NHS
Institute for Innovation and Improvement

Safer Care

SBAR

Situation • Background • Assessment • Recommendation

Implementation and Training Guide

Contents

SBAR can be used very effectively to **escalate** a clinical problem that requires immediate attention, or to facilitate efficient **handover.**

Welcome

Getting started with SBAR

Welcome to the SBAR Training Guide. It has been developed by the NHS Institute for Innovation and Improvement working closely with clinicians and other frontline staff in the NHS.

This training guide is part of a suite of products designed to help you introduce and implement SBAR in your organisation or team. The guide will help cement your own understanding of the SBAR approach and support you in planning and delivering your own SBAR training – either as a classroom event, in a clinical setting, as an informal session or as part of a more structured learning curriculum.

SBAR resources included in this guide:

- DVD containing a series of filmed scenarios highlighting the difference of communicating with and without SBAR

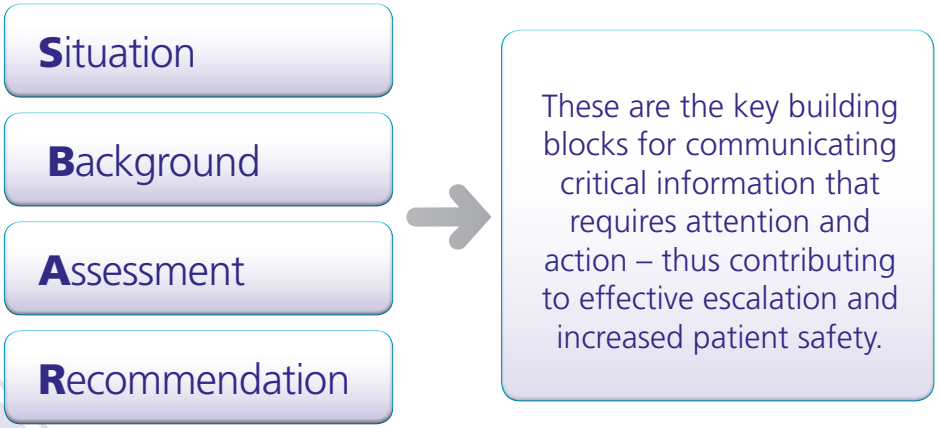
  SBAR resources downloadable at **www.institute.nhs.uk/SBAR**

- Series of filmed scenarios
- PowerPoint presentation introducing SBAR
- An SBAR e-learning module
- SBAR prompt cards and pads

What is SBAR?

SBAR is an easy to remember mechanism you can use to frame communications or conversations. It is a structured way of communicating information that requires a response from the receiver.

As such, SBAR can be used very effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover of patients between clinicians or clinical teams. SBAR stands for:



How can SBAR help you?

Inadequate verbal and written communication is recognised as being the most common root cause of serious errors – both clinically and organisationally. There are some fundamental barriers to communication across different disciplines and levels of staff. These include hierarchy, gender, ethnic background and differences in communication styles between disciplines and individuals.

Communication is more effective in teams where there are standard communication structures in place. This is where SBAR can add real value:

- SBAR takes the uncertainty out of important communications. It prevents the use of assumptions, vagueness or reticence that sometimes occur – particularly when staff are uncomfortable about making a recommendation due to inexperience or their position in the hierarchy. In short, SBAR prevents the hit and miss process of 'hinting and hoping'.
- SBAR helps prevent breakdowns in verbal and written communication by creating a shared mental model around all patient handovers and situations requiring escalation, or critical exchange of information.
- SBAR is an effective way of levelling the traditional hierarchy between doctors and other care givers by building a common language for communicating critical events and reducing communication barriers between different healthcare professionals.
- SBAR is easy to remember and encourages staff to think and prepare before communicating.
- SBAR can make handovers quicker yet more effective, thereby releasing more time for clinical care.

> SBAR prevents the hit and miss process of 'hinting and hoping'

How does SBAR work?

SBAR allows staff to communicate assertively and effectively, reducing vagueness and the need for repetition. The SBAR process consists of four standardised stages or 'prompts' that help staff to anticipate the information needed by colleagues and formulate important communications with the right level of detail.

