date of admission, list of any current medications or allergies, fluids, most recent vital signs, labs, code status or any other clinical assessment information — it could be a number of things.

Then you want to provide the assessment information, and this doesn’t mean physical assessment findings. This is the nurse’s assessment or the care provider’s assessment of the situation — what you think the problem actually is. Maybe it’s a cardiac problem, maybe it’s an infection, or neurological, or respiratory complication. Maybe it’s that the patient is deteriorating and you don’t exactly know what is happening, but there has been a change in the patient that concerns you. It might be that you would say, “The key changes to the last assessment related to this specific concern are…” Whether it’s GI, cardio, respiratory, neurological, psychosocial, or spiritual — any concerns that you might have that relate back to why you’re calling are important. What is the problem? “It’s these changes that I’m seeing,” or “I think it’s because this patient has this problem.”

CLOSING THE LOOP

Next, you want to make a recommendation.

What is the nurse’s or care provider’s recommendation for the problem?

The recommendation closes that communication loophole, where you don’t just leave it open-ended; you have a care plan in mind.

You, in your profession, might know what is going to help this patient improve. Or maybe you don’t know and you need some help. Maybe you need the provider, or you need some additional healthcare team members there to assist you — or any number of things that could help that patient’s outcome. That is what we’re looking for under the heading of recommendation.
Maybe you are requesting that the patient get increased IV fluids, or orders for continued oxygenation, or maybe they need physical rehabilitation — it could be any number of different recommendations. Maybe you want the provider to come immediately. Any of those things could be part of the recommendation. Recommendations are aimed at helping improve the patients’ condition, and possibly saving their life.

CLARIFICATION

At the very end, you want to repeat back. “Just to be clear, we have agreed to do such-and-such,” or maybe, “I would like for you to come by. When are you able to be here?”

Repeat back what you thought that the person on the other end has said so that closes that communication loop.

REITERATION

Let’s revisit the case study.

Take a look at the information one more time. In the attached PowerPoint slides there are some worksheets (see PPT #18-22). It may be helpful to print a few of those, to jot down your ideas as we work through this case study using the SBAR format.

Recall that we have those abnormal labs. Here you have the situation.

“I am calling about…” (patient’s name and, perhaps, code status. Then you go onto the main problem.

“Hello, Dr. Fixit. I’m Venisa Morgan. I’m the nurse taking care of John Doe. He is in room 315, admitted yesterday with a UTI. The problem I’m calling you about is that, I’m concerned that the
patient’s infection has gotten worse since admission.” (SBAR makes use of critical language, such as, “I’m concerned” in order to focus the listener’s attention).

The phrase, “I’m concerned,” grabs the listener’s attention.

Now, we move on to the background.

For example:

“I’ve just assessed the patient and I have some concerns about the patient’s vital signs, assessment findings, and laboratory results.” That introduces the listener to the information that you’re about to present.

Include any changes that support the problem that you’re calling about.

“The current set of vital signs at 0600 include: A heart rate of 104; blood pressure of 86/52; a respiratory rate of 26; a temperature of 101; O₂ sat of 90% on room air.

“Upon assessment, the patient is only oriented times 2, and his skin is warm and flushed. They have 1-plus pedal pulses palpated to all extremities with mild edema noted in the lower extremities. The patient’s bowel sounds are hypoactive times 4-quadrants, and the patient’s urinary output has been less than their fluid intake. The patient’s intake was 1100 mL, their output was 600 mL, and amber-colored, cloudy, with sediment noted in their existing Foley catheter. I’m also concerned about Mr. Doe’s morning labs. The white count is now 12,500 with neutrophil bands at 11%; blood glucose levels are starting to rise — currently 117, and the BUN and creatinine are becoming elevated as well, at 24 and 1.5. Clotting times are elevated and the patient’s ABG is showing compensated metabolic acidosis with a lactate level of 2.5.”
ASSESSMENT

This is the assessment portion.

This is when you assess the problem. It could be a number of different things, but for this patient, based on the preceding information, “I’m concerned that the patient is septic. He meets the systemic inflammatory response syndrome criteria, and has a known UTI.”

When making a recommendation, what is it that you can do, within your scope at this time, to improve this patient’s outcomes, improve their care, etc.? And what needs to be done to possibly save this patient’s life?

Let’s say, for example:

“The patient has maintenance fluids running, Dr. Fixit, and it’s normal saline infusing at 50mL an hour to a peripheral IV. Would you recommend that we increase this patient’s IV fluids, possibly a bolus to increase their blood pressure? What other orders would you like for me to carry out?”

The recommendations really could go on, and on. It could be that maybe you are concerned about their Rheumatrex® causing immunosuppression, and that you want to hold or discontinue that medication; maybe you would like to discontinue the Foley catheter, which is probably the cause of their UTI and the further complicated infection causing the sepsis.

It could be that you would like to transfer the patient to an ICU setting. It depends on the patient’s state at the time, and the recommendations that could improve their outcomes right now.

