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Improved Communication for Safer Patient Care: The Implementation of SBAR

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Zuckerberg San Francisco General (ZSFG) Urgent Care Center (UCC) opened in 1999 in order to alleviate the non-emergent caseload from the Emergency Department (ED). As a safety net hospital ZSFG traditionally provides care to a predominantly under served and underinsured community, of whom 31% are Hispanic, 24% Asian/Pacific Islander, 23% white and 16% African American (San Francisco Department of Public Health, 2015). Patient encounters range in acuity from primary care to medical emergencies requiring transportation to the ED, with the most frequent complaints including chronic and acute pain, exacerbation of chronic diseases such as hypertension, diabetes and asthma, urinary symptoms, upper respiratory infections and medication refills.

Effective communication is essential in urgent care centers, and crucial in the delivery of safe, quality, patient centered care, whilst generating a safe work environment. Facilitation of urgent care for non-emergent patient encounters reduces ED patient volume, with significant financial benefit for the City and County of San Francisco, since care delivery costs are considerably higher in the ED setting. Requirements of the Emergency Medical Treatment and Labor Act (EMTALA), stipulate all patients must receive a medical screening exam (MSE) performed by a provider, regardless of ability to pay or medical coverage (Center for Medicare and Medicaid Services, 2012). To fulfill this requirement in the UCC, support staff, either an RN or a medical assistant (MEA), will conduct a patient intake and verbalize a report to their paired provider, who will determine the priority of the patient and possibly write an MSE based on the hand-off report. In order to sustain a culture of patient safety, implementation of the standardized communication tool SBAR (situation, background, assessment and recommendation), aims to

improve the clarity and consistency of patient hand-offs, in order to improve the safety and quality of patient care.

Clinical Leadership Theme

The purpose of this Clinical Nurse Leader (CNL) improvement project is to improve the consistency of communication between UCC staff through standardized SBAR patient hand-offs between RN's and providers. The focal clinical leadership theme associated with this project is communication. The role of the CNL in this capacity is to build interpersonal relationships through the implementation of quality improvement strategies based on evidence and risk anticipation (American Association of Colleges of Nursing, 2013). The CNL role in this project strives to demonstrate effective communication, collaboration and interpersonal relationships with members of the care delivery team across the continuum of care (AACN, 2013). In a unique position to facilitate intradepartmental collaborations based on evidence based practice, as both a team member and a team leader, the CNL aims to promote a culture of collaboration and teamwork. Working to motivate on a group level, as well as the individual, the CNL strives to develop characteristics of effective teams, including qualities of mutual trust, and closed loop communication, with leadership capable of task coordination, and planning, in addition to inspiring motivation with a positive atmosphere (Weller, Boyd, & Cumin, 2014).

The aim of this project is to improve communication processes in the ZSFG UCC. The process begins with staff training on SBAR utilized in the Agency for Healthcare Research and Quality's (AHRQ) Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) curriculum. The process ends with an assessment of SBAR use between RN's and providers through observation, and staff understanding reflected in pre and post survey score

changes. By working on the process, we anticipate greater consistency in patient handoffs to providers, improved staff satisfaction scores relative to attitudes on teamwork and communication, improved AHRQ patient safety scores relative to teamwork, intradepartmental respect, and communication. Significantly below benchmark scores on the AHRQ patient safety survey indicate a need for improvement in standardized communication within the UCC. Poor communication is frequently related to adverse patient outcomes, costly to both the patient and the organization. It is important to work on this now in order to sustain a culture of safety, and ensure the best patient outcomes.

Statement of the Problem

The mission statement of the UCC is to support the healthcare safety net in San Francisco by meeting the unmet need for urgent care, and by promoting the health and welfare of patients, including linkage to primary and specialty care. An upcoming move to a larger facility in close proximity of the ED, scheduled for January 2018, anticipates an increase in UCC patient volume, in addition to a potentially higher level of patient acuity. Adherence to EMTALA criteria, providing all patients with a provider MSE, must be maintained through these care delivery changes. Staff have indicated through surveys and focus groups the lack of cohesiveness within the department, reflected in poor survey scores relative to communication and teamwork (see Appendix A for staff survey results).

The range in experience among providers and intake staff, including RN's and MEA's, varies greatly from over 25 years of experience with backgrounds in emergency medicine and ICU, to newly graduated. More than 50% of staff having less than 5 years of experience in the UCC and 23% with less than 5 years in their profession (AHRQ, 2017). Subsequently, variance

is reflected in the consistency of patient reports between support staff and providers noted in patient hand-off observations (see Appendix B for pre intervention observation SBAR criteria and Appendix C for pre intervention observation data). As new staff are oriented to the department, a lack of standardized communication stands to perpetuate the cycle of inconsistent communication cohesiveness, as varying hand-off techniques are learned from peers.

Additionally, communication styles tend to differ relative to training, such as physician and RN, as well as variance relative to gender (Curry Narayan, 2013). Standardized communication systems are beneficial in order to negate the inconsistency and establish a neutral ground for effective communication to take place.

Project Overview

This clinical nurse leader quality improvement project aims to standardize patient hand-offs between support staff and providers, enabling better organizational methods in relaying patient information among staff members. Originally adapted from the US navy, used to clarify critical information at times of high stress in a standardized format, articulating the situation, background, assessment, and recommendation (SBAR), the communication technique has become a multidisciplinary standard of communication (Curry Narayan, 2013). Through the implementation of SBAR as a standardized hand-off technique to relay pertinent information to colleagues, staff will have an opportunity to be more organized in their approach, empowering them to clarifying key details with a structured template to increase cohesiveness, and negate opportunities for relevant information to be lost in transition. Three objectives this SBAR implementation aims to achieve are (1) consistency and clarity of patient hand-offs, (2) staff experience and satisfaction with communication during hand-offs, and (3) prevention of adverse

patient outcomes resulting from poor communication. Ultimately these objectives stand to save money for the City and County of San Francisco through the avoidance of sentinel events and adverse patient outcomes, whilst improved efficiency and quality in care delivery in the UCC increases the capacity to relieve non emergent care from the ED.

In order to sustain a culture of patient safety, providing opportunities for improved quality patient outcomes, this clinical nurse leader project aims to enhance provider and support staff's communication skills. Through reported surveys, staff will report a 90% positive response in post-intervention survey questions regarding use and explanation of SBAR, following the one hour, small group SBAR training conducted in the UCC. Subsequent observations of patient handoffs will see an increased use of SBAR criteria pertaining to appropriate situation, background, assessment, and recommendation in relayed information organization.

Rationale

In order to identify and assess the opportunities for improvement within the UCC, a needs assessment was conducted. Staff surveys, including an AHRQ hospital survey on patient safety, indicated communication and teamwork were consistent themes requiring improvement (see Appendices A, and D, for pre-intervention staff survey and AHQR survey results). Staff acknowledged inconsistencies within the UCC department associated with patient hand-offs, in addition to intradepartmental communication as a whole. A cause and effect fishbone diagram was constructed to assess the factors impacting communication, including variance in staff communication styles, and role hierarchy (see Appendix E). A SWOT analysis was compiled to identify strengths, weaknesses, opportunities and threats (see Appendix F). Strengths included a managerial team committed to quality improvement measures, and newer staff members who

were open to change. Weaknesses identified the difficulty in attributing data relative to the intervention. Identified threats included staff push back and frustrations relative to changes in care delivery models. Opportunities such as improved, safer patient care delivery and avoidance of negative patient outcomes were also identified.

Communication issues within a department affect patient care delivery and staff morale, impacting the quality of patient outcomes. Communication is frequently attributed as a causal factor in sentinel events. The Joint Commission estimated through root cause analysis, 60 – 70% of sentinel events can be attributed to communication (2017). It is important to address communication concerns as a preventative measure in quality patient care delivery, to ensure patient safety and reduce costs. Standardization of patient hand-off communication through the implementation of SBAR establishes a baseline of acceptable criteria pertinent for safe patient hand-offs. By this measure, it is possible to identify inadequate communication techniques, whilst establishing a clarity in communication expectations. Also, effective communication in patient hand-offs can positively impact other areas of communication within the department, potentially impacting staff satisfaction in their work and staff retention (Song, et al., 2017). Additionally, strong communication is optimal in an urgent care setting where interdepartmental transfer is a frequent component of care delivery (Shamji, Baier, Gravenstein, & Gardner, 2014).

Primarily this project is aimed at sustaining a culture of safety, and is principally based in a philosophy of prevention. Averting poor patient outcomes and delays to patient care delivery, provides a cost benefit to both patients, and healthcare organizations. Additionally, investing in the care delivery of the UCC contributes to its viability as an alternative for non-emergent patient care delivery, relieving patient load and organizational costs for the ED. According to the Office

of Statewide Health and Planning Development (OSHPD) (2015), the average emergency department (ED) visit at ZSFG was estimated at \$1,260 in 2015. By comparison, according to Lankford, the average urgent care visit cost is estimated to be around \$135 (2014). Support and improvement of care delivery systems within the UCC stands to benefit the organization as a whole, in its mission to provide care in a safety net setting. Advancing the quality and safety of patient care, additional benefits relative to improved communication and workplace interaction may also have potential benefit. Urgent care centers have much to gain by standardized communication practices, beneficial to continuity and safety in patient care delivery (Shamji, et al., 2014). Preventative measures such as SBAR implementation, can be introduced for a minimal cost, whilst standing to save organizations extensively through the avoidance of medical errors and sub-standard care delivery (see Appendix G for Estimated Project Implementation Cost).

Methodology

The theoretical model applied to this quality improvement initiative is Lewin's three step theory of change (as quoted by Wojciechowski, Murphy, Pearsall, & French, 2016), which has historically been successfully applied in nursing initiatives, providing the fundamental principles necessary for process modification. The simplicity of the three stages in the theory; unfreezing, change and refreezing, are an appropriate template for the implementation of the SBAR communication tool. The unfreezing stage of Lewin's theory is where the equilibrium is destabilized, allowing for the old behavior to be "unlearned", clearing the way for a new behavior to be absorbed (Wojciechowski, et al.). During this phase of the project implementation, concerns relative to communication inconsistencies and errors will be explored, in addition to

data analysis from staff surveys and national statistics. The second stage is the introduction of the new behavior change or movement, where driving and restraining forces are identified and a plan for change may be established. At this stage, the TeamSTEPPS SBAR communication tool will be explored as an organizational framework, with examples of appropriate use. The third stage of Lewin's Theory is refreezing, during which positive changes are implemented, integrated and evaluated (Wojciechowski, et al.). During the refreezing stage of the project implementation, participants apply SBAR to patient hand-off scenarios, followed by patient hand-off observations in the clinic. Additional hand-off observations will take place at 3 and 6 week intervals, conducted by the instructor or a project champion. The impact of the SBAR implementation will be assessed through documented observation, evaluated and applied accordingly.

