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Implementation of SBAR tool in a Rural Hospital

Molly M. Tschetter
South Dakota State University, molly.tschetter2@gmail.com

Implementation of SBAR Tool in a Rural Hospital: Literature Review

BY

Molly M. Tschetter

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This Doctor of Nursing Practice (DNP) Project is approved as a credible and independent investigation by a candidate for the DNP degree and is acceptable for meeting the project requirements for this degree. Acceptance of this DNP Project does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

Brandi Pravecek, DNP, RN, CNP Date
DNP Project Advisor

Leann Horsley, PhD, RN, CHSE, CNE Date
DNP Project Advisor

Melinda Tinkle, PhD, RN, WHNP-BC, FAAN Date
Associate Dean for Academic Programs

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Abstract

Introduction: Patient handovers between healthcare providers during shift change or unit and interfacility transfers are a vulnerable time for inadequate communication. To ensure a handover is concise, healthcare organizations must implement and educate their staff on evidence-based communication tools.

Methods: SBAR is a communication tool commonly used during a handover. SBAR allows for a steady flow of report and a reduction of information missed. When nurses use SBAR, the efficiency of their report improves and handover time is decreased. By decreasing interfacility handover time, patients may be transferred to higher levels of care faster. By receiving more advanced care faster, patient safety may be enhanced.

Gaps: There is a gap in the literature regarding SBAR report to interfacility transfer teams and decreased information is available comparing SBAR to other communication tools.

Recommendations for Practice: Implementation of the SBAR tool during interfacility patient handover may reduce transfer times and improve patient safety. The SBAR template must be customized to meet the needs of those utilizing it. It takes a team effort with solid leadership to implement and sustain the SBAR tool on a nursing unit.

Keywords: SBAR, handover, handover time, efficacy, interfacility

Implementation of SBAR Tool in a Rural Hospital

Healthcare professionals strive to ensure patients continuously receive the best possible care. Unfortunately, this optimal care weakens during patient handover far too often (The Joint Commission, 2017). Patient handover occurs when patient care is transferred from one healthcare professional to another. These transitions are a vulnerable time for insufficient communication (American Psychological Association [APA], 2016). Therefore, The Joint Commission created a National Patient Safety Goal to ensure patient handover is clear and complete. This goal is commonly not met, and poor patient handover continues to be a serious issue in healthcare (The Joint Commission, 2017).

To resolve this issue, communication protocols or tools need to be implemented. In addition, nurses need to be properly trained on the tools to allow them to be confident their report is clear and concise (The Joint Commission, 2017). SBAR (Situation-Background-Assessment-Recommendation) is an evidence-based communication tool commonly used by nurses during patient handover. The tool serves as a guide and provides structure to nurses during this vulnerable time. By utilizing SBAR, the quality and efficacy of nurses' report may increase, as the tool allows for efficient, smooth flow and decreased information missed (Stewart, 2017).

PICOT Question

The purpose of this project was to implement the SBAR tool within a rural Midwest hospital with the intent of strengthening the report between nurses and transfer teams. The PICOT question that guided this quality improvement project was: For emergency, medical-surgical, and intensive care nurses working in a rural Midwest hospital (P), how does the utilization of the SBAR tool during patient handover report to

interfacility transfer teams (I) compared to the current practice of not utilizing a communication tool (C) impact transfer teams' bedside times (O) within a three-month period (T)?

An extensive search of the literature was conducted on the SBAR tool. The databases searched for this literature review included Cochrane Database of Systematic Reviews, CINAHL, PubMed, and Google Scholar. The key terms utilized within the databases were *SBAR, Situation-Background-Assessment-Report, nurse report, handover, handoff, handover time, efficiency, interfacility, transport, rural hospital, patient safety, and communication.* To be included in this project, studies had to focus on SBAR utilized during handover, in inpatient settings, with human subjects, and be conducted within the last six years. Articles concentrating on only SBAR between nurses and providers were excluded from this review, as the focus of this project was the utilization of SBAR during patient handover.

After a systematic review of the literature and evaluation of numerous research articles, 19 studies met inclusion criteria. These 19 articles were appraised using the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Research Appraisal Tool (Appendix B). Permission to utilize the JHNEBP Research Appraisal Tool is included in Appendix C. This tool evaluates studies by determining the level of evidence and quality of research conducted. Levels range from I to V, and quality grades include A, B, or C with IA being the highest level and VC being the lowest level of research (Dang & Dearholt, 2018). Of the 19 research articles appraised, five were level II, 13 were level III, and one was level V. One of the level IIs was given a quality grade of A, and four were given a B. Seven of the level IIIs were given an A, and six were given a B. Lastly,

the one level V was given a B quality rating. An evidence table (Appendix A) displays a summary of the research found within the 19 articles. In addition to the information provided in the 19 articles, recommendations from The Joint Commission, APA, Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), and Controlled Risk Insurance Company (CRICO) were considered for this literature review.

Evidence Findings

Background

The idea of SBAR was brought into the healthcare field by Michael Leonard, M.D. and his colleagues of Kaiser Permanente. Initially, it was utilized for nurse to physician communication to report urgent patient updates and needs (Leonard et al., 2004). TeamSTEPPS, which was developed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense to improve healthcare communication, strongly recommends the utilization of SBAR during these interactions. TeamSTEPPS recommends using SBAR to explain the status of what is happening with a patient (S), what the patient's clinical background includes (B), what the assessment of the patient is (A), and what the recommendation to the receiver entails (R) (AHRQ, 2019).

SBAR is still commonly used during nurse to physician interactions, but as SBAR has grown in popularity, it has become a common template for patient handover as well. SBAR is now recommended for patient handover report by several healthcare corporations including the Institute of Healthcare Improvement and the World Health Organization (WHO) (Institute for Healthcare Improvement, 2018; Shahid & Thomas, 2018). According to the WHO (2007), complications with poor patient handover are an international issue. Therefore, numerous countries have conducted research on the topic

and found the necessity of forming a common language between patient report givers and receivers. The SBAR template is an evidence-based tool designed to improve communication among healthcare providers. What is included within the template will vary based on the unit and the healthcare professionals utilizing the SBAR tool. The SBAR tool must be customized to fit appropriately within the unit to ensure all necessary information is passed along (Shahid & Thomas, 2018). A customized SBAR template is key to improving the quality and efficacy of the tool and bettering communication among the healthcare team during handover (Fabila et al., 2016).

Patient Outcomes

When communication among the healthcare team is poor, medical errors may occur. Medical errors are the third ranked cause of death among Americans. Around 251,000 people in the United States die each year due to healthcare professionals' mistakes. Many times, these mistakes occur due to poor teamwork, insufficient leadership, or inadequate communication (APA, 2016).

Poor patient outcomes are directly related to inadequate communication and handover in healthcare. Between the years of 2009 and 2013 in the United States, 30% of malpractice cases were linked to errors in communication. In addition, 1,744 patients died, and 1.7 billion dollars were spent on malpractice cases due to inadequate communication between healthcare professionals. Of the serious medical errors during those years, 80% involved handover miscommunication. Of the communication failures, 44% occurred in inpatient settings (CRICO, 2015). Poor communication and inadequate handover jeopardize patient safety and lead to a waste of resources and money (Vermeir et al., 2015).

Poor communication skills and language barriers can sometimes be linked to inadequate handover but not always. Errors in communication can arise due to information that is misdirected, overlooked, or never received (CRICO, 2015). Handover is a vulnerable time that often creates an opportunity for errors in communication and results in harmful patient outcomes (Abraham et al., 2015; Kostiuk, 2015; Pokojova & Bartlova, 2018). Ensuring handover is successful is everyone's responsibility. The evidence and tools are available, and healthcare professionals must take advantage of their resources (CRICO, 2015).

Benefits of SBAR

SBAR is an evidence-based tool available to healthcare professionals and should be utilized during patient handover, as the tool focuses on important points and helps decrease pertinent information missed (Nagammal et al., 2016). SBAR acts as a checklist (Stewart, 2017) and provides nurses with a logical sequence of information that needs to be shared (Abela-Dimech & Vuksic, 2018). In addition, SBAR helps nurses recall important information rather than depending on their memory for a complete report (Arumugam et al., 2016). When nurses use SBAR, their confidence in giving report rises, as the tool allows for a steady flow of information (Stewart, 2017).

Nurses play a significant role in communicating patient information, and their report needs to be efficient and of high quality (Abela-Dimech & Vuksic, 2018). Proper education and simulation involving SBAR are effective techniques to improve report efficacy and quality; therefore, the tool should be introduced to nursing students and reiterated to experienced nurses (Kostiuk, 2015; Uhm et al., 2019). Once SBAR becomes

the unit norm, a common report language is formed and givers and receivers of patient report identify information effectively (Stewart, 2017).

Patient information can be easily missed during rushed handovers, such as interfacility transfers. SBAR is an effective tool in these situations (Pokojova & Bartlova, 2018; Wilson et al., 2017), as its use allows nurses to quickly gather their thoughts and follow a checklist (Stewart, 2017). When patients become complex, SBAR can be more challenging to use (Shahid & Thomas, 2018), but it is still favored over other communication tools (Fabila et al., 2016). The SBAR tool can offer numerous benefits, supporting its use during every patient handover (Shahid & Thomas, 2018).