The tool can be used to construct letters, e-mails or other communication at any stage of the patient's journey - for example the content of a GP's referral letter, consultant-to-consultant referrals and communicating discharge back to a GP.

When staff use the tool in a clinical setting, they make a recommendation which ensures that the reason for the communication is clear.

Recommended uses and settings for SBAR:

- Urgent or non-urgent communications
- Verbal or written exchanges
- Emails
- Escalation and handover
- Clinical or managerial environments

The SBAR process consists of four standardised stages or 'prompts' that help staff to anticipate the information needed by colleagues and formulate important communications with the right level of detail

What should an SBAR communication convey?

S: Situation

- Identify yourself and the site/unit you are calling from
- Identify the patient by name and the reason for your report
- Describe your concern.

Firstly, describe the specific situation about which you are calling, including the patient's name, consultant, patient location, resuscitation status and vital signs. An example of a script would be:

> *This is Lou James a registered nurse on Nightingale Ward. The reason I'm calling is that Mrs Taylor in room 225 has become suddenly short of breath, her oxygen saturation has dropped to 88 per cent on room air, her respiration rate is 24 per minute, her heart rate is 110 and her blood pressure is 85/50.*

B: Background

- Give the reason for the patient's admission
- Explain significant medical history
- Inform the consultant of the patient's background: admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results and other relevant diagnostic results. For this, you need to have collected information from the patient's chart, flow sheets and progress notes. For example:

> *Mrs Taylor is a 69-year-old woman who was admitted from home three days ago with a community-acquired chest infection. She has been on intravenous antibiotics and appeared, until now, to be doing well. She is normally fit and well and independent.*

A: Assessment

- Vital signs
- Clinical impressions, concerns.

An example of what you might say or write is:

> *Mrs Taylor's vital signs have been stable from admission but deteriorated suddenly. She is also complaining of chest pain and there appears to be blood in her sputum. She has not been receiving any venous thromboembolism prophylaxis.*

You need to think critically when informing the doctor of your assessment of the situation. This means that you need to have considered what might be the underlying reason for your patient's condition. Not only have you reviewed your findings from your assessment, you have also consolidated these with other objective indicators, such as laboratory results.

If you do not have an assessment, you may say:

> *I think she may have had a pulmonary embolus*

Or

> *'I'm not sure what the problem is, but I am worried*

R: Recommendation

- Explain what you need - be specific about the request and time frame
- Make suggestions
- Clarify expectations.

Finally, what is your recommendation? That is, what would you like to happen by the end of the conversation or communication with the doctor?

> *I would like you to come immediately*

Readback: making sure you have been understood

Following any communication using SBAR, it is important that the receiver of the information 'reads back' a summary of the information to ensure accuracy and clarity. The readback will follow the same SBAR format. For example:

S: Situation
'Mrs Taylor, on Nightingale ward.'

B: Background
'Admitted three days ago with a community-acquired chest infection; has been receiving IV antibiotics but no VTE prophylaxis.'

A: Assessment
'Has suddenly deteriorated; her blood pressure and sats have dropped, whilst her heart rate and resp rate have increased. It does sound like a PE.'

R: Recommendation
'I will come immediately. In the meantime can you start her on 15 litres of oxygen via a non-re-breathe mask; prepare IV Hartmans, 500 mls stat; and repeat her observations. Please call Outreach.'

Implementing SBAR

If you think SBAR is a process that could add real value to your patients and staff, your next questions might be:

- How do I make SBAR the norm in my organisation or team?
- How will we know it has improved care?

It's at this point that you need to think about **implementation**.

Why take a structured approach to implementation?

Although it may be tempting to go straight ahead and start using SBAR, there are good reasons to pause and spend some time planning a structured implementation that will:

- Clarify exactly what your team or organisation wants to accomplish through SBAR
- Allow you to measure and demonstrate its true impact for patients and staff
- Give you a chance to modify or change your approach if it's not working or could be even better.

The good news is that a structured implementation does not have to be a lengthy and onerous part of the process.