The PDSA model will be utilized in order to test the SBAR implementation project. An effective change model, the PDSA model is frequently used in improving the quality of patient care, focused on making healthcare safer, more patient centered, effective, efficient, and equitable (Donnelly & Kirk, 2015). The acronym PDSA stands for plan, do, study, and act, representing the stages used to test incremental change (see Appendix H for an SBAR implementation PDSA template). During the planning phase of the PDSA cycle, a needs assessment and microsystem analysis took place in order to establish objectives based on service and patient needs. During this stage data was collected from staff surveys and assessed in order to identify concerns with care delivery, specifically in this case related to communication continuity (see Appendix A for staff survey results). A plan was developed to introduce SBAR as a standardized communication tool for patient handoffs in the UCC. At this time, two project champions are appointed for the project implementation. An educational SBAR presentation was

prepared, using Lewin's theory of change as a template, exploring the impact of communication on healthcare delivery and variations in patient handoffs as part of the unfreezing phase.

In the PDSA model's Do phase, the SBAR presentation will be given to small groups of two to four participants. Hand out materials include a wallet sized, laminated SBAR card that fits onto an ID badge, and patient scenario SBAR sheets (see Appendix H for an SBAR scenario example), to be covered as a group, providing an opportunity for a new method of behavior change. SBAR sheets will be available for use during intakes also. During this phase, participants will be encouraged to explain the SBAR acronym to one another. Simulation scenarios will give an opportunity for participants to verbalize SBAR scenarios in a patient handoff to one another. Participating staff members will then be observed during patient handoffs during their shift, and SBAR use documented with the SBAR observation tool (see Appendix B for the SBAR criteria observation tool). The observational data will be compared to the pre intervention SBAR observation data collected prior to the intervention and adjustments made to the process accordingly.

Project champions are chosen in order to support the facilitation of the SBAR implementation, utilizing elements of transformational leadership, supporting the philosophy of individual empowerment through a willingness to encourage and guide team members to a greater understanding of their role within the organization. These project champions will be selected based on their aptitude to effect positive change, and willingness to participate in departmental quality improvement measures. Effective leadership plays a pivotal role in nurse innovation, psychological empowerment, self-awareness and knowledge sharing (Masood &

Afsar, 2017). Through transformational leadership, change may be embraced as a positive opportunity, as opposed to a negative barrier.

Data Source/Literature Review

A PICO search was conducted in order to source relevant literature, using the following criteria;

1. P: RN and healthcare provider communication.
2. I: TeamSTEPPS SBAR.
3. C: No retraining or standardized communication.
4. O: Communication impact, patient safety.

Utilizing the Gleeson Library electronic search engine, with CINAHL, PubMed and Medline data bases, a filter for peer reviewed journals from 2012 produced 74 results. Most of the articles were relevant for the project, although not specifically for urgent care centers. Testing alternate criteria to include urgent care centers did not yield more specific results. Through extensive review, additional articles were found also supporting the need for the implementation of SBAR communication tool clinical nurse leader project.

As healthcare strives to improve patient care delivery, with a priority to patient safety, communication is a major concern. According to The Joint Commissions Center on Transforming Healthcare's (TJCCTH), *Improving Transitions of Care: Hand off*

Communications initiative, communication breakdown was the leading root cause of reported sentinel events (2014). In conjunction with several participating hospitals, TJCCTH applied a systematic approach to analyze breakdowns, explore underlying causes and develop targeted solutions, shared via an educational format for health care organizations (TJCCTH, 2014). Substandard patient handoffs were attributed to a number of factors impacting patient care, including delays in treatment, adverse events, readmissions, increased hospital stays, increased costs, inefficiency, and both major and minor patient harm (TJCCTH). Findings identified in contributing factors impacting poor handoffs included a culturally lacking environments due to a deficiency of teamwork or respect, and ineffective communication methods. Suggested solutions to these shortcomings, include prioritizing patient handoffs as an organization with performance expectations, staff education on components of successful handoffs, engaging staff with real time performance feedback, and standardized communication tools, such as SBAR (TJCCTH).

Urgent care centers are pivotal points in the continuum of care, reliant upon effective communication to run successfully and safely. A 2014 study conducted by Shamji, Bair, Gravenstein, & Gardner, sought to establish guidelines specifically for communication issues pertaining to urgent care settings, involving a multistage approach with literary reviews, clinician and stakeholder feedback pertaining to content and preference. As reliant as urgent care centers are upon well executed transitions for optimal patient outcomes, there is great variability in the frequency and effectiveness of communication during transitions (Shamji, et al.). A deficit in urgent care specific literature was noted in the studies literature review of best practices relevant to communication, and focused feedback was sought from urgent care center RNs and providers, ED and primary care physicians, in order to identify best practices. There was much emphasis in the recommendations regarding the transitional care between “upstream and downstream

partners”, necessitating high quality patient transitions, with all stakeholder expressing frustrations when patient handoffs are inadequate (Shamji, et al.). The best practice recommendations resulting from the study, included recording PCP, or lack thereof, in upstream communication, with a clinical summary sent to the PCP at the visits conclusion. Downstream communication to ED physicians recommended sending clinical summary, in addition to verbalizing a patient handoff (Shamji, et al.).

Numerous studies have tested SBAR in a variety of healthcare settings to assess applicability, demonstrating a positive impact on patient care, in addition to staff experience in the workplace. The format as follows: Situation is a concise statement of the problem; What’s going on now? Background refers to pertinent information about the situation; What has happened? Assessment is an analysis and consideration of options; What you found, what do you think is going on? Finally, recommendation is a request for, or recommendation of actions; What do you want done? The template facilitates organization of information so that pertinent facts may be expressed with clarity, benefiting both the “sender” of information, as well as the “receiver”. Although more commonly used in inpatient settings, SBAR has been shown to positively impact healthcare across the continuum in a variety of healthcare settings (TJCCTH, 2014).

Advantages of expanding the use of SBAR from more traditionally acute settings, to a broader range of non-acute care has been studied by Curry Narayan. Addressing the impact ineffective communication has on hospitalizations from the home healthcare setting, the researcher notes the negative influence on patient outcomes, and the subsequent costs incurred by unnecessary hospitalizations (Curry Narayan, 2013). Identifying inter-professional

communication issues, such as hierarchal structure and differences in the communication styles between clinicians and physicians, the researcher goes on to examine the complexity of multifaceted healthcare delivery, recommending SBAR as a universal communication technique to overcome these barriers. The application of SBAR in acute healthcare settings is customary, and studies have shown substantial benefits in the application to ambulatory healthcare settings in reducing costs and improving care.

A study by Cooke examines the impact a two day educational TeamSTEPPS training program had on the knowledge and attitudes of participants (2016). Referring to identified inconsistencies in the delivery of safer patient care, the researcher states the importance of redesigning the care processes on leadership, culture, collaboration, teamwork, and communication. Acknowledging the critical need for effective communication, the author identifies a lack of investment in leadership training within the clinical setting. Referencing a focus group study the American Society for Healthcare Risk Management (ASHRM) conducted to determine the needs for the future of the profession, Cooke noted a “lack of teamwork and communication among departments, providers and patients creates vulnerability and exposes patients and organizations to risk throughout the continuum of care” (2016). In response to the challenges leaders of healthcare organizations face in redesigning organizations in the delivery of consistently safer care, a two day TeamSTEPPS training, including the SBAR communication tool, was conducted. Measures of knowledge and attitudes were used to assess the impact of the program through pre and post course surveys, resulting in significantly positive results.

In light of the highly consequential impact communication effectiveness has on patient outcomes, as noted in the Institute of Medicines 2000 report; *To Err is Human* (as referenced by

Cornell, Gervis, Yates and Vardaman), a research study was conducted on RN SBAR shift reports and staff rounding. In preparation, the study notes the compounding factors “imbedded in organization processes, spanning social, cognitive, and technological factors” and identifies the central role of the nurse in providing patient care, necessitates a critical role in measures to improve communication (Cornell, et al. 2014). Standardized communication, such as SBAR, provides a model for structuring information with prioritization, in addition to promoting critical thinking skills and improving situational awareness. Pre and post intervention data indicated increased consistency in patient hand-offs and more concise patient reports (Cornell, et al. 2014). Clarity in intradepartmental communication is imperative in safe patient care delivery, and is also beneficial to creating a more positive workflow.

Teamwork and communication have a significant effect on patient outcomes. In response to an estimated 180,000 deaths annually attributed to miscommunication within healthcare teams, much emphasis is placed on standardized communication to improve teamwork and deliver high quality patient care (Martin & Ciuzyński, 2015). Performance improvement measures studied in the ED setting, utilized SBAR with an objective to improve communication and strengthen teamwork, with positive results (Martin & Ciuzyński). Furthermore, collaborative measures to have nurse practitioners and RNs perform patient histories and physical assessments together, resulted in greater job satisfaction. Positive results reflected in all areas studied indicated the feasibility of improved communication protocols to improve care delivery, and it was noted that staff buy in to the project was a contributing factor in its success (Martin & Ciuzyński). Teamwork is an essential component of effective communication, and empowering intradepartmental teams to have shared accountability for patient outcomes is beneficial for staff experience.

Timeline

The clinical nurse leader quality improvement project, “Improved communication for safer patient care: The implementation of SBAR”, began in the beginning of September 2017, and is planned to conclude in January of 2018 (see appendix J for GANTT chart). As part of a departmental quality improvement initiative, the small group trainings are planned to continue until 80% of the UCC staff have completed the SBAR implementation project. A microsystem assessment was conducted September 1st through 29th to assess departmental needs, staff surveys were conducted between September 29th and October 13th, and analyzed between October 13th and 27th. Preparation of training tools began October 20th and preparation for an educational presentation began on October 27th. Small group trainings began November 3rd and will continue through till the end of the year. PDSA cycles will began following the first small group training, collecting observational data of patient handoffs between staff, and will continue intermittently through to the end of the project.