Handover Time and Interfacility Transfer

Interfacility handover has become a very common and crucial aspect of healthcare today. Often, patients are transferred from rural hospitals to larger facilities that provide higher levels of care. Sometimes patients are transferred due to bed availability, but mostly, patients are transferred for specialized treatment, especially for cardiac, neurological, or trauma-related purposes. Due to the severity of patient conditions, high-quality handover report is vital (Sethi & Subramanian, 2014). Once the decision to transfer is made, it is crucial this process occurs as quickly as possible. The prognosis of a critical patient depends on timely intervention (Pham et al., 2017; Sethi & Subramanian, 2014).

Since critical patients require timely intervention (Pham et al., 2017; Sethi & Subramanian, 2014), a reduction in handover time would be to their benefit. SBAR allows for a reduction in handover time, as the tool generates a more efficient report (Cornell et al., 2014; Muller et al., 2018). When nurses utilize SBAR, they spend less

time on non-pertinent information and focus more on key points within the SBAR template (Stewart, 2017). A prospective study of 44 nurses and eight pediatric intensivists evaluated SBAR from the receiver's viewpoint. The receivers of SBAR stated they spent less time looking elsewhere for patient information missed during report. In addition, they reported their patient assessments more often matched the one they received during report, and they had the opportunity to ask questions and clarify information as needed (Fabila et al., 2016). SBAR use by nurses during handover leads to faster transfers (Cornell et al., 2014; Muller et al., 2018), which results in better patient prognoses (Pham et al., 2017; Sethi & Subramanian, 2014).

Nursing

Many nurses have recognized the benefits SBAR offers. Nurses that have utilized SBAR reported it was easy to use (Shahid & Thomas, 2018) and helped them give a more efficient report (Blom et al., 2015). The receivers of SBAR handover appreciated the tool as well and were pleased when a paper-copy of the filled-out template was provided. They felt the tool offered clarity and reduced the amount of information missed (Fabila et al., 2016). Some nurses felt SBAR was time-consuming (Abela-Dimech & Vuksic, 2018), but many enjoyed the tool after becoming familiar with it (Arumugam et al., 2016). Nurses appreciated the tool and reported increased comfort with giving patient report (Chapman, 2016) and an enhanced culture of safety in their workplace (Randmaa et al., 2014).

Gaps in the Literature

Although abundant research is available on SBAR and the culture of safety the tool creates, gaps in the literature exist. No studies focused directly on SBAR report from

nurses to flight teams and none assessed SBAR in rural facilities. Only a few studies evaluated SBAR use during interfacility transfer. In addition, minimal articles compared SBAR to other report tools. Lastly, SBAR sustainability was not widely evaluated.

Recommendations for Practice

The sustainability of communication protocols is important to patient safety. All healthcare professionals should evaluate their communication skills for areas of weakness and continuously work to make improvements. One of the most important skills related to communication is recognizing when important information is not passed on. This must be a team effort, as ensuring that communication is concise is everyone's responsibility (CRICO, 2015).

Ensuring communication is complete and accurate occurs through well-organized, standardized handover (APA, 2016; Arumugam et al., 2016). The SBAR communication tool is an effective tool for ensuring this occurs. SBAR is an evidence-based tool to improve the communication between healthcare professionals. SBAR improves the flow of report (Blom et al., 2015) and decreases pertinent information missed (Fabila et al., 2016; Pokojova & Bartlova, 2018). When nurses have a checklist to guide the handover, their confidence in giving patient report increases. When nurses are confident their report is complete and accurate, patient safety increases (Stewart, 2017). Therefore, the SBAR tool should be utilized during every patient handover (Abela-Dimech & Vuksic, 2018; Blom et al., 2015; Kostiuk, 2015; Pokojova & Bartlova, 2018; Shahid & Thomas, 2018; Stewart, 2017; Uhm et al., 2019)

Since the SBAR tool is effective at improving communication among healthcare professionals, it should be introduced to future nurses during their education programs.

Nursing students should be learning about the tool in didactic, practicing its use in simulation, and utilizing the tool during clinical rotations (Kostiuk, 2015; Vermeir et al., 2015). The SBAR tool should then be carried over throughout their nursing careers. SBAR should become the standard for every nursing unit that requires patient handover report. Due to the vast differences among healthcare floors, the SBAR tool must be customized to fit the needs of the specific unit. By having a unit specific SBAR tool available, the quality and efficacy of handover report may improve (Fabila et al., 2016) and the safety culture may expand (Nagammal et al., 2016).

SBAR can be effective for interfacility transfers. Interfacility transfer can be a busy and vulnerable time (Pokojova & Bartlova, 2018; Wilson et al., 2017). SBAR allows for a more efficient report and reduced handover length (Cornell et al., 2014; Muller et al., 2018). By reducing the handover time during interfacility transfer, patient prognoses can be enhanced (Pham et al., 2017; Sethi & Subramanian, 2014), and the culture of safety may be improved (Randmaa et al., 2014). The key is to sustain that improvement.

The sustainability of the SBAR tool must be a team effort. Leaders must continually encourage the use of SBAR, and staff must take advantage of the communication tool. In addition, leadership must ensure new staff are properly trained on the tool and re-education is offered whenever needed (APA, 2016; Arumugam et al., 2016). Proper training and dedicated staff can ensure the SBAR tool is a nursing unit expectation (Kostiuk, 2015). By making communication a priority, patient safety may benefit. Therefore, communication should be highly accurate and complete during every transition of care. The time and effort spent creating protocols and using tools to improve

communication is less stressful than the time and effort spent defending malpractice cases and coping with the guilt of patient harm that may result from poor communication (CRICO, 2015).

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Appendix A

Evidence Table

Author (s) & Date	Level, Quality	Study Design	Sample/Setting	Intervention	Results	Strengths Weaknesses	Gaps	Recommendations for practice
Abela-Dimech, F., & Vuksic, O. (2018). Improving the practice of handover for psychiatric inpatient nursing staff. *Archives of Psychiatric Nursing*, *32*(5), 729–736.	IIIB	Retrospective Study	Audits of 20 nurses in first phase, 19 nurses in second phase; 17 nurses' opinions evaluated	Compliance of SBAR; nurses' opinion of the tool	SBAR helps capture all important information in nursing report; nurses play an important team role of passing along relevant and crucial patient information; SBAR allows for easy flow of communication; most nurses felt the SBAR tool was	Small sample size; evaluated nurses' opinion of SBAR	Did not look directly at the report receiver's perspective	Nurses are a critical aspect of the healthcare team when it comes to communicating patient information; SBAR allows for easy flow of information and should be utilized routinely

					useful, but some nurses felt SBAR was time-consuming			
Abraham, J., Kannampallil, T.B., Brenner, C., Lopez, K. D., Almoosa, K. F., Patel, B., Patel, V. L. (2015). Characterizing the structure and content of nurse handoffs: A Sequential conversational analysis approach. *Journal of*	IIB	Sequential Conversational Analysis	16-bed medical ICU, 16 intensive care nurses over a two-month period	Evaluation of nurse handover communication through mixed-methods approach; qualitative analysis and statistical data analysis	Patient care transitions are a vulnerable time for communication breakdown; handover should include critical patient treatments	This study did not look directly at SBAR; this study looked at handover from qualitative and quantitative methods	Only looked at an intensive care unit	Handover is a vulnerable time for communication errors and missed patient information

Biomedical Informatics . 59, 76–88.								
Arumugam , Y., Hassan, H., Putra, P., & Irwan, S. (2016). Managing patient progress report through SBAR tool in non-critical areas. *International Journal of Current Innovation Research, 2*(9), 495–503.	IIB	Quasi-Experimental Study	140-bed hospital, 83 nurses	The implementation of SBAR and its influence on reliability of patient report	The handover process needs to be well-organized and standardized; effective communication is essential to prevent patient harm; proper training and creating an SBAR culture leads to better report and increased use of the SBAR tool;	This study looked at several benefits of the SBAR tool; this study only evaluated the afternoon nursing shift and failed to incorporate the morning and night shift	This study did not evaluate the sustainability of the SBAR tool	Handover needs to be well-organized to prevent patient harm; proper training on SBAR and the creation of an SBAR culture leads to better adherence; SBAR is better than recall from memory regarding patient report; SBAR is more appreciated after usage

					continuous feedback and reminders from leadership increases the usage of the SBAR tool; SBAR is more effective in helping nurses remember important patient information rather than recall from their memory; after utilizing SBAR and realizing its benefits and uniqueness, nurses			

