Communication (SBAR)

Care transitions are complex and high-risk moments for patient safety (CMPA, 2021, RNAO, 2014). Effective communication between care providers is essential during care transitions.

Information Transfer is the act of passing along relevant details regarding a patient from one care provider to another. An example of information transfer is the student providing a case update on a patient to their nurse preceptor. Transfer of Accountability (TOA) is the exchange, process, and act of turning over responsibility for some or all aspects of a patient's care from one care provider to another. TOA includes Information Transfer. TOA is also often referred to as giving report or handover.

At St. Joe's we use SBAR as a tool to transfer information between clinicians. SBAR is an acronym, which stands for Situation, Background, Assessment, and Recommendation.

S	Situation	Give a clear, succinct overview of the pertinent issues
B	Background	Briefly state the relevant history
A	Assessment	Provide a summary of the facts and give your best assessment
R	Recommendation	What actions are you asking for? **and/or** What actions do you recommend?

When should we use SBAR?

SBAR should be used to transfer information between clinicians, and should be used to transfer of accountability between healthcare providers at various transition points:

- At shift handover
- Interdepartmental transfers
- When consulting a colleague (i.e. NP, Physician, Nurse, Social Worker, Pharmacist, OT/PT, RD, SLP, etc.)
- When providing temporary relief for clinicians leaving the unit/ area i.e. break coverage
- When a patient leaves and returns from the unit/area where they are primarily receiving care.
- Transfers to an external facility

What do I need to remember when using SBAR?

It is important for both clinicians to have access to the patient's record when transferring information. For example, in areas that uses electronic documentation, both clinicians should be accessing the patient's electronic patient record (SCM) and reviewing all active orders, critical findings, outstanding orders, etc. The following information is required for nurse to nurse TOA:

- Patient's full name
- Age or birth date
- Diagnosis/ procedures
- Isolation status and type of isolation (even if the patient is *not* on isolation)
- Cardiopulmonary Resuscitations Status (even if Full Code)
- Allergies
- Mental Health Form status (yes or no) & whether the patient has an observer (yes or no)
- Any relevant alerts and safety concerns
- Current Condition and any recent or anticipated changes concerns
- Outstanding items for follow-up
- Clinical test results, treatments as relevant
- Client goals as relevant