This section offers you an overview of one of the most well-used and effective improvement methodologies in the NHS and wider industry - **the Model for Improvement**.

The Model for Improvement (see page 14) is a simple four–stage cycle that will help make sure you are getting the benefits **you want** out of SBAR and that they **stick**, rather than fizzling out once the launch is over.

Form a small improvement team

You may already have a small team of interested people who are enthusiastic about SBAR and the potential benefits it can bring. Now is a good time to firm up this team and ensure you have the expertise and support you need.

As well as including representatives from the teams or departments where you are hoping to introduce SBAR, it is crucial to engage senior managers and clinicians as early as possible – these are the people who will help you champion the idea and give it credibility and status across the wider team or organisation.

Specifically, you need to gain early agreement from your senior managers and clinical governance team with the need to introduce SBAR. To do this, you are likely to need to demonstrate some evidence of the benefits and how these might be realised in your organisation:

Invite your prospective 'champions' to a short session where you can show them SBAR PowerPoint presentation, selected SBAR films and some of the SBAR tools - all available on the SBAR DVD or on our website at: **www.institute.nhs.uk/SBAR**

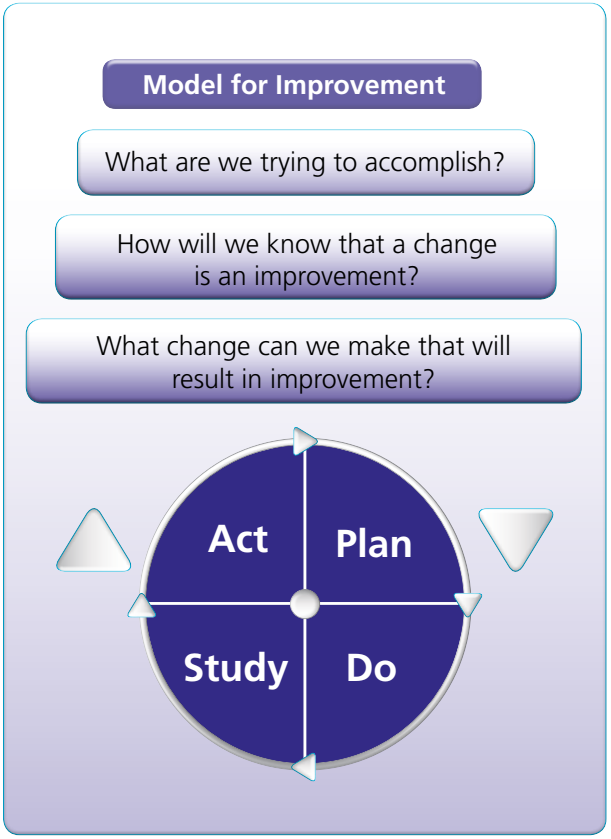
Outline your ideas for testing and measuring SBAR – sharing the Model for Improvement methodology (explained next)

Using the Model for Improvement

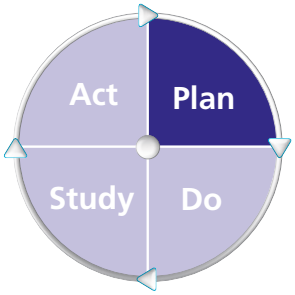
The Model for Improvement is based on 'Plan, Do, Study, Act (PDSA) cycles. It will take you through three big questions and four key steps:

Answering the 'big 3'

- Agree and communicate a clear aim for SBAR
- Decide how you will measure the improvements (see page 15)
- Decide which SBAR tools to test: eg SBAR aide memoire pads (you can use or modify the resources on the DVD or make your own).



An example aim for SBAR might be:
'**For SBAR to be the way all everything which requires an urgent response is escalated in this organisation**'



This is the stage where you plan what you will test (eg SBAR structured notepads by the phone), where you will test them, who will support you and how you'll train and inform all staff. The key to this step is to understand the importance of involving all relevant groups right from the start.