					learn to appreciate the tool			
Blom, L., Petersson, P., Hagell, P., & Westergren, A. (2015). *International Journal of Caring Sciences*, *8*(3), 530–535.	IIIA	Quantitative, descriptive, comparative pre- and post-intervention design.	Study performed on two surgical and one orthopedic unit; survey filled out by 116 healthcare professionals before the intervention and 86 after	Implementation of SBAR communication tool to be utilized during shift-to-shift report and report to physicians	Nurses felt the SBAR tool provided them with more structure and allowed their report to be more efficient; nurses felt the tool was very helpful; instilling change will take a team effort	Opinion based surveys, 30 healthcare professionals did not fill out post-survey, evaluated the opinions of healthcare professionals using the SBAR tool	Did not look at report from nurses to interfacility transfer teams	SBAR should be implemented for nurse-to-nurse report to add structure and improve their communication; SBAR improves the quality and efficiency of handover report
Chapman, Y. L. (2016). Nurse satisfaction with information	IIIB	Descriptive, non-randomized study	44 nurses filled out surveys	Implementation of SBAR tool to be utilized during bedside report	Most nurses were either highly satisfied or satisfied with the tool; senior	Small sample size, convenience sampling; evaluated nurses' perception of	Only looked at satisfaction and comfort in	Nurses are often satisfied with the SBAR tool, as it increases their comfort with giving nursing report. Senior nurses were

technology enhanced bedside handoff. *MEDSURG Nursing*, *25*(5), 313–318					nurses were very satisfied with the SBAR tool	the SBAR tool	giving report	satisfied with the SBAR tool more than new nurses
Cornell, P., Townsend Gervis, M., Yates, L., & Vardaman, J. M. (2014). Impact of SBAR on nurse shift reports and staff rounding. *MEDSURG Nursing*, *23*(5), 334–342	IIB	Quasi-experimental Study	48-bed medical surgical unit; 36 nurses; 51 observations	Shift report time; interdisciplinary rounds	Communication among healthcare providers must occur in a timely manner; report time was decreased; SBAR allowed for a more focused and efficient report	Looked at report time; small sample size	Did not look at interfacility transfers	SBAR should be utilized during handover, as it allows for a more focused and efficient report; decreases handover time
Fabila, T. S., Hee, H. I., Sultana, R., Assam,	IIIB	Prospective Interventional Study	16 bed children's intensive care unit; eight	This study compared their current handover	The new SBAR tool was greatly favored;	This study compared an old handover process to	This study did not look at	SBAR is favored over other report handover methods; SBAR offers more

P. N., Kiew, A., & Chan, Y. H. (2016). Improving postoperative handover from anesthetists to non-anesthetists in a children's intensive care unit: The receiver's perception. *Singapore Medical Journal*, *57*(5), 242–253.			pediatric intensivists and 44 nurses participated	process to the implementation of a new SBAR handover process	recipients felt the tool offered more clarity and reduced the amount of information missed; receivers felt the SBAR tool was the most important communication tool to meet demands; customization of the SBAR tool is necessary to meet unit's needs and improve handover; receivers of report	the implementation of SBAR; small sample size	patient outcomes	clarity of report and reduces information missed; unit's should customize their SBAR tool to meet their specific needs, as this improves handover report; specific SBAR components are better than generalized sections; receivers of SBAR handover appreciate the tool and appreciated the paper copy of the SBAR tool for later reference

					spent less time looking elsewhere for information, had time to clarify and ask questions, and reported their patient assessment matched the assessment provided to them during SBAR report			
Kostiuk, S. (2015). Can learning the ISBARR framework help to	IIIB	Mixed-methods pre- and posttest design	28 nursing students participated in the study	Nursing students were educated on the use of the SBAR tool and then asked	Education on how to utilize the SBAR tool increased the confidence, decreased	Looked specifically at the confidence of those utilizing the SBAR tool,	Did not included experienced nurses	The SBAR tool increases the confidence of those utilizing it, as it allows them to feel more competent with giving report;

address nursing students' perceived anxiety and confidence levels associated with handover reports? *Journal of Nursing Education*, *54*(10), 583–587				to utilize the tool in a case scenario	the anxiety, and improved self-efficacy of those utilizing it; confidence in giving report was increased with utilized of the SBAR tool	small sample size		SBAR education should be implemented for nursing students and new nurses
Muller, M., Jürgens, J., Redaèlli, M., Klingberg, K., Hautz, W. E., & Stock, S. (2018). Impact of the communication and patient hand-off	IIIB	Systematic Review	11 articles included; Pubmed, EMBASE, CINAHL, Cochrane Library and PsycINFO were searched	The impact of SBAR on at least one patient outcome	SBAR improves handover quality and increases positive patient outcomes; SBAR reduced handover length	Reviewed multiple articles, but not all articles were of high quality	Did not focus on interfacility transfers	SBAR should be utilized to improve handover quality and patient outcomes; SBAR reduced handover length

tool SBAR on patient safety: A systematic review. *BMJ Open*, *8*(8), e022202. https://doi.org/10.1136/bmjopen-2018-022202								
Nagammal, S., Nashwan, A. J., Nair, S., & Susmitha, A. (2016). Nurses' perceptions regarding using the SBAR tool for handoff communication in a tertiary cancer	IIIA	A cross-sectional descriptive study	117 nurses, large oncology unit	The implementation of SBAR tool; evaluation of structure of handover and perception of the tool	The utilization of SBAR decreased handover time, allowed for a more logical sequence of information, nurses felt the tool reduced the amount of communica	Only looked at an oncology unit; looked at the opinions of those utilizing the tool	Did not look at the SBAR tool and rates of patient outcomes	SBAR should be utilized as it allows for decreased report time when the nurse is efficient in utilizing the tool; the tool allows for a logical sequence of information, keeps the nurses focused on the report, and reduces the information missed, which leads to a higher quality of report

center in Qatar. *Journal of Nursing Education and Practice, 7*(4), 103-110.					tion errors; nurses were satisfied with the tool and recommended it for other units			and safer care provided
Pham, H., Puckett, Y., & Dissanaike, S. (2017). Faster on-scene times associated with decreased mortality in Helicopter Emergency Medical Services (HEMS) transported trauma patients. *Trauma surgery & acute care*	IIIA	Retrospective Study	288 trauma patients	Mortality defined as death during initial hospital admission compared to on-scene/transfer time	Longer on scene/transfer times of trauma patients lead to increased patient mortality	Focused on trauma patients; looked at patient safety regarding transfer times	Did not focus on SBAR	Decreased transfer time improves outcomes in trauma patients

open, *2*(1), e000122. https://doi.org/10.1136/tsaco-2017-000122								
Pokojová, R., & Bártlová, S. (2018). Effective communication and sharing information at clinical handovers. *Central European Journal of Nursing & Midwifery*, *9*(4), 947–955.	IIIA	Systematic Review	28 articles included; PubMed, Science Direct, Embase and Google Scholar were searched	Ensuring continuity of care and patient safety at nurse handovers	Poor handover creates an opportunity for adverse events; incorrect information /missed information can lead to misinterpretation of patient report; the quality of handover is improved with mnemonics and checklists; SBAR is recommend	This study evaluated other report methods/mnemonics as well as SBAR	This study did not compare SBAR to other methods	Poor handover leads to adverse events due to missed information and misinterpretation of the information by the receiver; SBAR is recommended during patient transfers due to the quick necessity of care transfer

					ed during shift handovers and patient transfers			
Randmaa, M., Mårtensson, G., Leo Swenne, C., & Engström, M. (2014). SBAR improves communication and safety climate and decreases incident reports due to communication errors in an anesthetic clinic: A prospective interventio	IIB	Quasi-Experimental	Anesthetic clinics in two hospitals; 230 pre-implementation and 169 post implementation questionnaires filled out	Implementation of the SBAR tool	Increased staff perception of communication and safety culture; decreased incident reports related to communication	Evaluated staff perception and incident reports related to communication errors; loss of participates in post-intervention group	This study focused on the memory of the receiver of handover report	SBAR can improve communication between healthcare professionals, increase the culture of safety, and reduce incident reports related to communication SBAR improves the quality and efficacy of handover report

n study. *BMJ open*, *4*(1), e004268.								
Sethi, D., & Subramanian, S. (2014). When place and time matter: How to conduct safe inter-hospital transfer of patients. Saudi Journal of Anesthesia, 8(1), 104–113. Retrieved from https://doi.org/10.4103/1658-354X.125964	IIIB	Systematic Review	76 articles included; Google Scholar and Medline were searched	Inter-hospital transfer of patients	Critical patients' prognoses depend on timely interventions; when critical patients receive proper care faster, better outcomes are more likely; high quality inter-hospital handover report is very important and impacts patient safety	This review did not look directly at SBAR but reviewed many articles	This review did not look directly at SBAR during handover	Fast inter-hospital transfers and timely interventions can positively impact patient safety

Shahid, S., & Thomas, S. (2018). Situation, background, assessment, recommendation (SBAR) communication tool for handoff in health care – A narrative review. *Safety in Health, 4*(7).	IIIA	Systematic Review	12 articles	Evaluation of the SBAR tool in patient handovers; how SBAR compares to other communication tools	SBAR provides a logical and concise format to present medical information; easy to use; can be challenging to use with complex patients; culture change may be needed to sustain the use of the SBAR tool	Not all the articles focused on nurse-to-nurse handover	This study did not look at interfacility transfer	A culture change may be needed to sustain the SBAR tool; once sustained, the SBAR tool can offer numerous benefits to a unit; SBAR can be modified and generated based on clinical setting and its needs
Stewart, K. R. (2017). SBAR, communication, and patient safety: An integrated literature review.	IIIA	Systematic Review	26 articles included; PubMed, CINAHL, and Cochrane data bases were searched	Implementation of SBAR and its effect on communication among healthcare professionals and the	SBAR creates a common language and organized format to share pertinent information	High level of evidence, focused on how SBAR improves communication, which can increase the confidence of	Did not look at quantitative data regarding patient safety	SBAR should be utilized as a framework/checklist for nurses as they give report as it decreases pertinent information missed and reduces time spent

