



# SBAR PROCESS

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*July 2012*



## SBAR HAND-OFF TRIAL

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- ❖ The goal is to standardize the current hand-off process, housewide, and improve communication among all healthcare providers.

## WHY IS HAND-OFF SO IMPORTANT?

❖ JCAHO studies estimate that 80% of serious medical errors involve miscommunication during the hand-off between medical providers.

Reference: Joint Commission for Transforming Healthcare



# Measuring A Successful Hand-off Between Clinicians: Sender/Receiver

## Expectations Out of Balance

- The expectation of the Receiver is to get the critical information needed in order to safely care for the patient.
- The expectation of the Sender is to be able to communicate the critical information to the Receiver in a timely manner.
- However, there is a disconnect between the critical information the Receiver actually receives versus the critical information the Receiver actually needs to care for the patient.
- Receivers experienced less successful hand-offs than Senders.\*

**Sender Comments:**  
"Too many delays"  
"Receiver did not call back"  
"Receiver too busy to take report"



**Receiver Comments:**  
"No hand-off occurred"  
"Information is incomplete"  
"No opportunity to discuss hand-off with sender"

\*Statistically significant, P value = .001

# ACHIEVING BALANCE: SBAR HAND-OFF IMPLEMENTATION

- ❖ Ticket to Ride – eliminated as of August 21 (except ED-ED and Same Day)
  - Found to be ineffective due to poor face-face interaction
- ❖ Ticket to Ride will be replaced with the Rounds Report
  - Print at time of transfer
- ❖ Sending Nurse will document (on Rounds Report):
  - Orientation/LOC
  - Rhythm
  - Restraints
  - His/Her Phone #
- ❖ Utilize *NEW* Cerner “Patient Transfer” PowerForm



# ACHIEVING BALANCE: SBAR HAND-OFF DOCUMENTATION

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## Charting for SBAR Hand-Off

**NEW Patient Transfer PowerForm**—Transfer between nursing units (i.e. Emergency Room and nursing Unit, PACU to nursing unit, ICU to Step-down or Medical/Surgical Unit, or Nursing Unit to Nursing Unit)

**Transfer/Not in Room (Sending/receiving RN without full report)**—Transfer between nursing unit and procedure/test area (i.e. Nursing Unit to Radiology, Heart Lab, or Nuclear testing)

**Transfer Outside Facility** – Transfer from Aultman to another Facility (i.e.- Emergency Room to Akron Children's, Heart Lab to Cleveland Clinic)



Pt. Transfer - TEST, AARON

✓ [Disk Icon] [No Icon] [Pencil Icon] [Eraser Icon] [Up Arrow] [Down Arrow] [Calendar Icon] [List Icon]

**\*Performed on:** 07/25/2012 [Dropdown] 1142 [Dropdown]

Type of Transfer	Type of Transfer		
Intrahospital Transfer			
Transfer - Not in Room			
Transfer - Outside Facility			
Vital Signs			
Cardiac Rhythm			
Provider Notification			

Intrahospital

☐ Yes

Not in Room

☐ Yes

Outside Facility

☐ Yes

# INTRAHOSPITAL TRANSFER SECTION WITHIN TRANSFER POWERFORM

Intrahospital Transfer - TEST, AARON

## Intrahospital Transfer

**Transfer Reason**

☒ Change in patient condition  
☐ Physician order  
☐ Rapid response  
☐ Code blue  
☐ Other:

**Transferring Physician**

**Accepting Physician**

**Date, Time Physician Accepted**

no pm power -- -- -- --

**Notified of Transfer**

☐ Spouse  
☐ Daughter  
☐ Son  
☐ Mother  
☐ Father  
☐ Sister

☐ Brother  
☐ Grandmother  
☐ Grandfather  
☐ Legal guardian  
☐ Durable power of attorney for health care  
☐ Other:

**Transfer Refusal**

☐ Patient refuses transfer  
☐ Patient's legal representative refuses transfer  
☐ Other:

