



SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool

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Type of document	Guidance	
Target audience	All clinical staff	
Document purpose	The purpose of this policy is to ensure that all clinical staff adopt the SBAR tool in order to improve clinical communications. Inadequate verbal or written communication is recognised as being the most common root cause of serious error both clinically and organisationally	

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CWP documents to be read in conjunction with	HR6	Trust-wide learning and development requirements including the training needs analysis (TNA)
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Training requirements	There is specific training requirements for this document.
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Financial resource implications	No
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Equality Impact Assessment (EIA)

Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? No		
Is the impact of the document likely to be negative?	No	
• If so can the impact be avoided?	No	

<ul style="list-style-type: none"> • What alternatives are there to achieving the document without the impact? • Can we reduce the impact by taking different action? 	No	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the human resource department.

Was a full impact assessment required?	No	
What is the level of impact?	Low	

Document change history

Changes made with rationale and impact on practice
1.

External references

References
<ol style="list-style-type: none"> 1. National Patient Safety Agency 2007 Recognising and Responding Appropriately to Early Signs of Deterioration in Hospitalised Patients. London: NPSA 2. National Institute for Clinical Excellence 2007 Acutely Ill Patients in Hospital, Recognition of and Response to Acute Illness in Adults in Hospital. London: NICE 3. Institute for Healthcare Improvement 2004 SBAR Toolkit. Cambridge, MA: IHI

Monitoring compliance with the processes outlined within this document

Please state how this document will be monitored. If the document is linked to the NHSLA accreditation process, please complete the monitoring section below.	
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1. Introduction

Effective communication is paramount in avoiding incidents relating to patient safety. Inadequate verbal or written communication is recognised as being the most common root cause of serious error both clinically and organisationally however there are few tools that actively focus on improving communication, in particular verbal communication. Within the healthcare setting 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. In 2007 the National Patient Safety Agency suggested that effective communication is a key factor in improving clinical practice and patient outcome. The National Institute for Clinical Excellence (NICE, 2007) supported these findings and advised that nursing and medical staff should use a formal structured handover supported by a written plan. In 2004 the Institute for Healthcare Improvement published a communication tool, SBAR (Situation-Background-Assessment-Recommendation), to facilitate a structured method of communicating.

2. What is SBAR?

SBAR is a nationally recognised tool to improve communication between all members of staff. It is an easy to remember mechanism that can be used to frame communications or conversations, facilitating a structured way of communicating information that requires a response from the receiver. It enables staff to clarify what information should be communicated between members of the team, and how. It can also help to develop teamwork and foster a culture of patient safety.

SBAR can be used very effectively to escalate a clinical problem that requires immediate attention (in conjunction with a Modified Early Warning Score MEWS), or to facilitate efficient handover of patients between clinicians and clinical teams. SBAR standards for:

- S** = Situation (a concise statement of the problem)
- B** = Background (pertinent and brief information related to the situation)
- A** = Assessment (analysis and consideration of options – what you found / think)
- R** = Recommendation (action requested/recommended – what you want)

These are the key building blocks for communicating critical information that requires attention and action, thus contributing to effective escalation and increased patient safety. Using the SBAR tool helps to prevent breakdowns in verbal and written communication, by creating a shared mental model around all situations requiring escalation or critical exchange of information (handovers). SBAR is an effective mechanism to level the traditional hierarchy between physicians and other care givers by building a common language platform for communicating critical events, thereby reducing barriers to communication between healthcare professionals. Initially developed by the US Navy and adapted for use in the healthcare environment by staff at Kaiser Permanente in Colorado, USA, SBAR can be used in the majority of situations and is very transferable to all communication interactions between professionals.

3. When to use SBAR

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

The tool can also be used at any stage of the patient's journey to construct letters, emails or other communications and can be used in the following situations:

- Inpatient or outpatient services;
- Urgent or non urgent communications;
- Conversations with a physician, either in person or over the phone:
 - Particularly useful in nurse to doctor communications;
 - Also helpful in doctor to doctor consultation.
- Discussions with allied health professionals;
- Conversations with peers e.g. handovers;

- Escalating a concern;
- Verbal or written exchanges;
- Emails;
- Clinical or managerial environments.

When the tool is used by staff in the clinical setting they make a recommendation which makes sure the reason for the communication is clear instead of 'hinting and hoping'. It can increase confidence of inexperienced staff or those communicating up the hierarchy who can feel uncomfortable with such communications.

4. What should an SBAR communication convey?

In order to successfully communicate using SBAR staff must use the tool to gather the relevant information before initiating the communication. Being prepared in this way will ensure that communications are concise but also that the relevant information is conveyed. An example of how SBAR would be used in a telephone conversation relating to a deteriorating patient is shown below.

S: Situation	<ul style="list-style-type: none"> - Identify yourself 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
B: Background	<ul style="list-style-type: none"> - Give the patient's reason for admission (or presentation/referral in community care settings) - Relevant past medical history and treatment to date - (it is imperative that this is brief, succinct and relevant)
A: Assessment	<ul style="list-style-type: none"> - Vital signs - Clinical impressions and/or concerns
R: Recommendation	<ul style="list-style-type: none"> - Explain what you need – be specific about 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 with the clinician? - Any order that is given on the phone needs to be repeated back to ensure accuracy
<p>Read back: 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. This should also be documented in the patients' medical notes.</p>	

SBAR can be adapted for different healthcare settings and situations relevant to CWP services as demonstrated in Appendices 1 to 4.