Agreeing your measures for SBAR

There are several good resources dedicated to helping improvement leaders and teams develop the right measures and collect the right data in order to understand the impact of the changes they have made. If you are not very familiar with these measures, or need to refresh your knowledge, the following link will take you to a useful source of help:

www.institute.nhs.uk/SPC

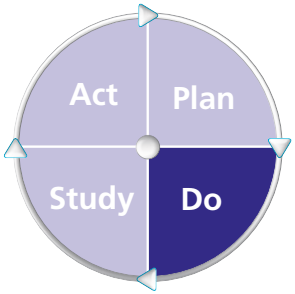
In essence, you are aiming for a set of around four or five key measures. Your measures should be balanced, reflecting the different dimensions of care which you are trying to improve.

The simple triangle diagram overleaf shows the four aims for the NHS Institute's Safer Care Programme and may be a useful guide when developing your balanced set of SBAR measures.

Measuring SBAR does not have to be complicated – a simple *value and efficiency* measure might be reduction in handover time using SBAR, or number of staff who report using SBAR each week. A *safety and reliability of care* measure might include seeking regular feedback from clinicians about whether urgent issues are being clearly and concisely articulated.

Plan: checklist

- Get strong, visible leadership from your senior managers and clinical champions.
- Decide where to start your SBAR test – think about where there is existing enthusiasm from staff for SBAR. Which teams or groups will be most willing to help you spread implementation to others in the organisation?
- Review the SBAR tools and agree which you will use, or whether you will develop your own. Handouts, posters, stickers and notepads placed near telephones have all helped other teams. (See: 'Examples of SBAR tools' on page 27).
- Decide how you will train staff to use the SBAR process and tools (see: 'Training staff to use SBAR' on page 20).
- Plan how you will assess the competency of staff using SBAR – eg voice recorders – but keep it simple.
- Communicate your decisions widely, and in as many ways as you can.

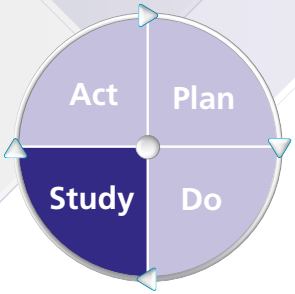


Four key steps

You now need to train your test team and start using the tools. Experience has shown that implementation works best when staff are fully involved and encouraged to develop or modify their own version of SBAR.

Do: checklist

- Deliver SBAR training to all staff – clinical and non-clinical.
- Provide a safe environment and opportunities for staff to practice and develop their SBAR skills during non-critical communications. Use simple clinical and operational scenarios that are typical for the department.
- Emphasise that the point is to experiment, to try ideas that the team wants to test.
- Monitor the progress of staff practicing SBAR using the methods you have selected (eg voice recorders).
- Be sure to brief or train those likely to receive SBAR communications as well as those giving them. Give positive feedback – this is vital to embed a change in behaviour.
- Keep communicating about your progress – especially through your champions.

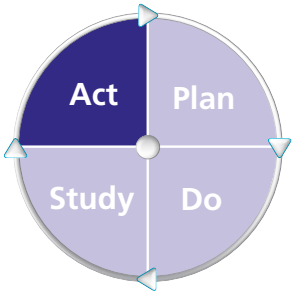


Four key steps

This is where you will assess the impact of SBAR using your agreed measures and start the review process. One of the most useful measures of success will come from staff feedback. Remember you may need to repeat the PDSA test cycle a few times to find the tools and processes which work best.

Study: checklist

- Assess the impact of SBAR using your set of agreed measures.
- Collect feedback from staff – consider asking 10 members of the team to outline their experiences of SBAR and how it has (or has not) helped in a critical situation. Remember to get feedback on the SBAR training too.
- Gain regular feedback from clinicians about whether urgent issues are being clearly and concisely articulated and escalated through SBAR. Have any serious incidents been averted because of more effective escalation?
- Review the SBAR tool with the test team, making time for discussion, reflection and refinement of the tools.
- As you collect and analyse your information, remember to display the stories and results so everyone can see your progress.



Four key steps

Is your tool ready to be implemented? If it is, you will need to plan how you will roll it out to the wider department or organisation and, crucially, how you will sustain the use of the tool in the long term.

