“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.
**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

**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.

**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

**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?