Expected Results

It is anticipated there will be an increase in staff survey responses relative to SBAR understanding and communication. Through the identification of project champions, it is hoped that SBAR use will continue beyond the project parameters. In the long run, it is anticipated efforts to increase communication within the department will impact staff satisfaction scores in a positive way. As identified through staff surveys, the majority of staff indicated they are invested in improving department communication. However, there was also push back to improvement measures indicated in a minority of surveys, and this push back is anticipated with implementation. It is estimated that nursing staff will be more mindful of the organization of

information relayed to providers, and that overall staff will pay more attention to the way they communicate information to one another.

Nursing Relevance

It is evident from the literature review that more work is to be done in exploring the potential for SBAR within urgent care centers, and non-acute health care settings, since over all there is a lack of urgent care center specific research. SBAR is relevant in all settings where pertinent information needs to be shared and prioritized, providing a format for information organization. As pivotal points in the healthcare continuum, urgent care centers can benefit from standardized communication, as they facilitate patient encounters ranging from primary to emergent. Continued efforts to adhere to TCC and IOM's recommendations for communication tools such as SBAR, in all healthcare settings, can have a positive impact on patient care and prevent adverse patient outcomes, impacting the cost of care delivery. Another factor for consideration, is the influence effective communication can have on staff satisfaction in the work place. Since nursing has a high burnout rates, improved clarity of communication in the workplace could positively impact staff experience in addition to patient outcomes. Standardized communication formats can offer a neutral ground for staff to communicate, negating hierarchal modes related to position, departmental longevity or personality dynamics.

Summary Report

The CNL quality improvement project "Improved Communication for Safer Patient Care: The Implementation of SBAR" aims to improve communication in the UCC at ZSFG. The primary focus of this project is to sustain a culture of safety, whilst improving the quality of

patient hand-offs between support staff and providers, through the implementation of a standardized communication tool, SBAR. Three primary objectives are (1) to improve the consistency and clarity of patient hand-offs, (2) staff experience and satisfaction with communication during hand-offs, and (3) prevention of adverse patient outcomes resulting from poor communication.

In keeping with ZSFG UCC's aim to meet the unmet need for urgent care in the City and County of San Francisco, with an annual patient volume of around 18,000, the CNL quality improvement project was implemented to assess the effectiveness of an SBAR training in an urgent care setting. In response to safety and staff surveys relative to communication, in addition to observational data, a plan was developed to implement standardized communication SBAR in patient hand-offs. Two provider and RN teams were invited to participate in a clinical trial of the SBAR implementation project and two separate dates agreed upon for the trainings.

Utilizing Lewin's three step theory for organizational change, reflecting the simplicity of the SBAR training project, an interactive training was developed. Mirroring the unfreezing component, the presentation began with a quiz on communication, its impact on patient outcomes and results from staff surveys reflecting 100% agreement there is room for improvement in departmental communication. The subsequent discussion explores the components affecting communication, both in general and specific to our department, in addition to variance identified in patient hand-offs. This includes the upcoming move to a larger facility with increased patient volume and acuity, as well as unfamiliar patient care flow.

In keeping with change/movement stage, SBAR is explored as recommended by the IOM and TJC, with specific application to the UCC setting. Data supporting the use of ambulatory

care setting standardized communication is discussed. SBAR simulations are done as a group using SBAR hand-outs, with the simulation process representing the beginning of the refreezing stage (See Appendix K for SBAR simulation sheets). Participants are given a laminated UCC SBAR card to attach to their ID badges for reference, and SBAR scratch sheets are available. Staff were then observed during patient hand-offs for the following 2 to 3 hours after the training and post intervention data was collected. Additional post intervention data is to be collected discreetly at three and six weeks post intervention, by either the instructor or the project champion to ascertain results.

Due to the time constraints, two trainings at 25 and 30-minutes were performed as opposed to an hour long training as is planned for future implementations. Observational data collected post intervention indicated greater consistency in the situation criteria of patient hand-offs, a promising trend also noted in the other intake sections. Staff indicated a clearer understanding of the SBAR criteria, comfort level in explaining SBAR, and the need for standardized communication in post intervention surveys, although is difficult to draw conclusions at this stage, with a sample size of four. Staff feedback was positive, although there may be less enthusiasm when the project continues to fruition as a departmental implementation in conjunction with other quality improvement initiatives to improve patient care flow.

Limitations of the implementation included the days chosen for training were times known to be quieter, and trainings were performed at the very beginning of the day. Although this was beneficial for the training, patient volume remained low those days, impacting the immediate post training observational data collection. Also, the staff chosen to participate were possibly already consistent with their patient hand-offs. Other factors impacting the data

collection accuracy was the difficulty in recording the order of information delivered in a timely fashion. The area where patient hand-offs take place is often crowded, and it was difficult to catch hand-offs in their entirety. Also, participants were aware they were being observed following the training, therefore hand-offs were likely affected, invalidating the data. However, this observation time could be considered as part of the simulation training in the process of refreezing. Additionally, since this is my project, there may be unconscious bias in the way I am recording data, so it may be beneficial to have a project champion collect the three and six week observations.

Moving forward, the SBAR Implementation project is to continue within the department, as part of a quality improvement measure aimed at increasing patient care flow, communication and teamwork. In conjunction with an adjacent project to train staff on standardized intake criteria. The appointed project champion will assist with further implementation, with full departmental support to complete the training program for the remainder of the staff in the UCC.

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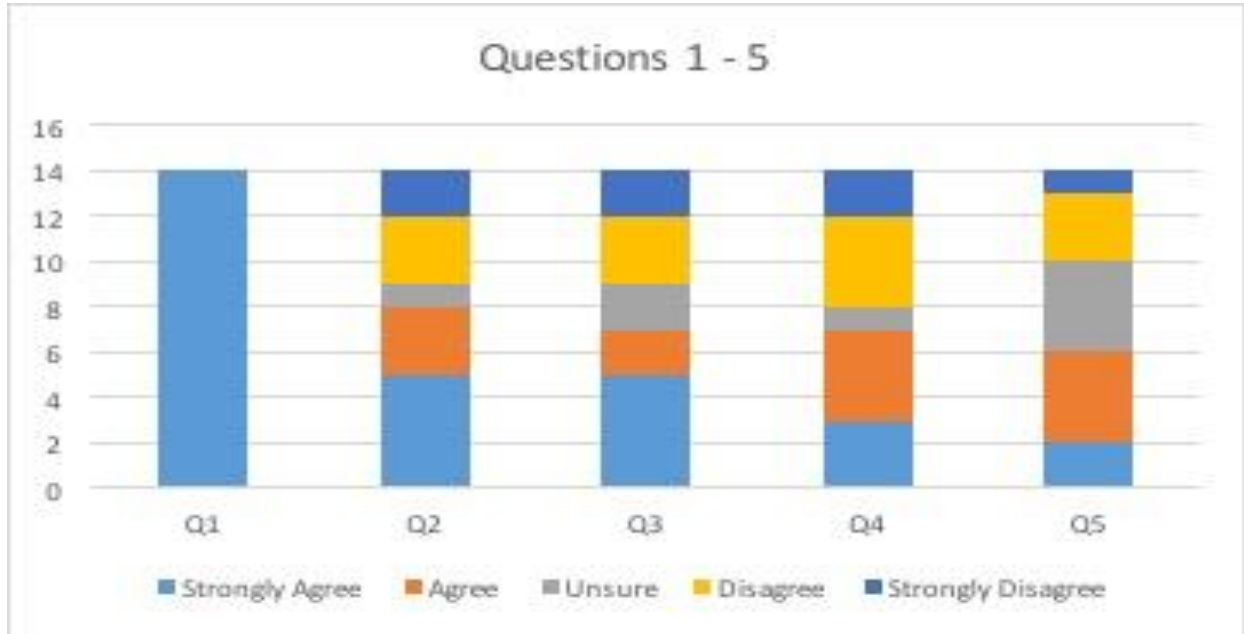
Weller, J., Boyd, M., & Cumin, D. (2014). Teams, tribes and patient safety: Overcoming barriers to effective teamwork in healthcare. *Postgraduate Medical Journal*, 90(1061), 149-154.

Wojciechowski, E., Murphy, P., Pearsall, T., French, E., (2016) A case review: integrating Lewin's theory with lean's system approach for change. *OJIN: The Online Journal of Issues in Nursing* Vol. 21 No. 2, Manuscript 4.

Appendix A
Staff Pre-Intervention Questionnaire Results

Staff Survey

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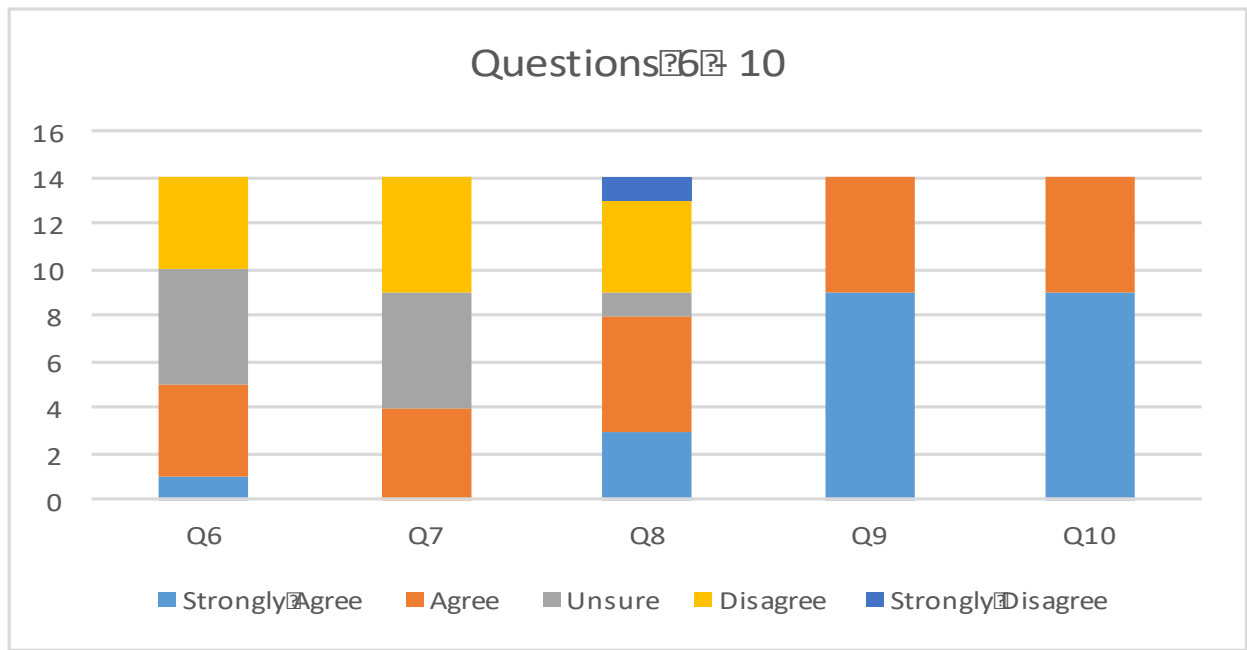
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Q1: Communication is an important part of patient safety?
Q2: I am familiar with the SBAR communication tool?
Q3: I know what the S, B, A, and R stand for in the SBAR acronym?
Q4: I use SBAR when I am relaying information regarding patients?
Q5: Communication between support staff and providers is consistent in the UCC?

