Implementation of a Situation, Background, Assessment, Recommendation (SBAR) Patient Handoff Tool in the Electronic Medical Record (EMR)

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Time: 11:30 a.m. to 12:15 p.m.
Place: Rm 2 – Seton

Abstract
Purpose and Problem: Handoffs that are poorly conducted are implicated in 80% of preventable adverse events in healthcare facilities. Within a Pediatric Rehabilitation Facility in Maryland Heights, Missouri it was observed that nurse handoffs were not conducted and lacked the use of a standardized evidence-based tool, resulting in nurse dissatisfaction with the handoff process and miscommunication. Recognized by the World Health Organization, The Joint Commission, and Agency for Healthcare Research and Quality, the Situation, Background, Assessment, Recommendation (SBAR) evidence-based tool is effective in improving handoff communication, improving nurse satisfaction, reducing adverse events, and promoting patient safety. The purpose of this Quality Improvement (QI) project was to implement a patient handoff tool into the electronic medical record (EMR) based on the SBAR method to help improve handoff communication and documentation.

Methods: Nurses were educated on the SBAR method and tool prior to implementation of the tool. A survey was distributed pre-implementation and again at the end of the 12-week implementation period. Observation audits were conducted weekly to determine nurse compliance with the use/documentation of the SBAR handoff tool.

Results: Findings indicated nurse compliance with the use of the SBAR handoff tool for day shift was 99.35% and for night shift was 99.37%. Meaning there was only a 1.43 standard deviation for day shift and a 1.29 standard deviation for night shift. Demonstrating the stated goal of increasing the minimum staff compliance to 80% with the use of a standardized shift report tool in the EMR was met. Comparison of pre and post survey mean responses showed modest improvements in items related to the use of an SBAR tool during handoff and there was an increased dissatisfaction with the amount of time it took to give handoff using an SBAR tool. Nurses stated that handoff took longer due to the cosigning requirement of the handoff.

Conclusion: Use of the SBAR tool improves nurse-to-nurse communication when used during handoffs. Future Plan-Do-Study-Act (PDSA) cycles and data collection should take place for ongoing quality improvement and analysis.

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