**Receiving Unit**

☐ Admitting  
☐ CCU  
☐ CVSD  
☐ CVSI  
☐ ER  
☐ LDRP  
☐ Main 5

☐ Main 6N  
☐ ME3E  
☐ ME4E  
☐ ME4N  
☐ ME4S  
☐ ME5E  
☐ ME5N

☐ ME5S  
☐ ME6E  
☐ ME6N  
☐ ME6S  
☐ MICU  
☐ SICU  
☐ Cyprus

☐ Hawthorn  
☐ Willow  
☐ Palliative Care

**Transport via**

☐ Ambulatory  
☐ Bed  
☐ Cart  
☐ Crib  
☐ Isolette  
☐ Wheelchair  
☐ With family

☐ with nurse  
☐ with nurse and monitor  
☐ with resp therapist  
☐ with staff member  
☐ Other:

**Nurse Receiving Report**

**Date, Time Nurse Received Report**

no pm power -- -- -- --

**Nurse Giving Report Contact Number**



# TRANSFER/NOT IN ROOM WITHIN TRANSFER POWERFORM

Transfer - Not in Room - TEST, AARON

Transfer / Not in Room

**Out of Room**

☐ Sent to  
☐ Went to  
☐ Remains in  
☐ Returned from

**Current Location**

☐ Cafeteria  
☐ CT Scan  
☐ Dialysis  
☐ ECT  
☐ EEG  
☐ EMG  
☐ Gift shop  
☐ Heart Cath Lab  
☐ LDA  
☐ Minor Surgery  
☐ MRI  
☐ Nuclear Medicine  
☐ PACU  
☐ Pulmonary Function  
☐ Radiation Oncology  
☐ Special Procedures  
☐ Stress testing  
☐ Surgery  
☐ Ultrasound  
☐ Vascular Lab  
☐ Wound Care Center  
☐ X-Ray  
☐ Other:

**Transport via**

☐ Ambulatory  
☐ Bed  
☐ Cart  
☐ Crib  
☐ Isolette  
☐ Wheelchair  
☐ With family  
☐ with nurse  
☐ with nurse and monitor  
☐ with resp therapist  
☐ with staff member  
☐ Other:

**Transfer**

☐ Transfer from  
☐ Transfer to

**Transfer Reason**

☐ Change in patient condition  
☐ Physician order  
☐ Rapid response  
☐ Code blue  
☐ Other:

**Nursing Unit**

☐ Admitting  
☐ CCU  
☐ CVSD  
☐ CVSI  
☐ ER  
☐ LDRP  
☐ Main 5  
☐ Main 6N  
☐ ME3E  
☐ ME4E  
☐ ME4N  
☐ ME4S  
☐ ME5E  
☐ ME5N  
☐ ME5S  
☐ ME6E  
☐ ME6N  
☐ ME6S  
☐ MICU  
☐ SICU  
☐ Cyprus  
☐ Hawthorn  
☐ Willow  
☐ Palliative Care  
☐ Other:

## ACHIEVING BALANCE: EXPECTATIONS OF THE SENDER

1. Call Report
2. Document interaction with receiving unit on NEW “Patient Transfer PowerForm”
  1. Sending and Receiving RN will access the form from the ad-hoc folder
  2. PACU / Same Day will continue to document SBAR in SurgiNet
3. Make courtesy telephone call to receiving unit/directly before transfer (except PACU-Same Day and Same Day-PACU)
4. Place call light on upon arrival to unit—wait for receiving nurse to enter room
5. Stay in room until receiving nurse places patient on monitor (if applicable). Note: Patient to remain on transport monitor until receiving nurse places patient on their unit monitor.
6. Provide updates as needed (using rounds report) including, but not limited, to the following:
  1. Code Status
  2. Orientation/LOC
  3. Rhythm