MEDSURG Nursing, *26*(5), 297–305.				safety of patients	; SBAR allows for an organized format, which increases the confidence of the nurse giving report; allows the individuals giving report to gather their thoughts; consistence use of SBAR allows the report giver and receive to identify important information missed; SBAR acts as a checklist;	the report given		on non-pertinent information; SBAR should become mandatory, as it allows for the giver and receiver to identify information missed more easily when he or she is well-trained on the report format

					use of SBAR consistentl y decreases report time and increases efficiency; decreases time spent on non-pertinent information ; SBAR promotes a culture of safety			
Uhm, J.-Y., Ko, Y., & Kim, S. (2019). Implement ation of an SBAR communica tion program based on experientia l learning	IIA	Quasi-experimental	81 participants, 41 in control group, 40 in experimental group; pediatric nursing practicum in University in South Korea	Experiment al group was educated on the SBAR technique and was involved in case scenarios; control group received	Experiment al group were significantl y more efficient with the SBAR tool; SBAR improved the students' confidence	The study only involved nursing students rather than nurses; Quasi-experimental	This study only looked at nursin g studen ts	Education and case scenarios regarding SBAR improve report givers' competency with SBAR; SBAR improves confidence with handover

theory in a pediatric nursing practicum: A quasi-experimental study. *Nurse Education Today*, *80*, 78–84				usual practicum education	in handover			
Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., Hallaert, G., Van Daele, S., Buylaert, W., & Vogelaers, D. (2015). Communication in	IIIA	Systematic Review	69 articles included in the review; PubMed, Web of Science, and The Cochrane Library were reviewed	Evaluation of the literature with the intent of identifying connections among patient handover, nurse communication, and patient safety	Poor communication negatively impacts patients' safety, inefficient use of resources, and loss of money; structured communication is needed to ensure all necessary information is included	This study evaluated communication in nursing; this study did not focus on SBAR	This study evaluated over 4,500 articles; it did not focus on SBAR but did evaluate health care communication	Proper healthcare communication should be taught in all healthcare programs, as effective communication is essential to providing safe, efficient patient care

healthcare: A narrative review of the literature and practical recommendations. *International Journal of Clinical Practice*, *69*(11), 1257–1267. doi: 10.1111/ijcp.12686					and time is not wasted; the importance of quality communication should be well-taught in undergraduate and graduate healthcare programs		thoroughly	
Wilson, D., Kochar, A., Whyte-Lewis, A., Whyte, H., & Lee, K.-S. (2017). *Air Medical Journal*, 36(4), 182–187.	VB	Quality Improvement project	94 calls before, 93 calls after	SBAR training program	SBAR training is effective at improving communication for interfacility transfers	Interfacility transfer report; study focused on pediatric and neonatal transfers	Interfacility transfer of adult patients	SBAR should be utilized for interfacility transfers

Appendix B

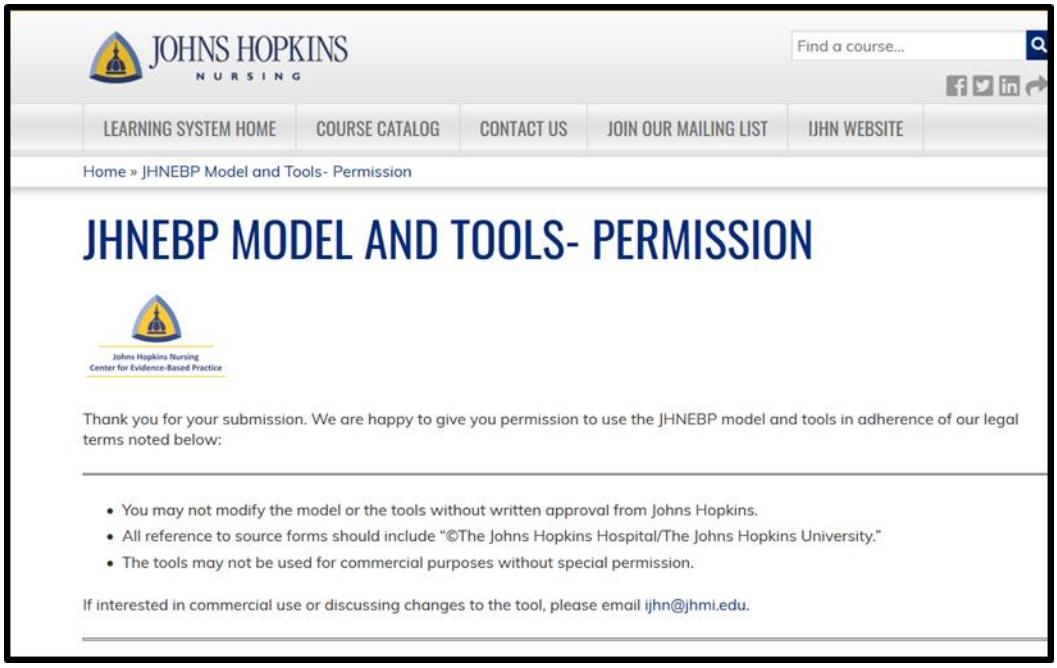
Johns Hopkins Nursing Evidence-Based Practice Quality Guide

Evidence Levels	Quality Ratings
Level I Experimental study, randomized controlled trial (RCT) Explanatory mixed method design that includes only a level I quaNtitative study Systematic review of RCTs, with or without meta-analysis **Level II** Quasi-experimental study Explanatory mixed method design that includes only a level II quaNtitative study Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis **Level III** Nonexperimental study Systematic review of a combination of RCTs, quasi-experimental and nonexperimental studies, or nonexperimental studies only, with or without meta-analysis Exploratory, convergent, or multiphasic mixed methods studies Explanatory mixed method design that includes only a level III quaNtitative study QuaLitative study Meta-synthesis	**QuaNtitative Studies** **A High quality**: Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence. **B Good quality**: Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence. **C Low quality or major flaws**: Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn. **QuaLitative Studies** No commonly agreed-on principles exist for judging the quality of quaLitative studies. It is a subjective process based on the extent to which study data contributes to synthesis and how much information is known about the researchers' efforts to meet the appraisal criteria. *For meta-synthesis, there is preliminary agreement that quality assessments of individual studies should be made before synthesis to screen out poor-quality studies*[1]. **A/B High/Good quality** is used for single studies and meta-syntheses[2]. The report discusses efforts to enhance or evaluate the quality of the data and the overall inquiry in sufficient detail; and it describes the specific techniques used to enhance the quality of the inquiry. Evidence of some or all of the following is found in the report: • Transparency: Describes how information was documented to justify decisions, how data were reviewed by others, and how themes and categories were formulated. • Diligence: Reads and rereads data to check interpretations; seeks opportunity to find multiple sources to corroborate evidence. • Verification: The process of checking, confirming, and ensuring methodologic coherence. • Self-reflection and scrutiny: Being continuously aware of how a researcher's experiences, background, or prejudices might shape and bias analysis and interpretations. • Participant-driven inquiry: Participants shape the scope and breadth of questions; analysis and interpretation give voice to those who participated. • Insightful interpretation: Data and knowledge are linked in meaningful ways to relevant literature. **C Low quality** studies contribute little to the overall review of findings and have few, if any, of the features listed for high/good quality.

Evidence Levels	Quality Ratings
Level IV Opinion of respected authorities and/or nationally recognized expert committees or consensus panels based on scientific evidence Includes: • Clinical practice guidelines • Consensus panels/position statements	**A High quality**: Material officially sponsored by a professional, public, or private organization or a government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise clearly evident; developed or revised within the past five years **B Good quality**: Material officially sponsored by a professional, public, or private organization or a government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise clearly evident; developed or revised within the past five years **C Low quality or major flaws**: Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the past five years
Level V Based on experiential and nonresearch evidence Includes: • Integrative reviews • Literature reviews • Quality improvement, program, or financial evaluation • Case reports • Opinion of nationally recognized expert(s) based on experiential evidence	**Organizational Experience (quality improvement, program or financial evaluation)** **A High quality**: Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial, or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence **B Good quality**: Clear aims and objectives; consistent results in a single setting; formal quality improvement, financial, or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence **C Low quality or major flaws**: Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial, or program evaluation methods; recommendations cannot be made **Integrative Review, Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference** **A High quality**: Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field **B Good quality**: Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions **C Low quality or major flaws**: Expertise is not discernable or is dubious; conclusions cannot be drawn

Appendix C

Consent for Use of Evidence Based Model and Evidence Rating Table



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Implementation of SBAR Tool in a Rural Hospital: Methodology

BY

Molly M. Tschetter

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Abstract

Background: Patient handover is a vulnerable time for poor communication and the loss of pertinent information. SBAR is an evidence-based communication tool that enhances the quality and efficacy of nurses' report by acting as a checklist to ensure pertinent information is communicated. By utilizing SBAR during report, handover length is reduced, and patients may be transferred more efficiently.