?

?

Staff Pre Survey



?

Q6: Things fall between the cracks when transferring patients from one unit to another.

?

Q7: Problems often occur in the exchange of information across hospital units.

?

Q8: I would be comfortable explaining SBAR to a colleague.

?

Q9: There are varying ranges of experience amongst UCC staff.

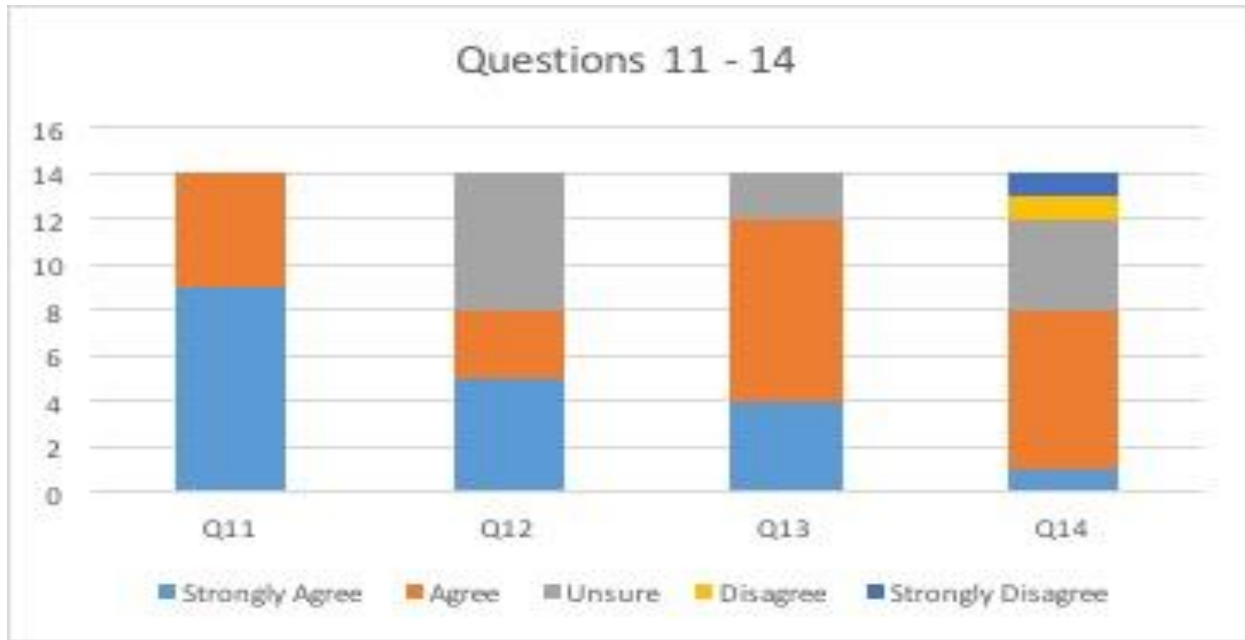
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Q10: Standardized communication tools for patient handoffs would help to keep communication consistent.

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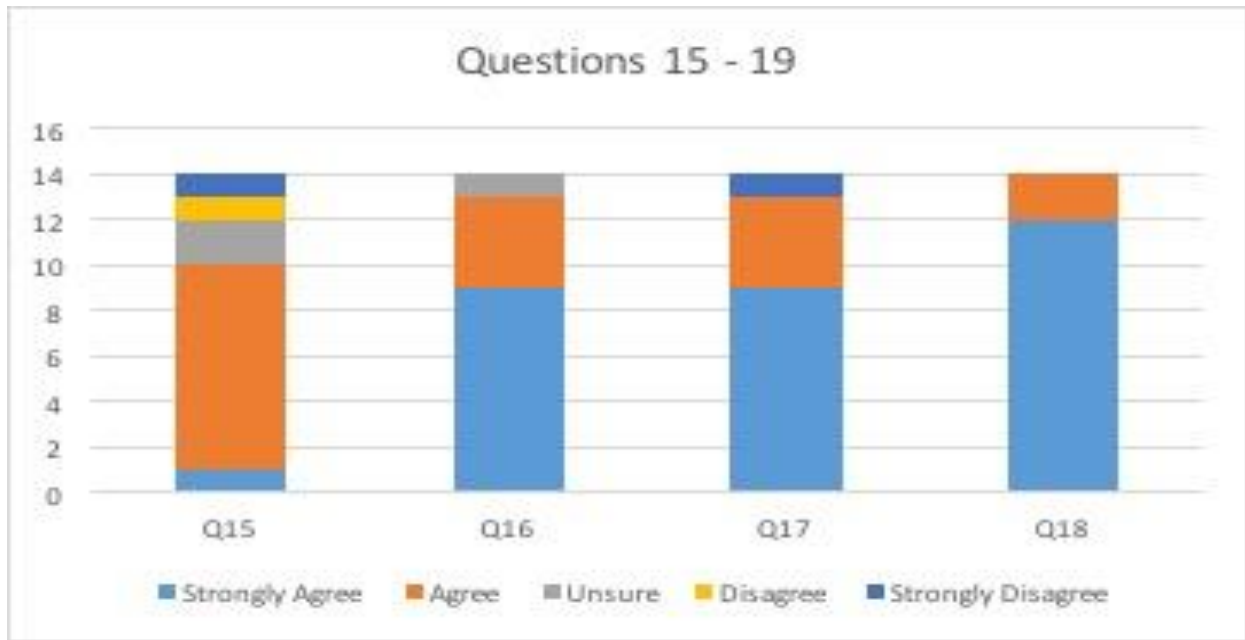
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Staff Pre Survey



<p>Q12: Adverse patient outcomes can occur with poor communication?</p> <p>?</p>
<p>Q13: SBAR helps to keep information organized when relayed to a coworker?</p> <p>?</p>
<p>Q14: I feel comfortable communicating with my peers?</p> <p>?</p>
<p>Q14: People support one another in this unit?</p> <p>?</p>

Staff Pre Survey



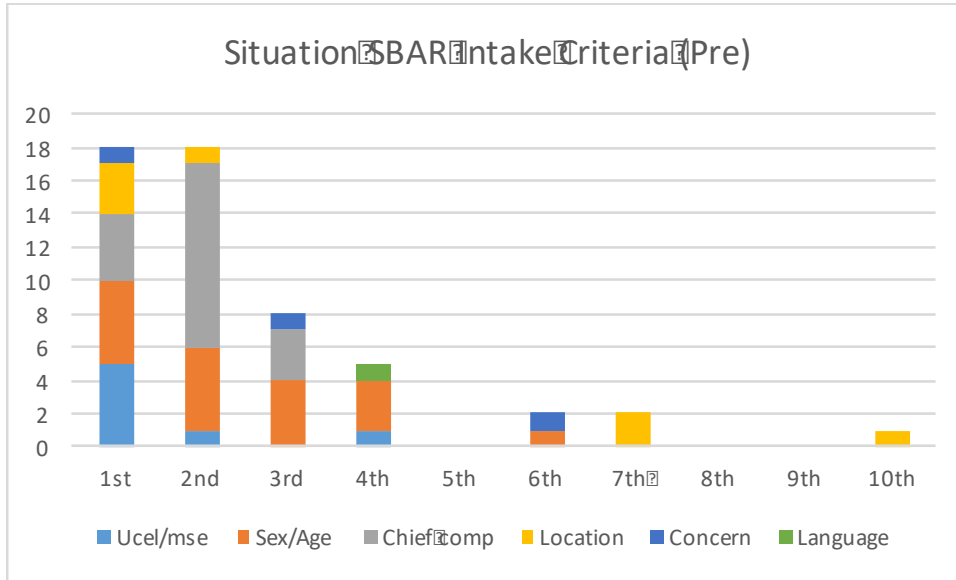
<p>Q15: In this unit people treat each other with respect?</p> <p>?</p>
<p>Q16: There is room for improvement in communication between staff members?</p> <p>?</p>
<p>Q17: I am interested in improving communication within the department?</p> <p>?</p>
<p>Q18: Communication has a direct impact on patient care?</p> <p>?</p>

**Appendix B
Patient Hand-off SBAR Criteria Observation Data**

Situation																			
*UCEL/MSE																			
Age/sex																			
Chief complaint																			
Location																			
Language																			
Concern																			
Background																			
Symptoms																			
Significant history																			
Medications																			
Appointments/PCP																			
Assessment																			
Of patient/situation																			
Symptoms																			
Vital signs (abn/wnl)																			
Pertinent negatives																			
*POC performed																			
Allergies																			
Concerns																			
Recommendation/plan																			
Request P to see pt?																			
Urgency																			
Discuss care plan																			
POC required																			

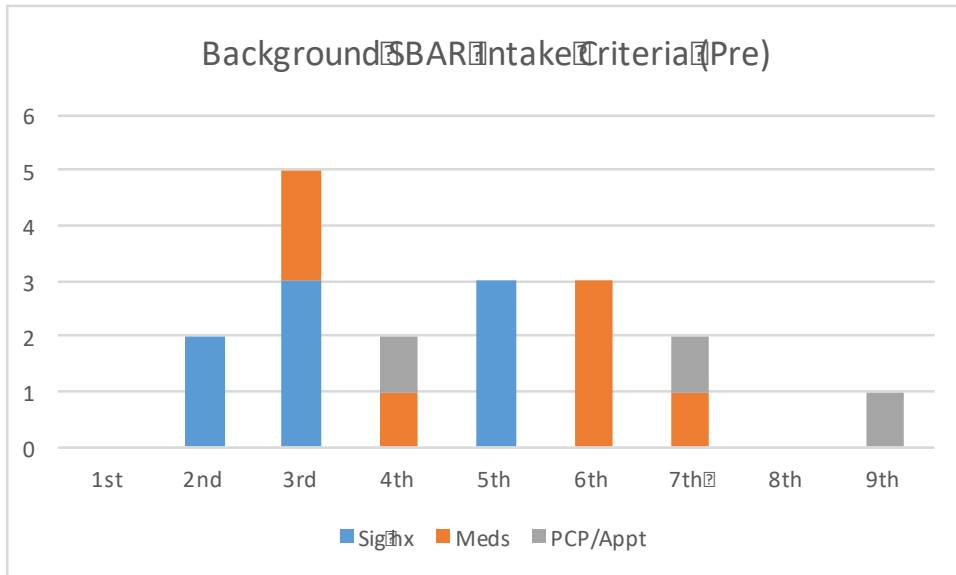
*UCEL refers to patients who do not automatically clear eligibility on check in, it is imperative they receive an MSE
 *POC refers to point of care testing, such as a pregnancy test to rule out ectopic pregnancy as a medical emergency