THE PREPARED TELEPHONE CALL
I usually evaluate a student’s communication in a simulated activity to give them confidence in calling the provider, and oftentimes I notice that the simple things get someone jumbled or distressed during that phone call.

Maybe you’re nervous already if you are a new graduate, or if you are inexperienced on that unit, or just not familiar with the provider that you are calling, but if you don’t come prepared, it just complicates the situation.

Before you ever make the phone call it is imperative that you are prepared to discuss problems with the provider. Prior to calling the physician or provider, you want to take the following steps:

Have a pen ready to go. I know that seems simple, but having a pen and paper ready to take orders, if necessary, is important, as is having the patient’s chart readily available.

Try to reduce any distractions; take care of other unfinished business, if the situation and the timeframe allows it, so that people aren’t trying to get your attention and distracting you while you are on the telephone with the provider.

Rosenstein’s research on disruptive behavior provided some interesting questionnaire responses about nurse/physician telephone communications, including that nurse respondents indicated that disruptive behavior commonly occurred after placing calls to physicians.

Physicians cited ill-timed calls, and calls that were placed before nurses had gathered all the necessary information, as factors in disruptive behavior.

Interruptions or other unexpected events may demand our attention so that a current activity is completed prematurely, or suspended, or not finished at all. Some nurses indicated that they were afraid
to call certain physicians and, therefore, delayed patient care. One nurse stated that, “Sometimes, it is still hard for me to know where all the pieces fit together.”

These are a few reasons why communication is often at the heart of poor patient outcomes or errors in patient care. So we want to be prepared before we make that phone call.

Make sure that you actually visited with the patient, that you’ve laid eyes on that patient, and that you’ve just assessed that patient. Make sure that you have their chart ready, that you’ve gotten their most current vital signs, that you have all of the important information in hand that the physician or provider may ask you about.

Be sure that you know the patient’s code status, and that you have that pen and paper ready to go.

BRIDGING COMMUNICATION

In the clinical scenario we discussed the use of SBAR to communicate effectively with the provider in a telephone conversation.

Of course, SBAR can also be used for other forms of communication, such as a handoff report or any type of face-to-face communication where you are trying, perhaps, to communicate a change in the patient’s condition.

So, try not to think of SBAR as just a telephone communication tool, although it is highly effective for use in telephone communications with providers.
Now, SBAR has some very positive outcomes following its implementation, including: Improved patient safety, increased quality of care, reduced patient falls during shift changes, decreased response time to nurses’ requests for patient reviews, and decreased reporting time by 70%.

“Nurses have expressed that SBAR facilitates the clarity of information through its structure, and simplicity. The effective use of SBAR should not only improve the outcomes, but also improve satisfaction in how the event was handled for everyone involved.” (Guise, 2006)

In 2013, Horgan stated that one study reported, “After implementing SBAR, the nursing staff reported high confidence levels in their ability to communicate issues regarding the patient’s condition to medical personnel.”

In 2010, in a study by Boaro, participants felt that, “The structured process enhanced the accountability and solution-focused approach to strategies rather than blaming the individual.”

APPLYING SBAR

You’re thinking to yourself, “How can I use SBAR in my workplace?”

Training and education are necessary to ensure a common understanding of the technique and the purpose for all staff. Although an organization-wide implementation of SBAR communication is optimal, individual practitioners can still structure their own communication in ways that are effective and efficient.

A study result suggested that both individual training for nurses, and team training is necessary to improve the quality of communication. Some studies have also shown an initial resistance to the introduction of a new SBAR worksheet. However, one study showed that after two months, staff
reported increased satisfaction with the worksheet, and increased satisfaction during shift and transfer reports.

Reference cards can be created, similar to the SBAR tables presented in the accompanying PowerPoint slides (#18-22), to facilitate effective communications on the job. The reference cards can be attached to employee identification badges for quick and easy reference to facilitate safe patient care, and encourage adequate handoff communication.

The formal use of SBAR in a sticker format may improve communication between members in the multidisciplinary team, as well as ensure accurate handover of all information between shifts. The technique can be implemented on any scale, from individuals to institutional facilities, and can be used for interdisciplinary teams.

Disciplines can spring from differing educational systems, hierarchies, power gradients, cultures, climates, relationships between its members, healthcare teams, etc., and ultimately, these communication techniques can improve patient safety.

A “one-size-Fits-All” approach to communication will not work. Nurses and other healthcare providers from all areas of practice should learn how to communicate using the basic SBAR format.

Using their expertise, they should then adapt the format to their practice environment and mentor their less experienced colleagues. As with any worthwhile pursuit, improvement in communication will take time.
So I want each of you to commit to SBAR, because when patients entrust themselves to our care, we make two implicit but key professional and organizational promises: We promise to do everything possible to help patients, to provide good care; and we promise not to harm them.

Thank you so much for your time.

SLP: 082814
REFERENCES