The benefits of using the SBAR tool are that it encourages and promotes the following:

- The sharing of accurate and relevant information;
- Improve patient experience;
- Increases credibility of nurse handover;
- Facilitates better decision making by medical staff;
- Appropriate prioritisation of patients;
- Improved time management;
- Active listening.

5. SBAR and CWP

Cheshire & Wirral Partnership NHS Foundation Trust (CWP) recognises that effective communication is essential to good team work and that teamwork is essential to patient safety, therefore high quality handovers and the prompt recognition and appropriate early management of the deteriorating patient are key objectives for the safety and wellbeing of patients. CWP will take all reasonable steps to achieve this through:

- The adoption of standard documentation throughout CWP;
- Training in the use of SBAR for all registered clinical staff working in hospitals and community care teams within CWP;
- The use of SBAR as a communication template in handover situations through CWP;
- The establishment of robust mechanisms for accessing emergency assistance either on site or externally;
- The development of transfer protocols agreed with the ambulance service and receiving hospital.

6. SBAR Documentation

A short cut to the NHS Institute for Innovation and Improvement SBAR resource page can be found on the CWP intranet under 'favourites'.

7. Duties and levels of responsibilities

7.1 Chief Executive

As accountable officer, the Chief Executive has the overall responsibility for the implementation of the SBAR policy.

7.2 Senior managers

Senior Managers must ensure that units under their line management comply with the policy.

7.3 Line managers

Line managers must ensure that staff within their team adopt the SBAR tool to structure staff handovers, to escalate deteriorating patients to relevant medical staff and to improve clinical communications with the wider multi disciplinary team.

7.4 All other clinical staff

Should adopt the SBAR tool to structure their clinical communications with the wider multi disciplinary team.

Appendix 1 - Mental health inpatient SBAR example

S: Situation	I am (nurse X) on ward (X), I am calling about patient (X), I am calling because I am concerned that..... (e.g. patient's mood is very low and expressing suicidal ideation)
B: Background	Patient (X) was admitted on (X date) following (X) but has until today been well. Patient has a diagnosis of (X condition) and their Mental Health Act status is (X) and he/she is receiving (medication/therapy) The patient has deteriorated in the last (X) AND/ OR following (X)
A: Assessment	I think the problem is (X) and I have (e.g. Put the patient on higher level observation) OR I am not sure what is wrong but patient (X)'s mental state has deteriorated and I am worried they are at higher risk of X OR I do not know what is wrong but I am worried and concerned
R: Recommendation	I need you to (e.g. come and see the patient by X time) in order to (X)
Read back: Making sure you have been understood So we have agreed you will visit the ward in the next (X mins), and in the meantime we will (X) (e.g. Place the patient on level x observations)	

Appendix 2 - Inpatient physical deterioration SBAR example

S: Situation	I am (name), (X) a nurse on ward (X) I am calling about (patient X) I am calling because I am concerned that...(e.g. BP is low/high, pulse is XX, temperature is XX, MEWS is XX)
B: Background	Patient (X) was admitted on (XX date) with (e.g. MI/chest infection) They have had (X operation/procedure/investigation) Patient (X)'s condition has changed in the last (XX mins) Their last set of obs were (XX) Patient (X)'s normal condition is XX (e.g. alert/drowsy/confused, pain free)
A: Assessment	I think the problem is (XXX) and I have...(e.g. given O2 /analgesia) OR I am not sure what the problem is but patient (X) is deteriorating OR I don't know what's wrong but I am really worried
R: Recommendation	I need you to... Come to see the patient in the next (XX mins) AND Is there anything I need to do in the meantime? (e.g. stop the fluid/repeat the obs)
Read back: Making sure you have been understood So we have agreed you will visit the ward in the next (X mins), and in the meantime we will (X) (e.g. repeat MEWS every XX mins)	

Appendix 3 - Mental health community SBAR example

S: Situation	I am (name) a CPN with (X team) I am calling about (patient X) I am calling because I am concerned that.....(e.g. X is worsening/concerning me, they are saying/doing X)
B: Background	Patient (X) has been under our team since (X date) with (X problem) They have been receiving (X medicines/X intervention) They also have the following services Their last assessment indicated a risk of (X) Patient (X)'s normal condition is Their condition has changed in the last (XX mins/hours/days/weeks)
A: Assessment	I think the problem is (X) OR I am not sure what the problem is but I am concerned
R: Recommendation	I need you to See the patient (when?) / Consider prescribing (X drug) / Make a referral to (X) / Advise me what to do (when? what next?) AND Is there anything I need to do in the meantime?
Read back: Making sure you have been understood So we have agreed that I will (X) AND/OR you will (X)	

Appendix 4 - Primary care handover SBAR example

S: Situation	I am Dr (name) in (X) practice I am calling about (patient X) I am calling because I am concerned that / I am unsure about / the patient needs
B: Background	Patient (X) has been having / was seen on (XX date) with They have previously had (X operation/procedure/ investigation) Their other history includes Their normal condition is (e.g. alert/drowsy/confused/self-caring)
A: Assessment	On examination I have found....(e.g. wound inflamed, BP raised, breathingXX) I think the problem is / may be OR I don't know what's wrong but I am concerned
R: Recommendation	I need you to... See the patient (when?)
Read back: Making sure you have been understood So we have agreed that I will (X) AND/OR you will (X)	