Act: checklist

- Decide if your SBAR tool is ready to be implemented – the options at this stage of the PDSA cycle are to adopt, amend or abandon. If you decide to abandon a particular line of testing, consider with the team why this is and what alternatives might work better.
- Look at the NHS Institute's Sustainability Model and Guide and the 'ten factors' which make a change most likely to stick. Reflect these in your roll-out plan.
  See: **www.institute.nhs.uk/sustainability**
- Aim for a quick uptake by delivering a focused training campaign aimed at as many people as possible over a defined time period. Having a training pack readily available will enable you to take advantage of training opportunities as and when they occur – especially important in busy departments.
- Don't lose momentum – you risk losing the interest and enthusiasm of staff early.

Training staff to use SBAR

Incorporating SBAR within your organisation or team will require training. It can take time and effort to change the way people communicate, particularly with senior staff.

Including SBAR in a curriculum

Providing flexible learning opportunities which can be accessed by a variety of learners - from pre-registration students to senior professional colleagues - can be highly effective in developing confidence and competence for effective and structured communication.

You may find the following suggested lesson plan and supporting activities useful in introducing SBAR to a group of learners.

Session title:

SBAR - A tool for effective communication in contemporary clinical practice

Aim:

The aims of this session are to:

- Help learners understand the key features of effective communication exchanges.
- Introduce the SBAR tool as a common 'language' that staff from all disciplines and levels can use.

Learning outcomes:

Participants will be able to:

1. Identify how SBAR can enhance communication exchanges.
2. Discuss examples of situations where communication can be improved, using a structured tool such as SBAR.
3. Identify a range of communication scenarios where SBAR can be used successfully.
4. Practice using the SBAR tool in a communications scenario.
5. Identify how SBAR can be used effectively within learners' own practice areas.

Suggested lesson plan and activities:

1. Introduction to session:

Facilitator may use the SBAR PowerPoint presentation to structure the session.

- Introduce yourself and outline the session. Lead group introductions and agree the ground rules.
- Explore participants' experiences of situations where communication was pivotal in patient care.
- Clarify the key features of these experiences and list them on a flipchart, whiteboard or paper.
- As a group, prioritise the important and relevant issues for effective communication.

Available at **www.institute.nhs.uk/SBAR**

Available as DVD or at **www.institute.nhs.uk/humanfactors**

2. Show the DVD 'Just a routine operation' (run time 13 minutes)

- Lead the group in identifying the barriers to communication demonstrated in the film and reflect on the consequences of these.
- Refer back to personal examples shared by the group when communication was pivotal in patient care (see 1 above).

3. Show selected DVDs from 'SBAR scenarios'

- Select the scenarios that are most familiar to your audience to show first - there are a range of settings and a mix of roles, with examples of both escalation and handover communications (see 'SBAR scenarios' and selection table on pages 25 and 26).
- Play the 'without SBAR' scenario and pause the film for feedback before showing the 'with SBAR' scenario. Invite the group to discuss the main points which arise from this.
- Examine the consequences of not using a structured communication tool.
- Identify and discuss key features of the SBAR tool.

Available on the SBAR DVD or at **www.institute.nhs.uk/SBAR**

- Show selected SBAR scenarios again, replaying the scenario where communication was unstructured (without SBAR) and then the scenario of the structured communication sequence (with SBAR).

4. Group activity: Practice SBAR using the templates and card prompts provided and scenarios from participants' own experiences.

- Using the SBAR templates or card prompts, ask the group to construct a scenario from a clinical, managerial or even a social setting (for example organising a night out with friends) with and without SBAR. Ask them to examine each step in some detail.
- Ask the group to identify key points arising from using SBAR for each scenario and make comparisons (identify strengths and areas that need more practice).
- Repeat the scenarios to reinforce the learning, relating them directly to realistic work situations and personal development.