Appendix C SBAR Criteria Observation Pre-Intervention Data



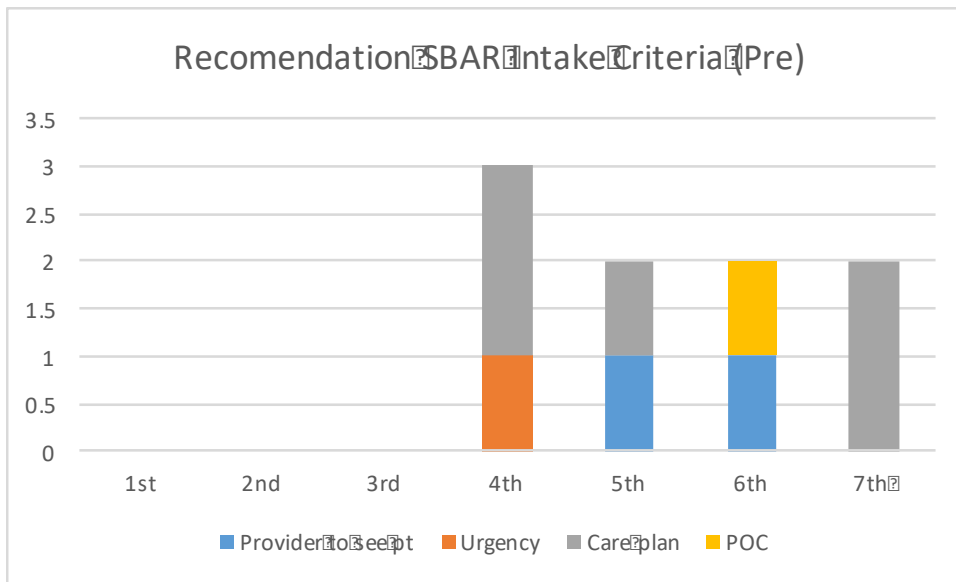
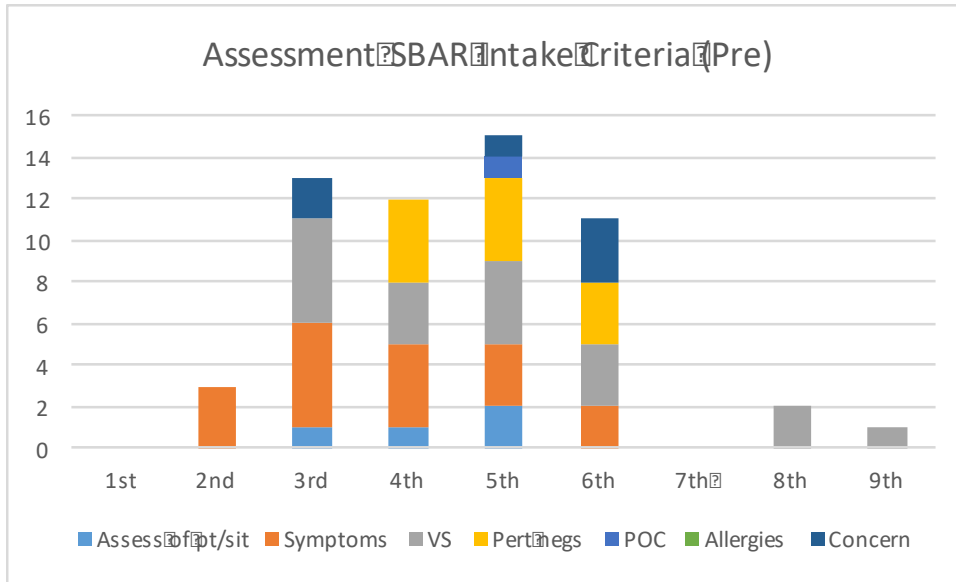
The order in which the intake criteria information is relayed between support staff and providers, listed as 1st, 2nd, 3rd etc, during patient hand-off observations.

N = 18



Appendix C

SBAR Criteria Observation Pre-Intervention Data



Appendix D

AHRQ Survey on Patient Safety Culture

AHRQ Hospital Survey on Patient Safety Culture

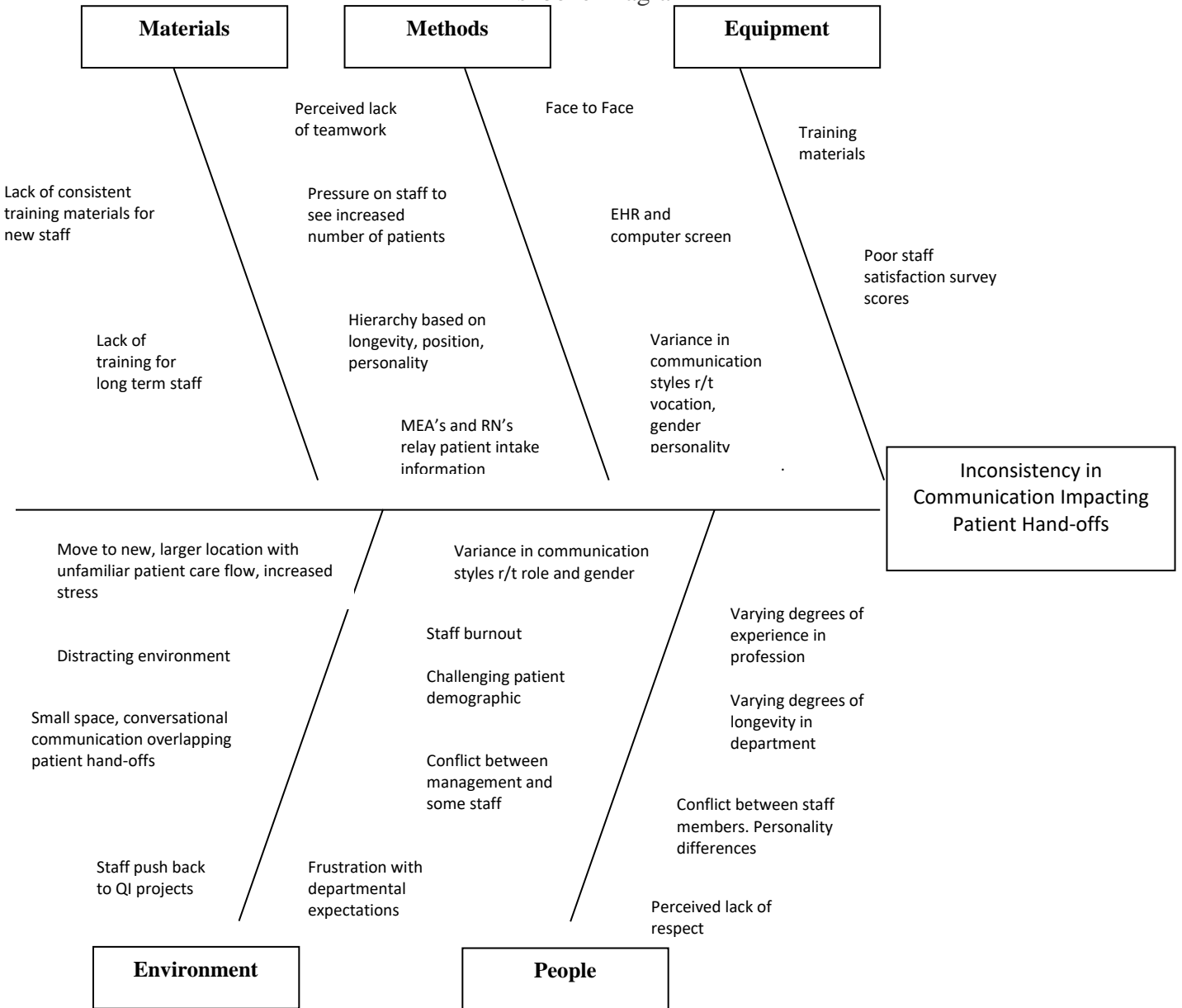
The AHRQ Survey Report you have requested:

Organization:	Zuckerberg San Francisco General Hospital
Report Type:	Single Survey Report
Details:	Program: Bldg 80/90: Adult Urgent Care Participants: 27 End Date: 03/14/2017
Benchmark Details:	Work Area / Unit: Emergency Hospitals: 565 Participants: 24,851