Methods: Nurses working in a rural Midwest hospital were educated on SBAR and asked to utilize the SBAR tool during their report to transfer teams prior to interfacility transfer. Transfer teams' bedside times throughout the project's three-month implementation period were compared to bedside times three-months prior when no SBAR was utilized.

Results: Descriptive statistics evaluated demographic data. The Mann-Whitney U statistical test was used to analyze the quantitative data, which was the difference in bedside times pre- and post-SBAR implementation. Statistical significance was not found, but clinical significance was likely present.

Discussion: The main barrier to this project was nurses' resistance to change. Some nurses may have improved their patient report skills through using SBAR.

Implications for Practice: Even though statistical significance was not found, some patients may have reached a higher level of care faster through reduced handover time.

Keywords: SBAR, handover, handover time, efficacy, interfacility

Implementation of SBAR Tool in a Rural Hospital

Accurate and complete communication among healthcare providers enhances patient safety (Controlled Risk Insurance Company [CRICO], 2015). Healthcare providers consistently make safety a priority, but handover is a vulnerable time for incomplete and poor communication (American Psychological Association [APA], 2016). The Situation-Background-Assessment-Recommendation (SBAR) communication tool is commonly used during handover to prevent the loss of pertinent information and improve patient safety (Blom et al., 2015). The purpose of this Doctor of Nursing Practice (DNP) Project was to implement the SBAR tool in a rural Midwest hospital with the intent of strengthening the report between nurses and interfacility transfer teams.

Significance of the Problem

Report between nurses and interfacility transfer teams is often rushed due to patients requiring time-dependent care (Pokojova & Bartlova, 2018; Wilson et al., 2017). Rushed patient report leads to pertinent information being missed. When pertinent information is missed, poor patient outcomes occur, lawsuits arise, and significant dollars are lost (The Joint Commission, 2017). In the United States, between the years of 2009 to 2013, 1,744 patients died, and 1.7 billion dollars were lost due to inadequate healthcare provider communication. In addition, 80% of the severe medical errors that occurred during those years were the result of poor patient handovers (CRICO, 2015).

To prevent severe medical errors related to patient handover, an adequate communication tool, such as SBAR, should be utilized (Arumugam et al., 2016). SBAR acts as a checklist and provides nurses structure, which allows for a steady flow of report (Blom et al., 2015) and a reduction in information being missed (Fabila et al., 2016;

Pokojova & Bartlova, 2018). When nurses utilize SBAR, their report efficiency improves and handover time is reduced (Cornell et al., 2014; Muller et al., 2018). Reduced handover time is important, as faster care transitions lead to better patient prognoses (Pham et al., 2017; Sethi & Subramanian, 2014).

PICOT Question

This DNP Project addressed the following PICOT question: For emergency, medical-surgical, and intensive care nurses working in a rural Midwest hospital, (P) how does the utilization of the SBAR tool during patient handover report to interfacility transfer teams (I) compared to the current practice of not utilizing a communication tool (C) impact transfer teams' bedside times (O) within a three-month period (T)?

Evidence Findings

SBAR is an evidence-based communication tool utilized to improve patient handover (Nagammal et al., 2016). Handover during interfacility transfer is a vulnerable time for error (Pokojova & Bartlova, 2018; Wilson et al., 2017). SBAR improves this vulnerable transition of care by ensuring essential knowledge is passed along and non-pertinent information is not (Stewart, 2017). By focusing on the SBAR template and only reporting pertinent patient information, handover time can be reduced (Cornell et al., 2014; Muller et al., 2018). When handover time is decreased, patients receive critical interventions faster and positive outcomes are more likely to occur (Pham et al., 2017; Sethi & Subramanian, 2014).

Many nurses have found the SBAR tool to be helpful during handover. They feel it improves their report skills (Blom et al., 2015) and enhances patient safety on their unit (Randmaa et al., 2014). The receivers of SBAR report were also in favor of the template

and appreciated when a paper-copy of the completed SBAR form was given to them (Fabila et al., 2016). The SBAR template must be adjusted to fit the needs of the unit utilizing it to ensure necessary information is being communicated (Fabila et al., 2016). Many benefits of SBAR exist, and healthcare providers involved in patient handovers should use it consistently (Stewart, 2017).

Recommendations for Practice

SBAR is a common communication template utilized throughout medicine, and healthcare providers should be trained on the tool early and re-educated often (Kostiuk, 2015; Vermeir et al., 2015). Since the tool increases the report giver's confidence by allowing for a steady flow of report and decreased information being omitted, SBAR should be utilized during every patient handover (Abela-Dimech & Vuksic, 2018; Blom et al., 2015; Kostiuk, 2015; Pokojova & Bartlova, 2018; Stewart, 2017). Interfacility patient handover is a vulnerable time; and therefore, it is recommended nurses utilize the tool while giving report to transfer teams (Pokojova & Bartlova, 2018). SBAR has numerous advantages, and the utilization of SBAR must be a team effort to ensure its sustainability on a healthcare unit (Arumugam et al., 2016).

Gaps in the Literature

Extensive research has been conducted on the SBAR tool, but gaps in the literature are still present. Only a few studies that focus on SBAR report during interfacility transfer exist, and no research has evaluated the use of the tool between nurses and flight teams. No studies were conducted in rural facilities, and only a few compared SBAR to other evidence-based communication tools. Lastly, not many articles examined SBAR sustainability.

Methods

Change Theory

The leaders involved in this project were guided by Lewin's Change Theory. Lewin's Change Theory is composed of the stages of unfreezing, moving, and refreezing. In addition, this theory emphasizes change is not a clear-cut process, and leaders may have to adjust their techniques for accomplishing their goals (Lewin, 1951). The DNP Project Coordinator had to be prepared to face challenges and barriers related to the implementation of the SBAR tool. Lewin's Change Theory was an effective guide to help the leaders of this project accomplish their goals and improve the safety of the patients involved.

Evidence-Based Practice Model

The Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP) acted as a guide throughout this project as the SBAR tool was implemented. This updated model includes the three elements of inquiry, practice, and learning. Inquiry entails asking questions to solve issues. The practice element advocates for routine evidence-based practice implementation, and the learning component involves the continuous obtainment of knowledge (Dang & Dearholt, 2018). See Appendix C for a visual representation of and permission to use the JHNEBP model.

Theoretical Framework

The Transitions Theory is a framework created by Afaf Meleis and was utilized throughout this project. This theory emphasizes patients go through transitions when their health status changes, which places them at risk for vulnerability. Those changes are unique to everyone, and nurses have the capability to help those patients through those

transitions (Meleis et al., 2000). Many of the patients transferred from the rural Midwest hospital this project took place at were transferred due to a health status change. Often, there was a transfer of care to a larger facility with specialized care (Sethi & Subramanian, 2014). The nurses involved in this project utilized the SBAR template to ensure adequate information was passed along to allow for a smoother transition of care.

Setting

This project took place in a rural Midwest hospital's medical-surgical unit, intensive care unit (ICU), and emergency department (ED). The town's population in which this hospital is located is approximately 14,000 people. The town has two ambulances and a fixed-wing aircraft available to transfer patients, weather permitting. Due to the high number of patients transferred via air from this rural hospital, this fixed-wing aircraft base was built at the town's airport. This allows the flight team to arrive at the facility within 15 minutes. Prior to this, a patient air-transfer would require a flight team from a much larger city to fly to the town's airport and be transferred to the hospital by the local ambulance to pick up their patient. By having a fixed-wing aircraft located in the same town as this rural hospital, patients are usually transferred to appropriate facilities much faster. When the local fixed-wing crew is unavailable, flight teams from larger hospitals fill in. When patients are less critical or ground travel is safer, the local ambulance service is asked to transfer (R. Masteller, personal communication, February 28, 2020).

The flight team includes a paramedic and nurse, and the ambulances consist of a paramedic and emergency medical technician. The hospital has an 18-bed medical-surgical floor, six-bed ICU, and eight-bed ED. Hospital protocol is to have two medical-

surgical, one ICU, and two ED nurses in house at all times. If the census is low, these nurses will float to other units within the hospital (R. Masteller, personal communication, February 28, 2020).

The patients admitted or transferred from this rural Midwest hospital vary greatly in age and diagnosis. The pediatric patients are frequently admitted or transferred for respiratory illnesses. The adult population is hospitalized or transferred for a variety of reasons, such as post-operative complications or endocrine, cardiac, and respiratory diagnoses. Among the three units, an average of 25 patients are transferred per month. Most of the transfers are via aircraft, but less critical patients are transferred by ground ambulance (R. Masteller, personal communication, February 28, 2020).

Sample

The population of interest for this project was medical-surgical, ICU, and ED nurses and house supervisors. The house supervisors are registered nurses and oversee all three units throughout their shift. All project participants were recruited through convenience sampling. All nurses work 12-hour shifts with shift changes occurring at seven in the morning and seven in the evening. The medical-surgical and ICU nurses often float between the two units, but the ED nurses typically stay in their home unit due to only two being scheduled each shift. There are over 40 nurses among the three units that work full-time, part-time, or pro re nata (PRN).