Templates and card prompts available at: **www.institute.nhs.uk/SBAR**

5. Conclude the session:

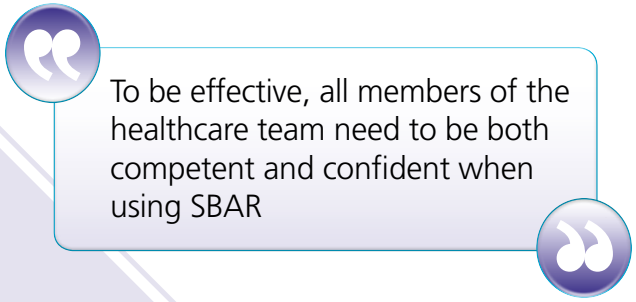
- Summarise the key learning points - refer back to the group's initial ideas about effective communication (flipchart/whiteboard work); highlight any areas that could now change following their learning about the use of the SBAR tool.
- Ask participants to identify key points that they can now use in their practice area to enhance effective communication.
- Signpost participants to additional resources such as the DVD film scenarios and e-learning module.

Avavailable at **www.institute.nhs.uk/SBAR**)

6. Assess the learning

To be effective, all members of the healthcare team need to be both competent and confident when using SBAR to enhance communication exchanges. Assessment of an individual's understanding can be done in a number of ways, including:

- Objective Structured Clinical Examination (OSCE) - where the learner is placed in an appropriate scenario and is asked to demonstrate effective communication using the SBAR tool.
- Written assessment – in which the learner is given unstructured communication scenarios and then asked to construct a formal 'handover' using the SBAR tool.
- Multiple choice questions - developed from the SBAR DVD and e-learning module.



SBAR film scenarios

SBAR film scenarios include:

- Acute (escalation and handover)
- Paediatric (escalation and handover)
- Mental health (handover)
- Ambulance and emergency department (handover)
- Recovery and theatres (escalation)
- Medicines management (escalation)
- Primary care (handover)
- Community pharmacy (escalation)

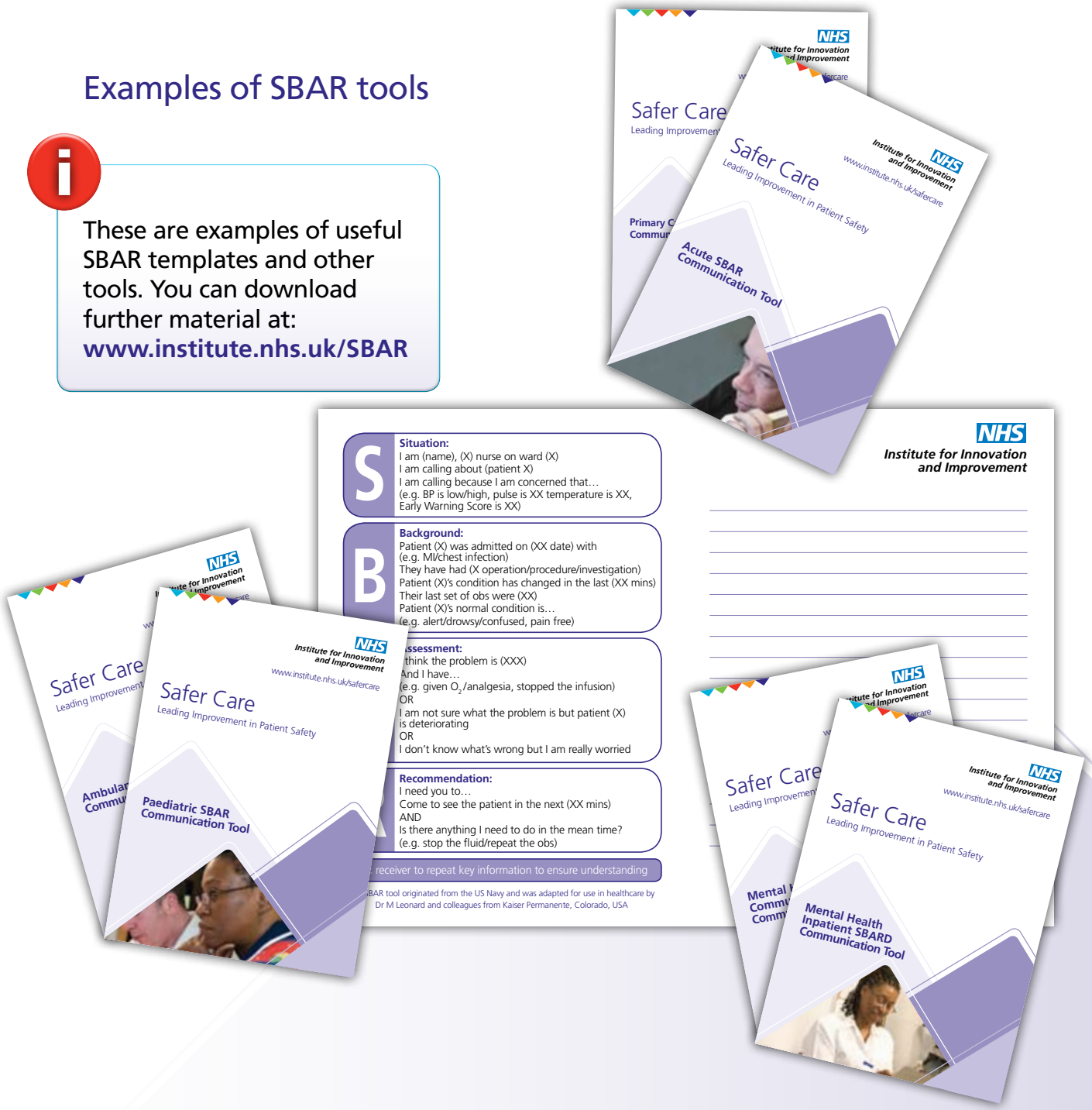
These are available on the SBAR DVD or at our website: **www.institute.nhs.uk/SBAR**