Composite Dimension & Item-Level Results

Hospital Survey on Patient Safety Culture	% positive responses	Bench: % positive responses	Delta
Overall perceptions of safety	57%	56%	1%
Patient safety is never sacrificed to get more work done. (A15) (25 of 27)	44%	53%	-9%
Our procedures and systems are good at preventing errors from happening. (A18)	63%	64%	-1%
It is just by chance that more serious mistakes don't happen around here. (A10R) (26 of 27)	62%	54%	8%
We have patient safety problems in this unit. (A17R)	59%	51%	8%
Frequency of events reported	35%	61%	-26%
When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported? (D1) (22 of 27)	23%	54%	-31%
When a mistake is made, but has no potential to harm the patient, how often is this reported? (D2) (22 of 27)	32%	58%	-26%
When a mistake is made that could harm the patient, but does not, how often is this reported? (D3) (22 of 27)	50%	71%	-21%
Supervisor/manager expectations & actions promoting safety	58%	74%	-16%
My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures. (B1) (25 of 27)	56%	75%	-19%
My supervisor/manager seriously considers staff suggestions for improving patient safety. (B2) (26 of 27)	69%	76%	-7%
Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts. (B3R) (26 of 27)	54%	71%	-17%
My supervisor/manager overlooks patient safety problems that happen over and over. (B4R) (24 of 27)	54%	74%	-20%
Organizational learning - Continuous improvement	58%	67%	-9%
We are actively doing things to improve patient safety. (A6)	74%	79%	-5%
Mistakes have led to positive changes here. (A9) (26 of 27)	42%	58%	-16%
After we make changes to improve patient safety, we evaluate their effectiveness. (A13) (26 of 27)	58%	65%	-7%
Teamwork within units	54%	80%	-26%
People support one another in this unit. (A1)	63%	86%	-23%
When a lot of work needs to be done quickly, we work together as a team to get the work done. (A3)	56%	86%	-30%
In this unit, people treat each other with respect. (A4)	48%	78%	-30%
When one area in this unit gets really busy, others help out. (A11)	48%	70%	-22%
Communication openness	51%	59%	-8%
Staff will freely speak up if they see something that may negatively affect patient care. (C2) (26 of 27)	62%	71%	-9%
Staff feel free to question the decisions or actions of those with more authority. (C4) (26 of 27)	46%	45%	1%
Staff are afraid to ask questions when something does not seem right. (C6R) (26 of 27)	46%	61%	-15%
Feedback & communication about error	51%	61%	-10%
We are given feedback about changes put into place based on event reports. (C1) (26 of 27)	50%	57%	-7%
We are informed about errors that happen in this unit. (C3) (26 of 27)	42%	61%	-19%
In this unit, we discuss ways to prevent errors from happening again. (C5) (26 of 27)	62%	67%	-5%
Nonpunitive response to error	49%	37%	12%
Staff feel like their mistakes are held against them. (A8R)	52%	44%	8%
When an event is reported, it feels like the person is being written up, not the problem. (A12R)	48%	39%	9%
Staff worry that mistakes they make are kept in their personnel file. (A16R) (25 of 27)	48%	29%	19%
Staffing	66%	46%	20%
We have enough staff to handle the workload. (A2)	78%	39%	39%
Staff in this unit work longer hours than is best for patient care. (A5R) (26 of 27)	62%	48%	14%
We use more agency/temporary staff than is best for patient care. (A7R) (24 of 27)	71%	61%	10%
We work in "crisis mode" trying to do too much, too quickly. (A14R)	52%	37%	15%
Hospital management support for patient safety	52%	63%	-11%
Hospital management provides a work climate that promotes patient safety. (F1) (24 of 27)	63%	72%	-9%
The actions of hospital management show that patient safety is a top priority. (F8) (24 of 27)	67%	67%	0%
Hospital management seems interested in patient safety only after an adverse event happens. (F9R) (24 of 27)	25%	51%	-26%
Teamwork across hospital units	43%	52%	-9%
There is good cooperation among hospital units that need to work together. (F4) (24 of 27)	46%	50%	-4%
Hospital units work well together to provide the best care for patients. (F10) (24 of 27)	50%	61%	-11%
Hospital units do not coordinate well with each other. (F2R) (24 of 27)	21%	41%	-20%
It is often unpleasant to work with staff from other hospital units. (F6R) (24 of 27)	54%	54%	0%
Hospital handoffs & transitions	34%	51%	-17%
Things "fall between the cracks" when transferring patients from one unit to another. (F3R) (24 of 27)	25%	46%	-21%
Important patient care information is often lost during shift changes. (F5R) (24 of 27)	46%	60%	-14%
Problems often occur in the exchange of information across hospital units. (F7R) (24 of 27)	21%	49%	-28%
Shift changes are problematic for patients in this hospital. (F11R) (24 of 27)	42%	49%	-7%
Total % positive:	51.1%		

Appendix E
Cause and Effect
Fishbone Diagram



Appendix F

SWOT Analysis

<p>S</p> <p>Strengths (+)</p> <ul style="list-style-type: none"> • Department management committed to positive change • Newer staff members more open to change • Department management experienced in PDSA cycles 	<p>W</p> <p>Weaknesses (-)</p> <ul style="list-style-type: none"> • Lack of quantitative data • Difficulty in assessing improvement outcomes other than staff surveys • Difficulty attributing variance in survey scores specifically to the project
<p>O</p> <p>Opportunities (+)</p> <ul style="list-style-type: none"> • Safer patient care delivery • Establish more cohesive patient hand off process for staff • Potential to avoid negative patient outcomes related to hand off process 	<p>T</p> <p>Threats (-)</p> <ul style="list-style-type: none"> • Push back from staff • Staff frustration with ongoing care delivery modifications • Staff frustrations shared through unofficial channels undermining project • Potential lack of buy in from staff

Appendix G**Predicted Expense of Project Implementation**

Preparation of SBAR training:

1 full time RN @\$54 x 2 hours to print and laminate 50 SBAR wallet cards = \$108

Materials for wallet handout cards = \$20

Preparation of 60-minute educational presentation delivered at UCC monthly meeting by 1 full

time RN @ \$54 x 2 hr = \$108

Follow up meetings with project champions for 15 minutes at a time:

nurse manager @ \$74 x 1 hr = \$74

Full time RN x 4 @ \$54 x 1 hr = \$216

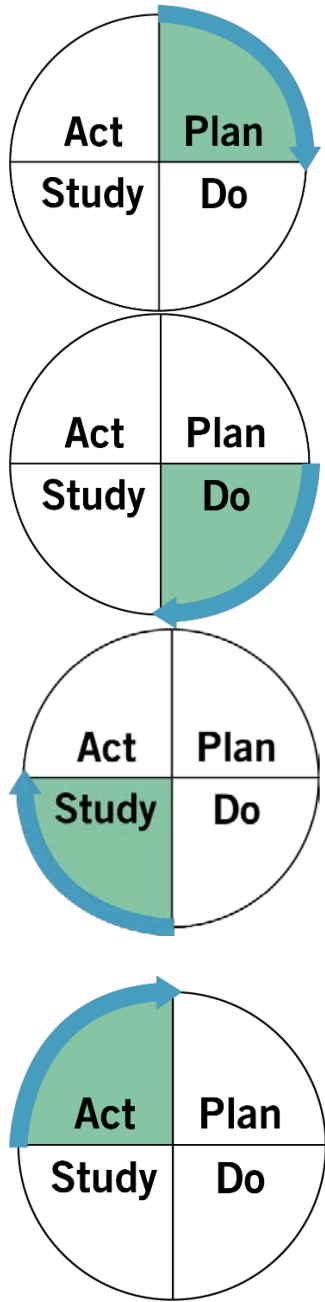
PDSA cycles to assess implementation

Full time RN @ \$54 x 4 = \$216

Total estimated cost of initial SBAR implementation project = \$742

Appendix H

PDSA Worksheet for Testing Change



AIM: To test the effectiveness of SBAR training intervention on the consistency of patient hand-offs between staff at the urgent care center.

- Clinical trial of initial SBAR implementation training program on small group sample.

PLAN:

- Prepare SBAR training PowerPoint presentation.
- Prepare supplemental material; SBAR scenario, handouts, laminated SBAR badge cards.
- Select a project champion.
- Approach potential provider/RN team participants, and arrange a time for the training session.

DO:

- Conduct training session.
- Conduct post intervention survey.
- Request feedback.
- Observe provider/RN team patient hand-offs.
- Follow up observation @ 3 weeks.

STUDY:

- Compare pre-intervention and post-intervention survey and observational data on patient hand-offs
- Assess feedback
- Assess effectiveness of criteria and collection methods
- Consider timing of study relative to patient volume

ACT:

- Make adjustments to observational data collection
- Make adjustments to presentation
- Adjust plan in timing of implementation
- Reschedule next SBAR training
- Continue to observe patient hand-offs

Appendix I

SBAR Simulation Scenario Worksheet

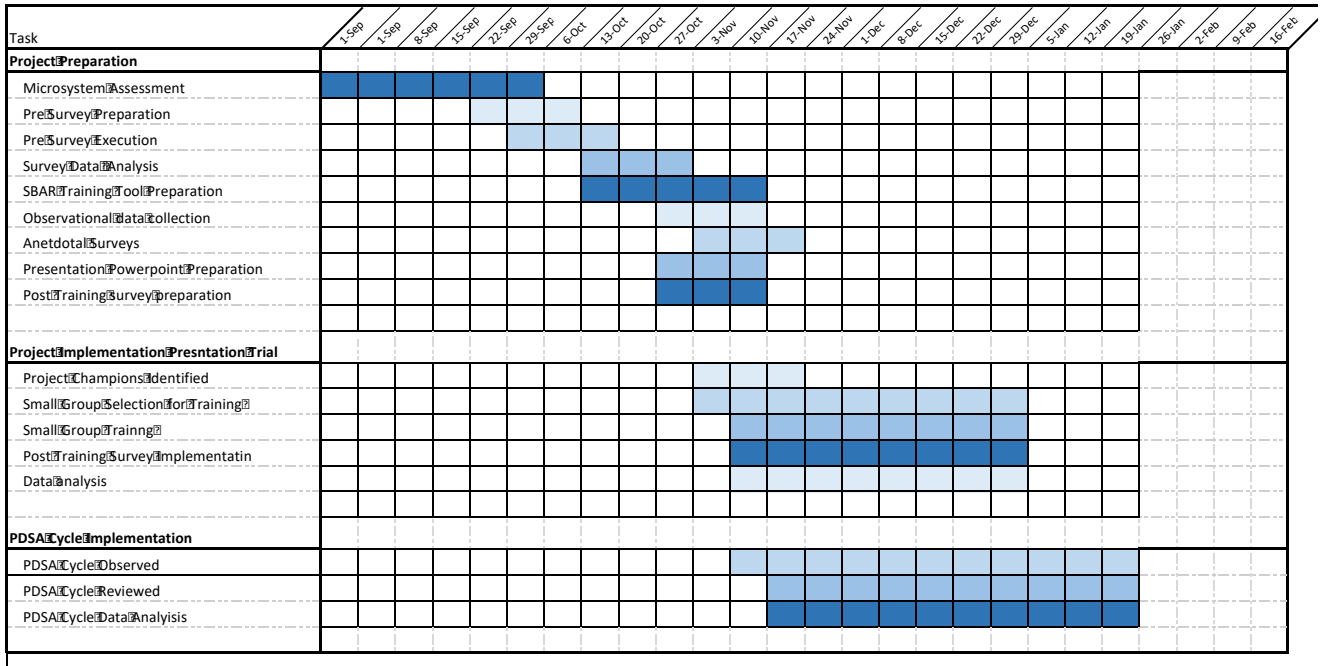
Mrs. Diaz drops into the UCC on a busy Monday morning. Although she is a Family Health Center patient, she states she is unable to get an appointment with the blue team today and would like to be seen at the urgent care. There are several patients ahead of Mrs. Diaz, since the clinic is down one provider and there are already 23 patients checked in. When the front desk staff check her in the LCR screen shows she needs to speak with eligibility. Mrs. Diaz has been in the clinic for 30 minutes before she is called for her intake. She states she has been coughing for about a week with yellowish phlegm. She appears to be a little SOB as she ambulates to room 6 for intake. She speaks some English but you use a Spanish interpreter to do the intake. Her vital signs are as follows BP 152/85, HR 102, RR 24, O2 sat 96%. She denies any chest pain. She appears a little uncomfortable, she is speaking full sentences. She takes 4 different medications, although she is not sure what the names of them are.