Intervention Tool

The SBAR template is an evidence-based communication tool commonly used during patient handover. SBAR acts as a checklist and provides structure to nurses during handover report (Stewart, 2017). When nurses utilize SBAR, their handover may become

more efficient and their report time may decrease (Cornell et al., 2014; Muller et al., 2018). The tool is composed of four sections: situation, background, assessment, and recommendation. In the situation section, the nurses often start their report by reviewing the current patient circumstance. The background section is for pertinent history and clinical background. The assessment section entails vital signs, patient condition, and medications given. Lastly, the recommendation portion leaves room for additional information and allows the report giver to voice their opinion (Leonard et al., 2004).

The opinions of facility managers and transfer company leaders were taken into consideration during the generation of the SBAR template for this project. The DNP Project Coordinator received permission from a Midwest ambulance company to utilize and adjust their SBAR template (Appendix D). Numerous nurses, paramedics, and healthcare leaders reviewed and offered suggestions for improvement to the original template. After many revisions, the final SBAR template for this project was developed (Appendix E).

Procedure

The purpose of this project was to implement the SBAR tool in a rural Midwest hospital with the intention of decreasing handover time as measured by transfer teams' bedside times. Bedside times of transfer teams are closely tracked by dispatch personnel, and the DNP Project Coordinator obtained permission to access this information (Appendix F). The project occurred over a three-month period, as this was enough time to allow nurses to be exposed to the SBAR tool.

The DNP Project Coordinator's original plan was to educate staff about this project at in-person quarterly meetings, but due to a worldwide pandemic, no large group

meetings took place at the facility during that time. Therefore, email was utilized to inform the staff of the project's purpose and educate them on the proper use of the SBAR tool. The DNP Project Coordinator emailed nurses at the Midwest hospital requesting their participation in the quality improvement project (QIP). Attached to the email was a copy of the SBAR template and a document explaining the proper usage of the SBAR tool (Appendix G). The nurses were asked to review the attachments and ask the DNP Project Coordinator questions as needed. They were then asked to sign a formal document acknowledging their understanding of the project and proper usage of the SBAR tool (Appendix H). In addition, a blank demographic questionnaire pertaining to nurses was stapled to the formal statement form (Appendix I). Nurses were asked to fill this out once prior to the start of the implementation period.

The blank formal statements and demographic questionnaires were located at the three nurses' stations. Staff were asked to separate the two documents, place their signed formal statement in one manila envelope, and place their completed demographic questionnaire in another. This allowed for confidentiality of the demographic data to be maintained. Once the nurses were properly educated on the tool and had filled out the paperwork, they were asked to utilize the SBAR tool during verbal report and supply a paper-copy of the completed template to transfer teams. The SBAR tool was utilized to give verbal report to the interfacility transfer team, not the nurse at the receiving facility.

Since patients are often transferred emergently, the nurses have far less time to prepare their patient for air transfer and obtain the appropriate information for report. If the transfer is going to be via ground, the preparation time is also limited due to the proximity of the ambulance station (R. Masteller, personal communication, February 28,

2020). Therefore, the SBAR templates were easily accessible within the nurses' stations. Nurses were asked to fill out the SBAR form, look up, and write down any pertinent information in the patient's chart they were unsure of. Once the transfer team arrived, nurses utilized the SBAR tool while they gave verbal report. Their report was not finished until all components of the completed SBAR tool were passed along.

Once the nurses were finished with the template and the patient had left the facility, they were asked to put the completed forms in patients' paper charts to be scanned into the facility's charting system. At the end of the three-month implementation period, the DNP Project Coordinator reviewed the charts of patients that were transferred in search of completed SBAR templates. The number of templates filled out was compared to the total number of transfers throughout the implementation period.

Ethical Considerations

Ethical considerations were addressed initially and monitored throughout the DNP Project. The outcome of this project, interfacility transfer teams' bedside times, was tracked outside patients' charts. Therefore, patient charts were only accessed for the purpose of searching for the completed SBAR templates. The facility in which this project took place did not have an Institutional Review Board (IRB), but the facility approval for this project is included in Appendix B. Permission from the university's IRB is included in Appendix A.

Results

Demographics

Descriptive statistics analyzed the demographic data of the sample. Forty-one nurses completed the demographic data survey. This data included years of overall

nursing experience, years of rural nursing experience, employment status, typical shift worked, estimated average patient transfers per month, home unit, and experience with SBAR training. Of the nurses included in this project (*N* = 41), 37% had less than five years of nursing experience, 66% worked full-time, and all but seven nurses received SBAR training during their formal nursing program (See Table 1).

Table 1

Demographic Data (N = 41)

Home Unit		
	Medical-Surgical	29%
	Intensive Care Unit	20%
	Emergency Department	32%
	Other (House Supervisor)	19%
Overall Years of Experience		
	Less than five	37%
	Between five and ten	29%
	Between eleven and fifteen	12%
	Between sixteen and thirty	17%
	Over thirty	2%
Typical Shift		
	Straight Days	44%
	Straight Nights	39%
	Rotating	17%
Employment Status		
	Full-time	66%
	Part-Time/PRN	32%
	Travel Nurse Contract	2%
Years of Rural Experience		
	Five years or less	49%
Patient Transfers/Month		
	Zero	7%
	One or two	39%
	Three or Four	22%
	Five or more	32%
Previous SBAR Training		
	Yes	83%
	No	17%

Clinical Outcome

The measured statistical outcome of this project was interfacility transfer teams' bedside times. Bedside times started and stopped when transfer teams arrived in and departed the ambulance bay. It is important to note this project was not measuring the time of report between the nurse at the initial facility and the nurse at the receiving facility. All air and ground transfer teams' bedside times were included in this QIP. Bedside times were gathered three months prior to and throughout the implementation period of this project. The bedside times three months prior to the start of the project were compared to the bedside times throughout the implementation period through statistical analysis.

Statistical Testing Results

The statistical analysis included the utilization of the Mann-Whitney U test. This test compares two independent groups. Since bedside times were not linked to certain nurses, the two groups had to be considered independent from one another. After the data were gathered, the distribution was evaluated through analyzing box plots and histograms within Statistical Package for Social Services (SPSS). The data did not have a normal distribution, which led to the utilization of the Mann-Whitney U test. The Mann-Whitney U test compares the distributions of the two groups by comparing the ranks of the two samples after all data points within the two samples are grouped together (Kim, 2014). A significance level of 0.05 was utilized, and a *p*-value of 0.250 was found. This meant there was not a significant difference between the two groups. Therefore, implementation of SBAR did not have a statistically significant impact on bedside transfer times.

Lastly, the number of templates utilized and placed in the SBAR boxes were counted and compared to the total number of patient transfers during the implementation period. A total of 88 patients were transferred via air or ground throughout the project's three-month implementation period, and the SBAR tool was utilized approximately 45% of the time to guide handover report.

Discussion

Barriers

It is worth noting the barriers that existed throughout this QIP. First and likely the biggest barrier to the implementation of the SBAR tool was the change the nurses were asked to participate in. Filling out the SBAR tool takes time, which is often limited during interfacility patient transfers. With the local transfer teams arriving promptly, some nurses found it challenging to make the SBAR tool a priority. Even though the use of the SBAR tool has the potential to decrease the amount of time the transfer team spends at the facility, it is one more task added to an already busy workload (O. Lewis, personal communication, August 25, 2020). Secondly, this project was conducted during a worldwide pandemic. Coronavirus Disease 2019 (COVID-19) may have impacted the number of interfacility transfers, which may have resulted in an inaccurate representation of this facility's monthly average of interfacility transfers. Also, due to no large group meetings at the start of the project, the DNP Project Coordinator had to educate staff about the SBAR tool via email. The nurses receive numerous emails normally, but the number of emails had grown substantially due to COVID-19. Therefore, education via email was likely not as effective as an in-person meeting could have been (R. Masteller, personal communication, August 25, 2020).

Statistical and Clinical Significance

Even though this QIP did not result in statistical significance, clinical significance likely existed. The DNP Project Coordinator received positive feedback from numerous nurses throughout the implementation period. One nurse found the tool to be very helpful in giving an organized and complete handover report. Another nurse stated, “I use the SBAR sheet to give patient report to both the transfer team and receiving facility nurse” (M. Blumer, personal communication, August 25, 2020). Lastly, the hospital management staff decided to initiate a project to implement a SBAR communication tool to utilize when clinic patients get directly admitted to the hospital. The DNP Project Coordinator was asked to offer suggestions and advice for the clinic SBAR project.

Implications for Practice

Impact

The implementation of this project positively impacted the rural Midwest hospital in which the project took place. The use of the SBAR tool may have reduced handover time during some transfers, as it may have helped some nurses give a more efficient report. By reducing some handover times, some patients may have reached a higher level of care faster. In addition, this project initiated another SBAR project at this facility and will hopefully continue to initiate positive changes in the future (M. Pickner, personal communication, August 1, 2020). Lastly, the electronic health record (EHR) utilized at this facility does not have a built in SBAR tool (R. Masteller, personal communication, February 28, 2019). This project could be the foundation for a new standard and the addition of a SBAR template within the EHR to be utilized during handover report.

