新界東醫院聯網
NEW TERRITORIES EAST CLUSTER

Implementation of SBAR in NTEC

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Introduction

Communication failure may lead to fatal consequences to patients. As one of the enhancement strategies, Situation/Background/Assessment/Recommendation (SBAR) Model is implemented in the New Territories East Cluster (NTEC).

What is SBAR?

It is an uniform approach for multi-disciplinary communication on patient's conditions and improves both the manner in which information is communicated and how it is received.

Why is COMMUNICATION important?

- The overwhelming majority of adverse events involve communication errors (Leonard, Graham & Bonacum, 2004)
- Communication breakdown is the leading root cause of sentinel event occurrence (JACHO, 2005)

How does SBAR work?

- Allows transfer complete and accurate information to the physicians
- Provides structural and logical information to receiver

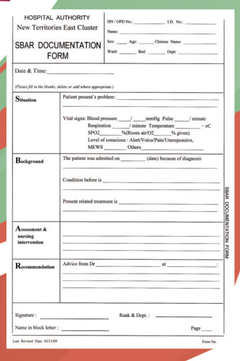
Objectives

- To improve staff communication through SBAR model
- To facilitate documentation of relevant information in medical notes

Implementation

- Staff training on SBAR model was conducted in June 2009
- A documentation form was designed to facilitate smooth communication and accurate documentation
- A pocket size cue card was distributed to each staff
- An A4 laminated cue card was posted in the nurses' station for easy reference.
- The pilot was commenced in September and then extended to some other departments in November 2009
- An evaluation in the form of record review and survey was conducted in December 2009

TOOLS


HOSPITAL AUTHORITY
New Territories East Cluster

SBAR DOCUMENTATION FORM

Date & Time:

(Please fill in the blanks, delete or add where appropriate.)

Situation — Patient present's problem:

Vital signs: Blood pressure ____/____mmHg, Pulse ____/ minute
Respiration ____/ minute, Temperature ____ oC
SPO2: ____%(Room air/O2 ____ % given)
Level of conscious: Alert/Voice/Pain/Unresponsive,
MEWS ____, Others ____

Background — The patient was admitted on ____ (date) because of diagnosis

Condition before is ____

Present related treatment is ____

Assessment & nursing intervention

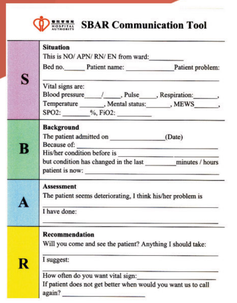
Recommendation — Advice from Dr ____ at ____

Signature : ____ Rank & Dept. : ____

Name in block letter : ____ Page ____

Last Revised Date: 30/11/09 Form No.

SBAR COMMUNICATION SCORE


SBAR Communication Tool

S — **Situation**
This is NO/ APN/ RN/ EN from ward:_____
Bed no. _____ Patient name: _____ Patient problem:
_____
Vital signs are:
Blood pressure _____/_____, Pulse _____, Respiration: _____,
Temperature _____, Mental status: _____, MEWS_____,
SPO2: _____%, FiO2: _____

B — **Background**
The patient admitted on _____(Date)
Because of: _____
His/her condition before is _____
but condition has changed in the last _____minutes / hours
patient is now: _____

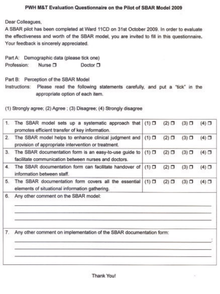
A — **Assessment**
The patient seems deteriorating, I think his/her problem is _____
I have done:
_____

R — **Recommendation**
Will you come and see the patient? Anything I should take:
_____
I suggest:
_____
How often do you want vital sign: _____
If patient does not get better when would you want us to call again? _____

Workflow on Using SBAR Form

Results

- The documentation form was found to be widely used in many cases
- Feedback from 254 staff (247 nurses & 7 doctors) from 14 departments in NTEC
- About 60% staff agreed the model could promote the transfer of key information
- Positive feedback mostly from junior staff


PWH M&T Evaluation Questionnaire on the Pilot of SBAR Model 2009

Dear Colleagues,
A SBAR pilot has been completed at Ward 11CD on 31st October 2009. In order to evaluate the effectiveness and worth of the SBAR model, you are invited to fill in this questionnaire. Your feedback is sincerely appreciated.

Part A: Demographic data (please tick one):
Profession: Nurse ☐ Doctor ☐

Part B: Perception of the SBAR Model:
Instructions: Please read the following statements carefully, and put a "tick" in the appropriate option of each item.

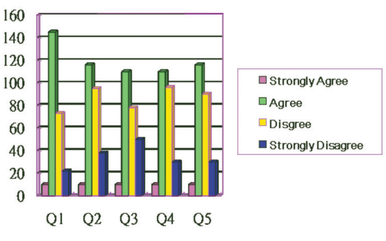
(1) Strongly agree; (2) Agree ; (3) Disagree; (4) Strongly disagree

1. The SBAR model sets up a systematic approach that promotes efficient transfer of key information.	(1) ☐	(2) ☐	(3) ☐	(4) ☐
2. The SBAR model helps to enhance clinical judgment and provision of appropriate intervention or treatment.	(1) ☐	(2) ☐	(3) ☐	(4) ☐
3. The SBAR documentation form is an easy-to-use guide to facilitate communication between nurses and doctors.	(1) ☐	(2) ☐	(3) ☐	(4) ☐
4. The SBAR documentation form can facilitate handover of information between staff.	(1) ☐	(2) ☐	(3) ☐	(4) ☐
5. The SBAR documentation form covers all the essential elements of situational information gathering.	(1) ☐	(2) ☐	(3) ☐	(4) ☐

6. Any other comment on the SBAR model:

7. Any other comment on implementation of the SBAR documentation form:

Thank You!



Conclusion

Results showed that the SBAR model could be widely applicable in many situations and many staff regarded that the model could promote the transfer of key information on patients' condition. However, regarding the tool for documentation, the junior nurses would find it particularly helpful while the experienced ones did not. After the evaluation, the SBAR model was rolled out in the NTEC in January 2010 for communication enhancement while the form is provided as one optional tool that can be used by staff for documentation.

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