For tips on selecting the most helpful scenarios for your needs, see the table on page 26...

I want to focus on	Featuring	Scenario selection
Acute audience	Nurses Doctors Pharmacists Paramedics	Acute escalation and handover Paediatric escalation and handover Recovery and theatres escalation Medicines management escalation Ambulance and emergency department handover
Paediatrics audience	Nurses Doctors	Paediatric escalation and handover Medicines management escalation
Community and mental health audiences	GPs Surgery staff Community nurses Mental health staff Community pharmacists Therapists	Primary care handover Community pharmacy escalation Mental health team handover Ambulance and emergency department handover
Multi-professional team	Nurses Doctors Care staff	Paediatric handover Mental health team handover
Role modelling - use of words Situation, Background… etc	Nurses Doctors	Paediatric escalation and handover Mental health handover
Role modelling - use of readback		All
Role modelling - coaching	Pharmacists Doctors	Medicines management escalation
Setting the scene for new staff	Nurses Doctors	Paediatric handover

Examples of SBAR tools

These are examples of useful SBAR templates and other tools. You can download further material at: **www.institute.nhs.uk/SBAR**



Further reading and resources

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Arora V, Johnson J, Lovinger D, Humphrey H J, and Meltzer D O: **Communication failures in patient sign-out and suggestions for improvement: a critical incident analysis.** Qual. Saf. Health Care 2005; 14(6): 401 - 407

Haig K M, Sutton S, Whittington J: **SBAR: A shared mental model for improving communication between clinicians.** Joint Commission Journal on Quality and Patient Safety, Volume 32, Number 3, March 2006, pp. 167-175(9)

Joint Commission Perspectives on Patient Safety. **The SBAR technique: Improves communication, enhances patient safety.** February 2005. Volume 5, Issue 2.

Patient Safety First 'How to Guides' for Reducing harm from deterioration
http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/How-to-guides-2008-09-19/Deterioration%201.1_17Sept08.pdf

Patient Safety First 'How to Guides' for Implementing human factors in healthcare
http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human%20Factors%20How-to%20Guide%20v1.2.pdf

Flin R, O'Connor P, Crichton M: **Safety at the sharp end: a guide to non-technical skills** (2008)

See also: The Productive Operating Theatre

For a structured approach to introducing SBAR in the operating theatre, see The Productive Operating Theatre module on Team-working www.institute.nhs.uk/theatres

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Notes

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