Limitations

The limitations of this project must be noted. First, the hospital this project took place at was a rural facility. Therefore, a small sample size was utilized, and specific transfers were not linked to individual nurses. Second, this project was conducted over a three-month period. There was a chance not every nurse was exposed to the SBAR tool, especially if they were part-time or PRN. Third, filling out the SBAR template is one more task added to an already busy shift. Due to the time aspect of filling out the template, there was no way to ensure every nurse was utilizing the SBAR tool during every transfer report. This was especially true during transfers when the patient was in critical condition. Fourth, not every nurse may have remembered to place the completed form in the patient's paper chart to be scanned. This may have altered the reliability of the actual template usage percentage. Lastly, the data obtainment method of bedside times could have posed as a barrier, as other factors play a role in handover length.

Recommendations for Further Projects

The comparison of the SBAR tool to other handover templates may be beneficial. In addition, more projects conducted in rural facilities evaluating patient morbidity and mortality are recommended. Interfacility transfer report is not well-evaluated; therefore, more projects looking at this encounter may be beneficial. Lastly, evaluating a correlation between SBAR and patient safety may be valuable.

Sustainability

The sustainability of the SBAR tool in this hospital was addressed by acknowledging the barriers from the beginning. In this hospital, nurses are tired of having to make changes and having their workloads increased (R. Masteller, personal

communication, February 28, 2019). The DNP Project Coordinator addressed this early in the project and showed how SBAR is an evidence-based approach to decrease information missed and improve patient safety (Stewart, 2017). After completion of this DNP Project, the DNP Project Coordinator's goal was to have SBAR usage become a facility norm. The DNP Project Coordinator communicated with management to have SBAR training incorporated into nurse orientation. Lastly, the DNP Project Coordinator encouraged the reiteration of the benefits of the SBAR tool at safety huddle meetings.

Conclusion

In conclusion, the SBAR template is an evidence-based tool to improve patient handover report (Stewart, 2017). The goal of this DNP Project was to reduce interfacility patient handover length through the implementation of the SBAR tool. Interfacility transfer teams' bedside times were measured, and the project was conducted over a three-month period. Even though this project did not demonstrate statistical significance, it likely offered many clinical gains. The SBAR template offers numerous benefits, and the DNP Project Coordinator hoped the participants of the project appreciated the tool upon completion. In addition, the sustainability of the SBAR tool would be ideal, as it is an effective method to strengthen communication and improve patient safety (Stewart, 2017).

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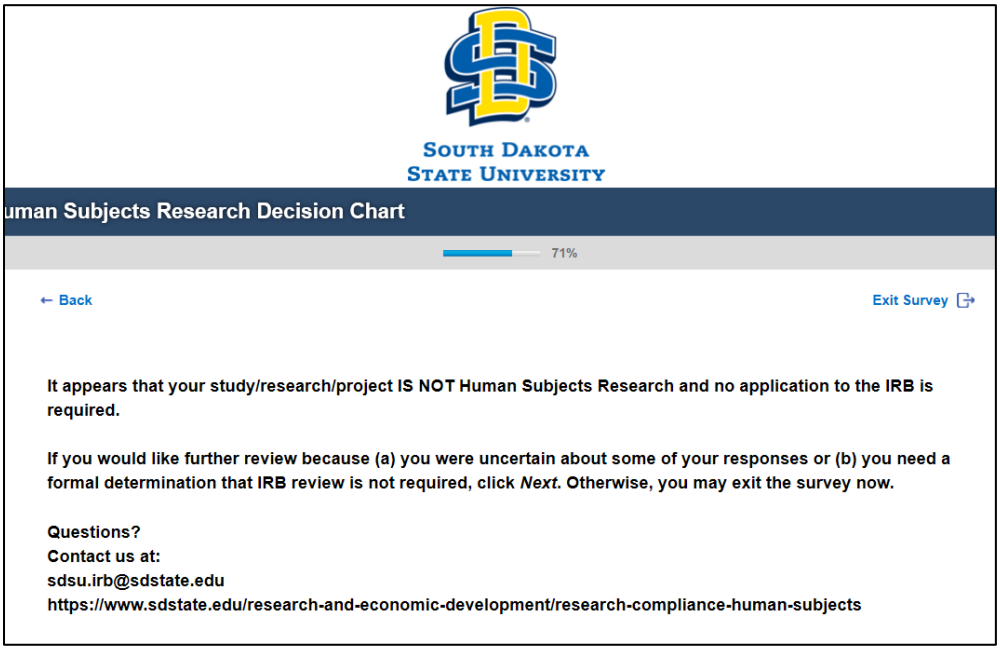
Appendix A

University IRB Approval



Appendix B

Facility Approval

DNP Project Site Agreement

Date: 04/28/2020

This letter is in support of **South Dakota State University** graduate student **Molly Tschetter's** DNP Project entitled **Implementation of SBAR Tool in a Rural Hospital** at [redacted] **Hospital**. This project will involve the implementation of a communication tool to be utilized by nurses during patient handover to interfacility transfer teams. Bedside times of interfacility transfer teams will be obtained three months prior to and throughout the three-month implementation period of the quality improvement project. Bedside times will start and stop when transport teams arrive at and depart the ambulance bay.

We look forward to the results of the project.

Connie Pierce, RN Date

DNP Project Stakeholder Agreement

I agree to serve as the DNP Project Stakeholder to the DNP student named in this agreement.

Name of Stakeholder:

Connie Pierce

Signature of Stakeholder

Name of DNP student:

Molly Tschetter

Signature of DNP student:

Date

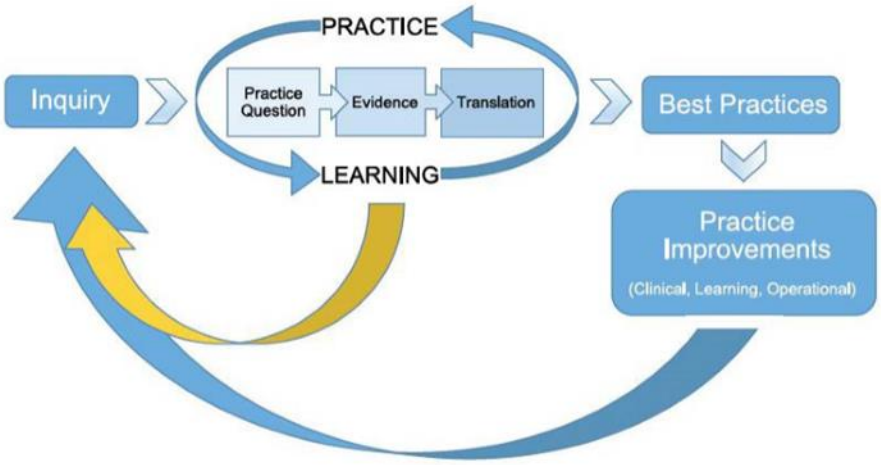
04/23/2020

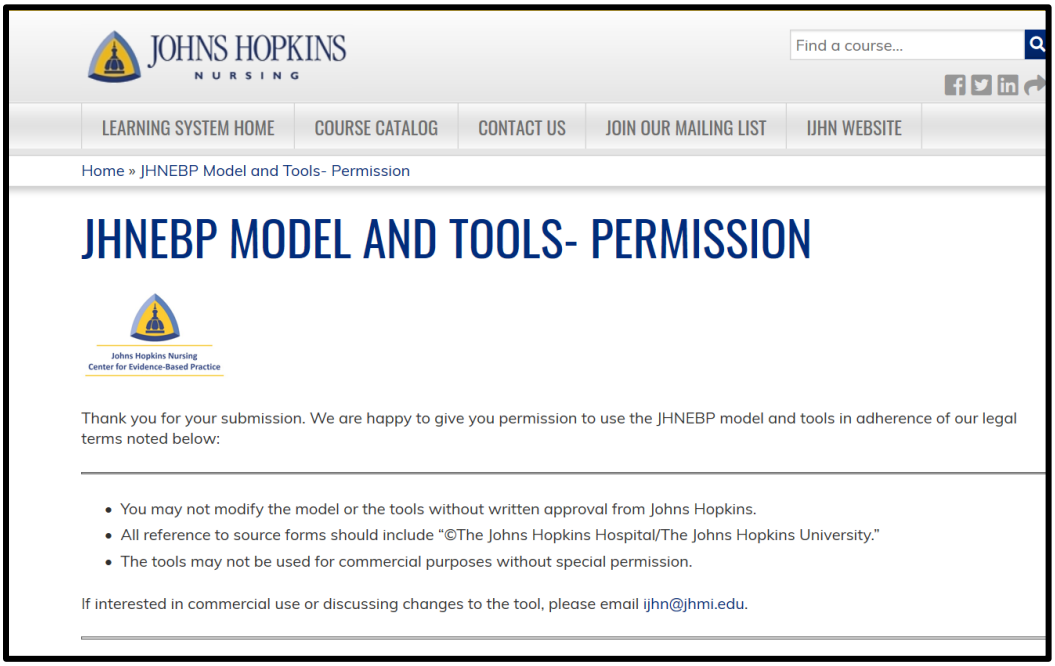
Approved by Graduate Faculty 5.10.19

Appendix C

The Johns Hopkins Nursing Evidence-Based Practice Model is shown below (Johns Hopkins Medicine, 2017).