## ACHIEVING BALANCE: EXPECTATAIONS OF THE RECIEVER

1. Respond promptly to the senders call light notification
2. Place patient on monitor and verify w/ central station (as applicable)
3. Document in real time upon arrival to unit on “Patient Transfer” or “Transfer/Not in Room PowerForm

### RN Expectations:

- ❖ Face-face interaction required between sending **staff member** and receiving RN
- ❖ The person whom **first** enters the room assumes care of the patient ...until report is given to the appropriate caregiver





## ACHIEVING BALANCE: ADDITIONAL ITEMS

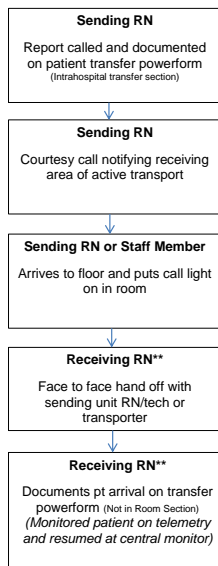
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- ❖ Vital signs must be completed within 30 minutes prior to transfer and within 30 minutes of arrival to unit
- ❖ Courtesy calls will be made before patient arrives to nursing unit
- ❖ Face-Face communication between sender and receiver is expected
- ❖ Prompt response to call light is expected upon arrival to nursing unit
- ❖ Monitored patients-Receiving RN must ensure monitoring is resumed at central station
- ❖ Documentation of SBAR should be completed by the sender and receiver on the appropriate Cerner power forms or in SurgiNet

# SBAR PROCESS-ALGORITHM

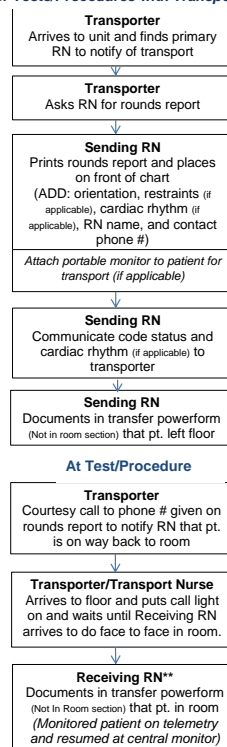


## For Admissions/Transfers



**\*\* If the Receiving RN is not the Primary RN for the patient, it is the responsibility of the Receiving RN to notify the Primary RN of the transfer.**

## For Tests/Procedures with Transporter



# SBAR PROCESS-SUMMARY

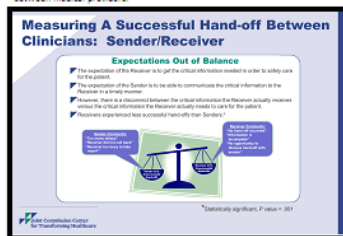
## SBAR: Process Improvement Event

Start Date: July 31, 2012

- The goal is to standardize the current hand-off process, housewide and improve communication among all healthcare providers

### Why is Hand-off SO Important?

- JCAHO studies estimate that 80% of serious medical errors involve miscommunication during the hand-off between medical providers.



### What you need to know/do:

- Elimination of Transfer Hand Off sheet and Ticket-to-Ride
- Rounds report printed directly before patient leaves floor. Write in patient orientation, restraints if applicable, cardiac rhythm if applicable, RN name, and contact #.
- Courtesy calls will be made before patients arrive to floor (new admit, transfers, and returning from test/procedure)
- Call light turned on in patient room on arrival
- Wait for face-to-face encounter with RN
  - If patient is heart monitored, both transporter and RN accompanying patient are to wait at bedside until face-to-face encounter occurs and patient is placed back on heart monitor.
- Remember vital signs needs to be complete within 30 minutes of transfer and on arrival to unit.

Questions: Notify Clinical Unit Director Kelly Uilly – Administrative Champion or Laurie Clark – Patient Safety Officer





# SBAR HAND-OFF TRIAL

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*Questions?*

*Notify Clinical Unit Director*