<p>S</p>	<p>Situation: UCEL MSE Age/sex chief complaint Location Language</p>
<p>B</p>	<p>Background: Pertinent history. Meds Appointments/PCP</p>
<p>A</p>	<p>Assessment: Of patient/situation Symptoms Vital Signs Pertinent negatives POC. Allergies. Are you concerned</p>
<p>R</p>	<p>Recommendation: Request provider see pt. Urgency. Further POC. Discuss care plan.</p>

Appendix J

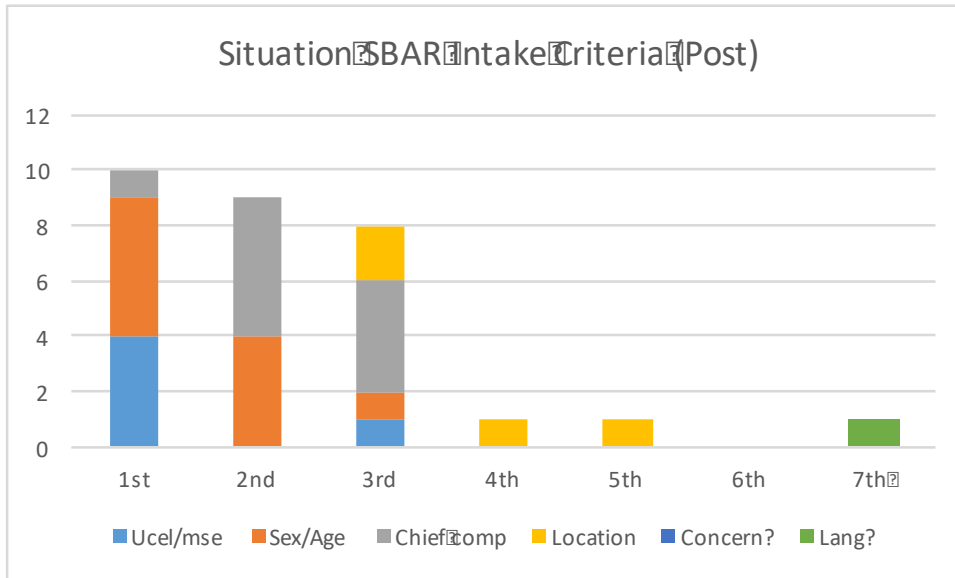
Gantt chart

SBAR Implementation Project
 Owners: Amanda Dowden
 Updated: 11/20/2017



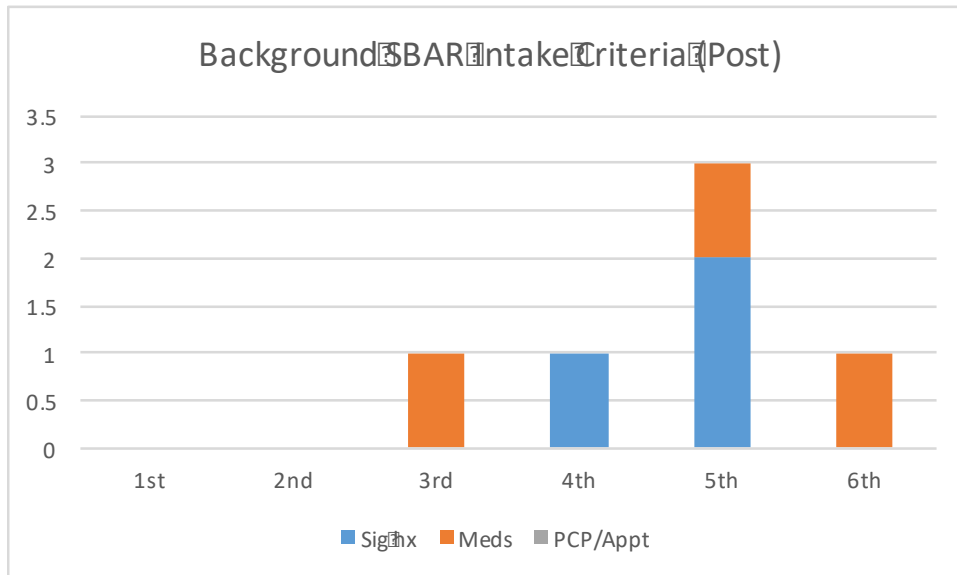
Appendix K

SBAR Criteria Post-Intervention Observation



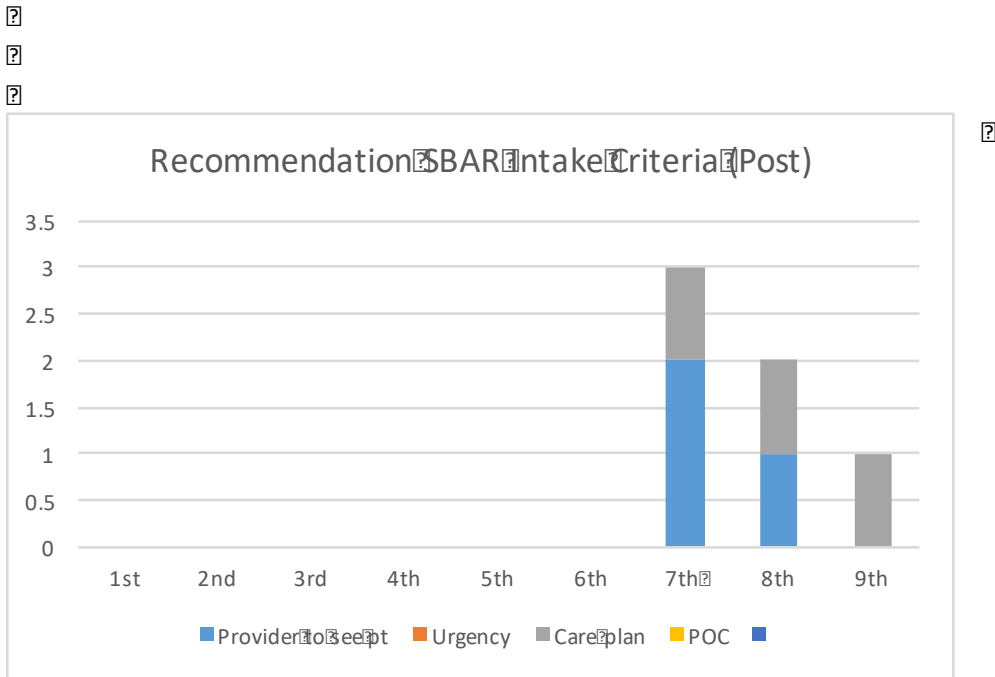
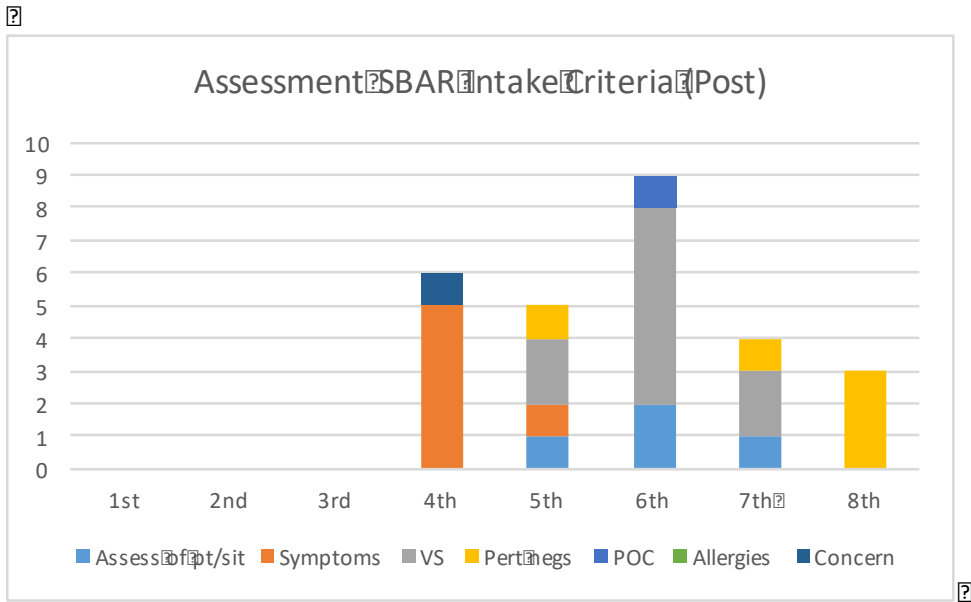
The order intake criteria information is relayed between support staff and providers, listed as 1st, 2nd, 3rd etc, during patient hand-off observations.

