“Hand-off Communication”

SBAR

When the care of a patient is transferred from one caregiver to another for any period of time, communication must take place between the caregivers to ensure caregivers are knowledgeable about the patient.

- Examples:
  - **Change of shift**
  - **Leaving unit for lunch or meetings**
  - **Transferring patient from one unit to another unit**
  - **Patient going to and from departments for surgery or testing**

- Hand-off information includes, but is not limited to:
  - Up-to-date information re: care, treatment, and services
  - Current condition
  - Recent or anticipated changes

- Hand-off communication provides opportunity to ask questions among caregivers

- **SBAR** technique has been adopted by PinnacleHealth:
  - The purpose is to help the health care worker gather the information needed and organize it into a format for communicating patient information or a question to another health care worker.

  - **S** – Situation
  - **B** – Background
  - **A** – Assessment
  - **R** – Recommendation

SBAR:

S = Situation
INCLUDE:

- Your name and location
- Patient name and location
- The problem or concern you are talking about
- Vital signs may be a component of the situation (Problems with vital signs may be the current situation)
- The duration of the problem
- The severity of the situation or the level of urgency

THINK:

What is going on that prompted you to communicate?
What is the situation you are calling about or talking about?

TIP:

Always be sure to express the level of urgency by stating the most serious problem first and stating your immediate need. It should take 8- 12 seconds and grab the listener's attention.

B = Background
INCLUDE:

- Date of admission
- Admitting diagnosis
- Code status
- Pertinent medical history
- Medications
- Pertinent treatment to date
- Baseline status
- Vital signs, if not part of the situation
- Labs with date, time and results of previous tests

THINK:

What background information is relevant to this situation?

TIP:

Avoid ambiguous terms and slang. Use specific data such as BP is 150/90 versus BP is high. Briefly state only the relevant background information

A = Assessment
TRY:

- "The problem is…"
  - (a knife wound to the chest, pre-term labor, a temperature of 104 with a wound that looks infected, a broken arm, uncontrolled postoperative pain)
- "I think the problem may be…"
  - (neurological, a stroke, gynecological, pelvic inflammatory disease)
- "I don't know what the problem is but…"
  - (the patient is deteriorating, something is wrong)

THINK:
What is your assessment of the situation?
TIP:
The assessment in SBAR refers to the clinician's assessment or analysis of the situation. It does not refer to the physical assessment traditionally associated with the word.

R = Recommendation
INCLUDE:

- Verify any critical information sent or received
- Review the history if necessary
- Seek clarification
- Ask and allow questions
- Read or repeat back critical test results

THINK:
What is your recommendation or what do you want?
In what timeframe should it be done?
Did I answer any questions?
Did I ask questions to clarify?

TIP:
Your recommendation may or may not be accepted, but it is expected and will be respected as a starting point to discuss solutions.

S	**SITUATION** **I am calling about** (patient name and location) **The patient's code status is** (code status) **The problem I'm calling about is** _____ I am afraid the patient is going to arrest. **I have just assessed the patient personally:** **Vital signs are:** Blood pressure ____/____, Pulse____, Respiration____Temperature____ **I am concerned about the:** Blood pressure because it is over 180 or less than 90 or 30 mmHg below usual Pulse because it is over 130 or less than 40 Respiration because it is less than 8 or over 32 Temperature because it is less than 35 or over 40
B	**BACKGROUND** **The patient's mental status is:** Alert and oriented to person, place, and time Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose, Eyes closed. Not responding to stimulation **The skin is:** Warm and dry / Diaphoretic Pale / Extremities are cold Mottled / Extremities are warm **The patient is not or is on oxygen.** The patient has been on ____(l/min.) or % oxygen for ____minutes (hours) The oximeter is reading ____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**ASSESSMENT** **This is what I think the problem is:** (say what you think is the problem) **The problem seems to be** cardiac infection neurologic respiratory _____ **I am not sure what the problem is but the patient is deteriorating.** **The patient seems to be unstable and may get worse; we need to do something**
R	**RECOMMENDATION** **I suggest or request that you** (say what you would like to see done) Transfer the patient to critical care. Come to see the patient at this time. Talk to the patient or family about code status. Ask for a consultant to see the patient now. **Are any tests needed:** Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others? **If a change in treatment is ordered, then ask:** How often do you want vital signs? How long do you expect this problem will last? If the patient does not get better, when would you want us to call again?