Used/reprinted with permission from the Johns Hopkins Hospital/ Johns Hopkins University School of Nursing, copyright 2017





Appendix D

SBAR Template Permission

Hi Molly,

Attached is a word document with our inter-facility documentation for our critical care team. Please remove any verbiage and contact information for [redacted]. The rest of the information is yours to modify and change to fit your needs.

Have a good weekend!

Nick Romenesko EMT-P, BAS
Systems Director

Appendix E

SBAR Tool

Patient Sticker:

S *Situation*	**Code Status:** *Full DNR DNI* **Weight:** _____*kg* **Height:** _____*in.* **Allergies:** _____ **Diagnosis:** _____ **Isolation/Precautions:** _____
B *Background*	**Pertinent History:** _____ **Pertinent Home Medication(s):** _____ **Procedures/Events leading to transfer:** _____ _____ □ **ABG** *pH*_____ *PCO₂* ____ *HCO₃* _____ *PaO₂* _____ *if on FiO2* ____*%*  **Other Pertinent Labs:** _____ **RSI:** *Time* _____ *Sedation* _____ *ETT: Size* _____*/ @ Teeth* ____ *cm* **Ventilator** *BiPAP CPAP Mode* _____ **Vent:** *FiO₂* _____ *PEEP* _____ *PIP* _____ *RR* _____ *Vt* _____ *IPAP/EPAP* _____ *I:E* _____
A *Assessment*	**Vascular Access(es):**_____ **IV Fluid(s)/Medication** (s) *Name/Dose/Rate/Time* □ _____ □ _____ □ _____ □ _____ □ _____ **Blood Products:** _____ unit(s) **Type:** _____ **Start time:** _____ **Drains:** *NG/OG Chest Tube Foley Other*_____
R *Recommendation*	**Receiving Facility:** _____**Accepting Provider:** _____ **Family Contact:** _____ **Comments/Additional Info:** _____ _____ _____ _____ _____ _____ _____ _____

Appendix F

Interfacility Transfer Teams' Bedside Times Permission

Kandace,

Thank you for your time and help with my project. Once my project starts, I will let you know. My plan is to compare bedside times throughout my three-month implementation period to bedside times three months prior to the start of my project. I could get all the times (6 months worth) at the end of my project or will take them whenever is easiest for you. With your permission I will move forward with my project. Thanks again!

Molly Tschetter

Sounds good, Molly. Once you have a start date, let me know the dates of the prior 3-month period. Researching will take some time, so I'd like to work on it when I get a chance. I can tell you the three biggest causes of (expensive) delays are:

1. Patient Certification Statement incomplete or conflicts with patient's current condition. This document is required by CMS and most insurance companies to be an accurate legal statement of why this patient needs to be transported by ambulance and no other means of transport would be appropriate at this time.

   Examples:

   PCS indicates that patient must go by ambulance because they need IV antibiotics during transport, but patient only has a saline lock and no antibiotics running.

   PCS says patient is bedridden, but we arrive to wait as patient finishes toileting and walks out of bathroom.

Staff must document what they find upon arrival. If insurance company refuses to pay due to conflicting PCS or insufficient documentation as to need for ambulance, the patient or facility may end up getting billed for the entire amount. As patient advocates, we try to prevent this and often requires us to spend extra time prior to transport.

2. Patient/paperwork not ready.
   a. When LDT request is made, it is usually "Patient is Ready Now." Per ASM request, we schedule pickup 1 hour from request. The process could move along if all necessary paperwork is complete and ready to go, including any DNR/MOLST/POLST.

3. Rider has "run home to pack a few things" or "gone to get something to eat" and should be back soon. As we've refused riders during the pandemic, this probably won't rear its ugly head during your study time period.

Good luck, Molly! I look forward working together for the betterment of the patient.

Molly,

I have no other questions. Given the times will be blinded, and not linkable to a specific agency, I will get you the times you'd like when our project gets to that point.

Good luck!

Molly-

You have permission to our times and information for the regards of your project.

Kind Regards,

Anna Vanden Bosch RN, MSN, CFRN | Director of Clinical Operations-Careflight

Appendix G

Request for Participation and Educational Tool

Hello Everyone!

I apologize for another email in your already long list of updates!

I am currently working on a project for school and would love/really appreciate your help. When I was trying to come up with a topic for a project, the idea of a written communication tool to utilize during report to interfacility transfer teams was brought to my attention. Therefore, I have worked with Anna Vanden Bosch from [redacted] and flight team members from [redacted] to generate a SBAR communication tool that meets their transfer teams' needs.

I very much understand how busy it can get with transferring a patient out; and therefore, we tried to make it as simple as possible.

If you do decide to participate in my project, please review the two attachments to this email. One is a blank template of the SBAR tool we created, and the other is a VERY short educational document on the tool. Please let me know if you have any questions!

I placed a stack of two-page packets on MedSurg, ICU, and ED that I would really appreciate you filling out once you have reviewed the attachments.

1. A statement saying you have reviewed the attachments
2. A short demographic questionnaire (please leave your name off)

Once you have filled the two documents out, please separate them and place them in the separate manila envelopes (just to maintain confidentiality).

Lastly, we would like to keep track of how many SBAR templates get filled out. If you could please put the filled-out templates in the patients' charts with the EMTALA forms, we would really appreciate it.

This form will be utilized for all air and ground interfacility transfers. My project will officially start next Monday (July 13th).

I know you already have a very busy workload, and I really appreciate your time if you do decide to participate. Thank you!

Also, I have brought a couple bags of candy for each unit. Please enjoy! 😊

Molly

SBAR

- SBAR stands for Situation-Background-Assessment-Recommendation.
- SBAR is an evidence-based communication tool to improve patient handover report.
- Fun fact: Those trained to intubate utilize patient height to ensure proper intubation.

S *Situation*	**Code Status:** *Full DNR DNI* **Weight:** _____*kg* **Height:** _____*in.* **Allergies:** _____ **Diagnosis:** _____ **Isolation/Precautions:** _____

- Not all parts of the SBAR tool will pertain to your patient (labs, ventilator settings, etc.). Leave those parts blank.

B *Background*	**Pertinent History:** _____ **Pertinent Home Medication(s):** _____ **Procedures/Events leading to transfer:** _____ _____ □ **ABG** *pH*_____ *PCO_2* ____ *HCO_3* _____ *PaO_2* _____ *if on FiO2* ____*%*  **Other Pertinent Labs:** _____ **RSI:** ***Time*** _____ ***Sedation*** _____ ***ETT***: *Size* _____/ *@ Teeth* ____ *cm* **Ventilator** *BiPAP CPAP Mode* _____ **Vent:** *FiO_2* _____ *PEEP* _____ *PIP* _____ *RR* _____ *Vt* _____ *IPAP/EPAP* _____ *I:E* _____

A	**IV Fluid(s)/Medication (s)** ***Name/Dose/Rate/Time*** ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____ **Blood Products:** _____ unit(s) **Type:** _____ **Start time:** _____

● Transfer teams really want to know what medications you gave, how much you gave, and when you gave those medications. This saves transfer teams a lot of time when they do not have to look that information up in the computer. In addition, it prevents medication errors when transfer teams do not have access to that information ([redacted], lack of internet in the air).

R ***Recommendation***	**Family Contact:** _____ **Comments/Additional Info:** _____ _____ _____ _____ _____ _____ _____ _____

● Many patients have family members that want to be updated by transfer teams.

● Utilize the extra room for whatever you feel is pertinent (more medications given) or leave it for transfer teams to make notes.

● Transfer teams would love a copy of the completed SBAR tool. This saves them time by not having to take their own notes.

● If a patient is in critical condition, it may be helpful to take the SBAR form into the patient's room initially instead of trying to fill the template out right before the transfer team arrives.

Appendix H

Statement of Understanding

Statement of Understanding

I have reviewed the documents related to the quality improvement project: **Implementation of SBAR Tool in a Rural Hospital.** I understand the intent of the project and have no further questions.

_____

Printed Name

_____

Signed Name Date

Appendix I

Demographic Questionnaire

Demographic Questionnaire

1. How long have you been a nurse?
    1. 0-5 years
    2. 6-10 years
    3. 11-15 years
    4. 16-20 years
    5. 21-25 years
    6. 26-30
    7. More than 30 years

2. How long have you been a nurse in a facility this size or smaller?
    1. 0-5 years
    2. 6-10 years
    3. 11-15 years
    4. 16-20 years
    5. 21-25 years
    6. 26-30
    7. More than 30 years

3. What is your typical shift?
    1. Straight days
    2. Straight nights
    3. Rotating

4. What is your employment status?
    1. Full-time
    2. Part-time/PRN
    3. Travel nurse contract

5. What is your home unit?
    1. Medical-Surgical
    2. Intensive Care Unit
    3. Emergency Department
    4. Other (house supervisor, float nurse)

6. How many patients (on average) would you say you transfer a month? This is both ground and air transfers (excluding law enforcement). This involves you giving the transfer team patient report.
    1. 0
    2. 1
    3. 2
    4. 3
    5. 4
    6. 5 or more

7. Did you receive training on SBAR during your formal nursing educational program?
    1. Yes
    2. No