Effectiveness of an adapted SBAR communication tool in a community nursing care setting

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Introduction
In a patient journey, a patient can potentially be treated by a number of specialists and practitioners in multiple settings before going on care by community nurses. Thus, handover communication should include all essential information or serious breakdowns in the continuity of care and potential harm to patients can result. The SBAR process has proven to be an effective communication tool in acute care settings but little is known of its effectiveness in community care settings. This study evaluated the effectiveness of an adapted SBAR tool for face to face handover situations within a community nursing care setting.

Objectives
(1) Adaptation of the SBAR communication tool to the community nursing care setting
(2) Implementation of the adapted SBAR tool into daily face to face handover situations
(3) Evaluate the effectiveness of the adapted SBAR tool related to patient safety culture

Methodology
Phase (1): Adaptation of the SBAR tool in December 2013 – Scenarios were developed based on usual practice, patient safety and previous incidents within community nursing setting. These were later used as teaching tools for the adapted SBAR. Phase (2): Implementation of the adapted SBAR tool in January 2014 – the implementation took place in 4 community centres within Hong Kong East Cluster. All community nurses (n = 41) including Advanced Practice Nurses (5) were offered the opportunity to take part in this demonstration intervention. A series of 4 on-site workshops totaling four hours were scheduled for all nurses. The use of real case examples helped to illustrate how SBAR may be implemented and applied within a community nursing setting. Phase (3): A pre-post test design was used to study the
effectiveness based on patient safety

**Result**
Near-miss reporting was tracked on a quarterly basis through AIRS. Data showed the numbers of near-miss report for the one year prior to the implementation of the adapted SBAR: \( n = 0 \) and for the one year following the implementation period: \( n = 16 \) with 14 cases related to wrong prescription and 2 cases related to wrong patient referral). Improvement was seen in safety reporting of near misses within Community Nursing Services of Hong Kong East Cluster. We anticipated that with improved communication and patient safety culture, community nurses would feel encouraged to adapted SBAR communication tool in a community nursing care setting and to report safety issues in an open and comfortable environment.