N = 10



Appendix K

SBAR Criteria Post-Intervention Observation

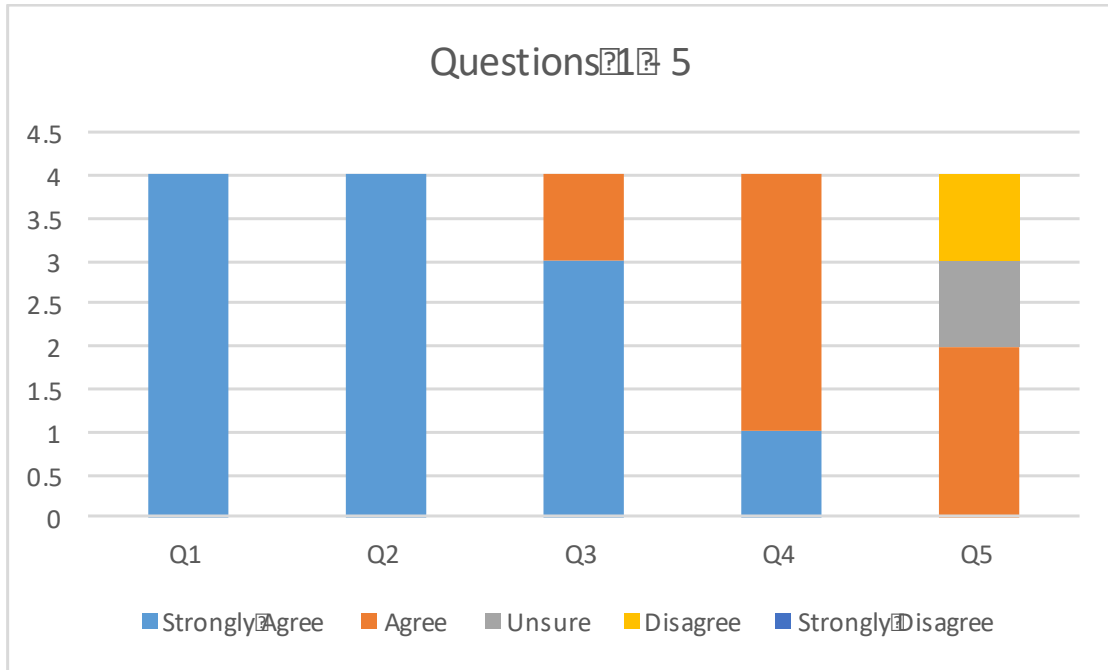


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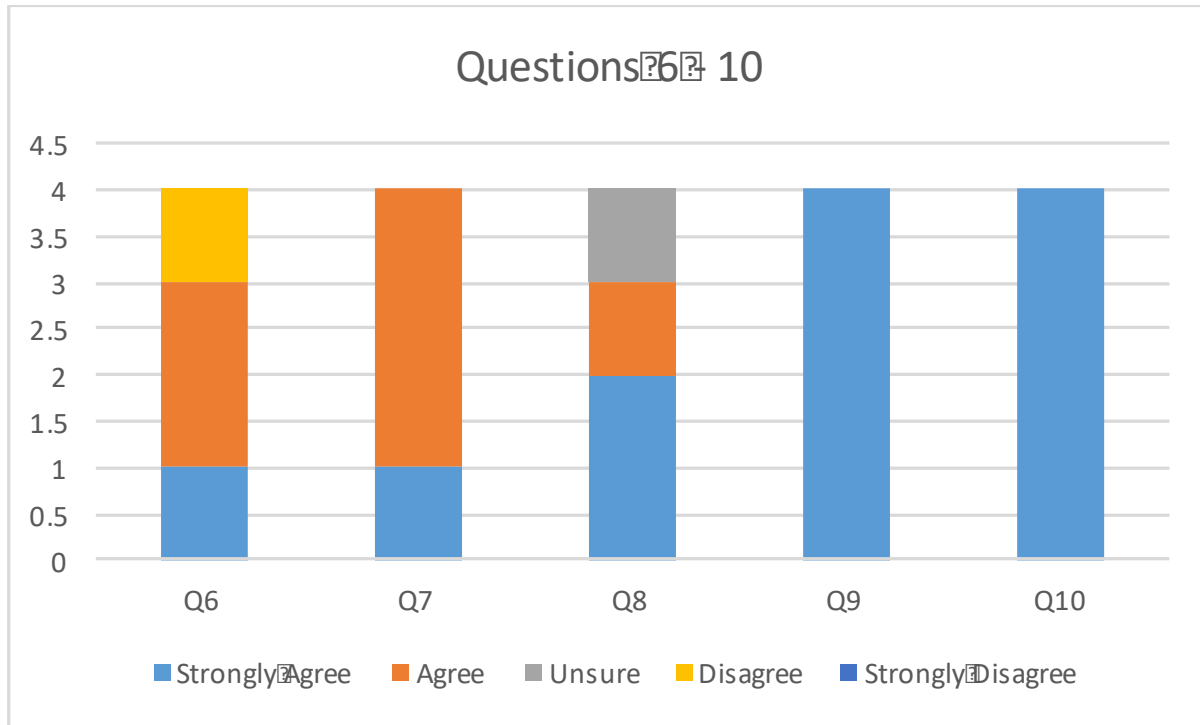
Appendix L

Post Intervention Staff Survey
Questions 1 – 5



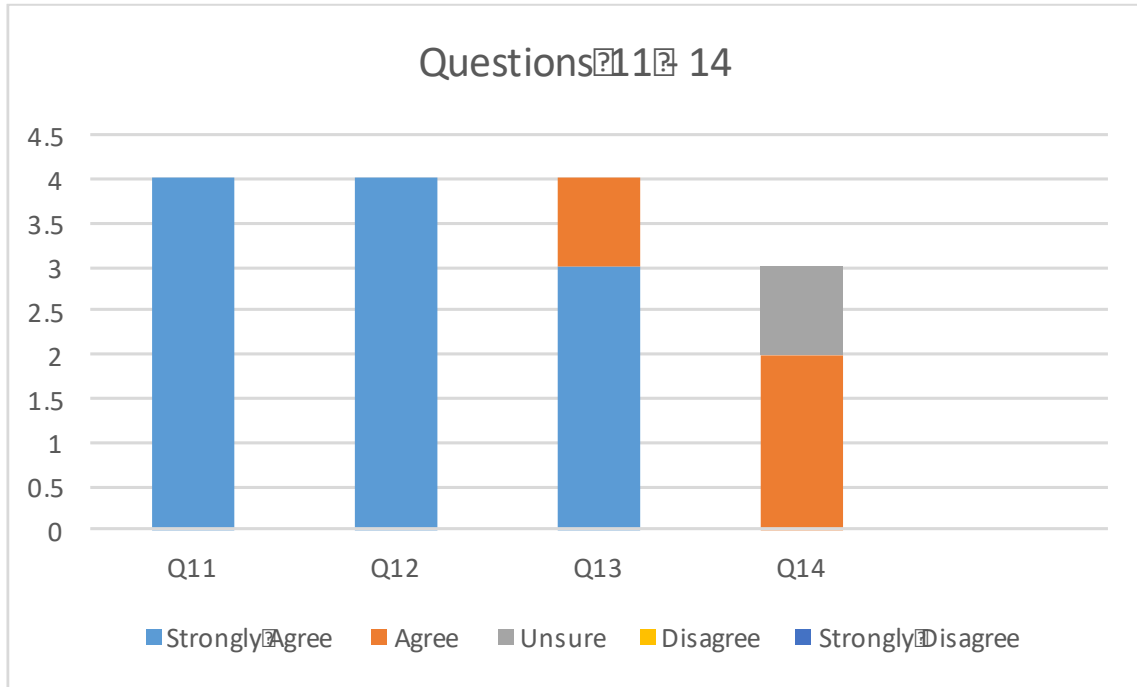
Q1: Communication is an important part of patient safety
Q2: I am familiar with the SBAR communication tool
Q3: I know what the S, B, A, and R stand for in the SBAR acronym
Q4: I use SBAR when I am relaying information regarding patients
Q5: Communication between support staff and providers is consistent in the UCC

**Post Intervention Staff Survey
Questions 6 – 10**



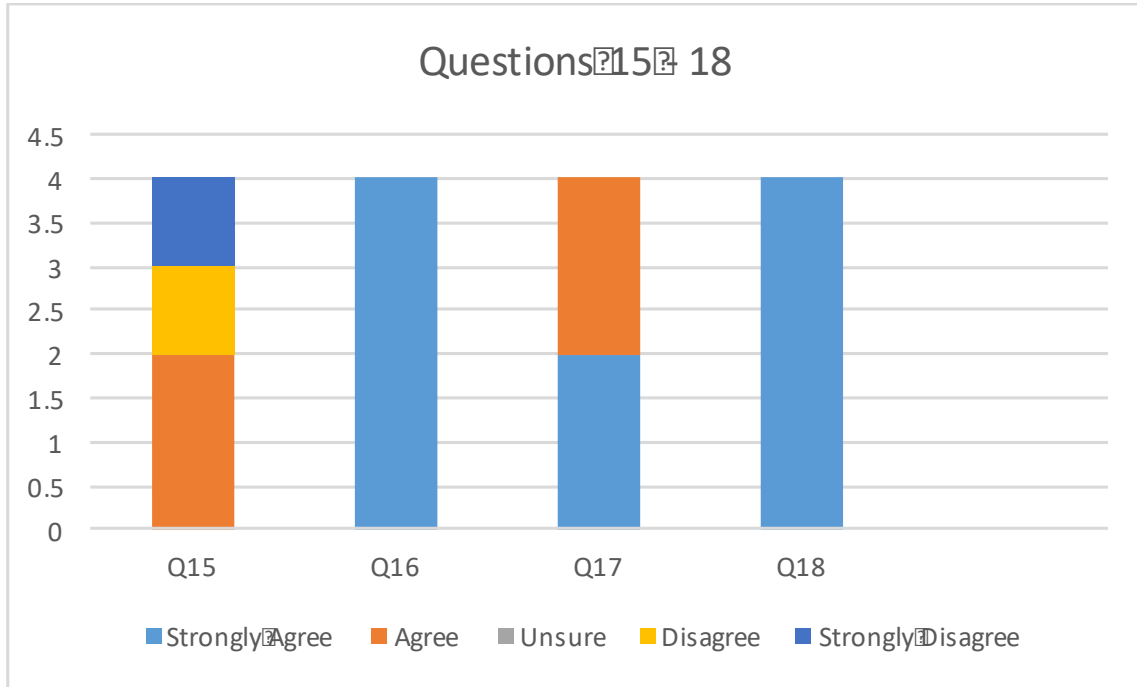
Q6: Things fall between the cracks when transferring patients from one unit to another
Q7: Problems often occur in the exchange of information across hospital units
Q8: I would be comfortable explaining SBAR to a colleague
Q9: There are varying ranges of experience amongst UCC staff
Q10: Standardized communication tools for patient handoffs would help to keep communication consistent

**Post Intervention Staff Survey
Questions 11 - 14**



Q11: Adverse patient outcomes can occur with poor communication
Q12: SBAR helps to keep information organized when relayed to a coworker
Q13: I feel comfortable communicating with my peers
Q14: People support one another in this unit

**Post Intervention Staff Survey
Questions 15 - 18**



Q15: In this unit people treat each other with respect
Q16: There is room for improvement in communication between staff members
Q17: I am interested in improving communication within the department
Q18: Communication has a direct impact on patient care