

Verbal Communication and Improving Patient Safety

*This is an official Seton Healthcare Family communication sanctioned
by the Seton Network Medical Executive Committee.*

***A message from Dr. Karen Swenson,
Chief of Staff, Seton Medical Center Austin***

As part of our high-reliability initiative, the Seton Austin MEC decided earlier this year to focus on verbal communication among nurses and physicians as their first initiative to improve patient safety. They chose as their first tool to highlight SBAR, or a template for clear, concise communication.

SBAR stands for Situation, Background, Assessment and Recommendation. It was first used in nuclear submarines as a way to facilitate clear and complete but concise information when dealing with high-risk situations where quick exchange of information is critical.

We would like you to become familiar with SBAR and have included a brief description and a few [examples](#) to show you what is expected during this information exchange and also to illustrate clear and complete transfer of information. Additionally, our emergency responders (code blue physician and critical response team responders) will be requiring SBAR when they respond to emergent situations.

If you have additional questions, please feel free to contact me or speak to another member of the Seton Austin MEC. You may see individuals wearing buttons "Ask Me About SBAR!" – we would appreciate your assistance helping all of us focus on improving our verbal communication.

What is involved in requiring SBAR?

Who:

- All SMCA Physicians, Nurses and other clinical associates

What:

SBAR is a standardized way of verbally communicating when a patient's status changes or something is requested from the physician. It promotes patient safety because it helps individuals communicate with each other with a shared set of expectations.

SBAR stands for:

- Situation Briefly describe the current situation
 Give a clear succinct overview of pertinent issues
- Background Briefly state the pertinent history
 What got us to this point?
- Assessment Summarize the facts and give your best assessment
 What is going on? Use your best judgment
- Recommendation What actions are you asking for?
 What do you want to happen next?

In health care, nurses and physicians have learned to communicate differently. Nurses use a more narrative description; whereas physicians learn to be very precise, and get to the "point" quickly.

When:

- Types of calls when nurses should use SBAR:
 - Physician visit and the urgency – visit requested
 - Moving patient to higher level of care
 - Change of status
 - Comfort
 - Clarification of order
- Physicians, critical responders (code blue and CRT responders) and those involved in delivery of patient care will be requiring an SBAR script be followed when conveying patient status information or requests about a patient.

Why:

- Effective communication and teamwork are essential for the delivery of safe patient care.
- Communication failures are the leading cause of adverse events.

[Back to Top](#)

SBAR Script Examples

Scenario #1

Situation: Hello Dr. Jones, this is Debbie from SMCA L & D and I am the nurse caring for Lauri Smith, a patient of Dr. Taylor's. **I am very concerned about her condition and think she may need urgent delivery due to her preeclampsia.** I need you to come immediately. Do you need more information at this time? She is here for a PIH workup.

Background: She is a G-1, P-0, 36.1 weeks gestation. She has mild frank preeclampsia for the last three weeks has been home on bedrest. Her pregnancy has been otherwise uneventful and she has no significant medical history.

Assessment: She presents with blood pressures ranging from 170-180/90, 1+ protein in her urine, 1+ reflexes and no Clonus 2+ edema in her lower extremities, she denies headache, visual disturbances, epigastric pain, and her platelets and liver function test are within normal limits.

She is afebrile, fetal heart rate with moderate variability and no decelerations noted with a baseline of 135 and mild regular contractions,

Recommendation: I would like you to come and evaluate her right away. Would you like me to start her on the magnesium sulfate protocol before you arrive? When do you think you will arrive? She is pretty concerned. Thank you

Scenario #2:

Situation: Dr. Nelson, my name is Linda Carter and I'm the SMCA nurse caring for Betsy Ross, a patient of Dr. Moore. She had an abdominal hysterectomy two days ago. **I am concerned about fever and would like an order for Tylenol.**

Background: The total abdominal hysterectomy was performed two days ago. She has had no other significant medical issues or history.

Assessment: Vital signs have been quite stable blood pressure running 110-120 systolic and diastolic of 70's. Heart rate in the 90s. Respiratory rate 22 with oxygen saturation in the high 90s. Within the last hour her temperature has gone from 99 to 102.4.

Recommendation: Would you like to order Tylenol PRN to control fever and would like to know if you'd like to order anything additional since her fever is a new symptom?

Scenario #3:

Situation: Dr. Smith, my name is Tom Lawton and I am an SMCA nurse caring for Cindy Larson, a patient of Dr. Roberts. **I am calling about a routine matter and need a comfort order.** Are you familiar with Mrs. Lawton?

Background: She was admitted on 10-9 and a planned cesarean section was performed.

Assessment: She's having trouble sleeping tonight and said that Restoril 15 mg usually works well for her at home. Her vital signs are stable with a blood pressure of 120/80 and heart rate between 75-90 BPM, respirations are 22 with O2 sats in the 90 range, no fever.

Recommendation: Would you consider an order for Restoril?

SBAR Script Examples, cont.

Scenario #4 - Emergent Scenario:

Situation: My name is Becky Carter and I am the nurse caring for Susie Smith a patient of Dr. Ruben. **I am calling about a very significant change in Ms. Smith's condition (low B/P of 70/40) and I have notified the critical response team to help in her care.** Would you like more information at this time or do you just want to come immediately?

Background: She was admitted on 10-9 with planned cesarean section and she has been quite stable until this evening when she started experiencing vital sign changes and altered mental status.

Assessment: Her blood pressure which usually runs 120/80 is now 88/50. Heart rate has changed from 70s-80s to 120 BPM, and respiratory rate usually in the low 20's to 44. Within the last 20 minutes RT has recently increased her oxygen to 6 liters to keep her O2 saturation in the high 80% range. Her mental status has changed from alert and oriented x 3 to restless and confused, not aware she is in the hospital. I think she's becoming severely septic and becoming shocky. I have instituted the severe sepsis emergency protocol and we are starting 500 ml of Normal saline per protocol and I have asked RT to draw a serum lactate. I have also called the critical response team.

Recommendation: I would like you to come right away. I'm concerned she needs to move to a higher level of care.

[Back to Top](#)

Thank you very much for promoting clear, concise and effective communication between nurses and physicians.