ASHRM Patient Safety Tip Sheet: Communication

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Situation: The Joint Commission, Department of Defense, and other agencies have collected data identifies communication as the leading cause of sentinel events, which are the most serious adverse events. Communication failures contribute to 50-80% of sentinel events, according to the Joint Commission.[1]

Background: Michael Leonard, MD, Physician Leader for Patient Safety, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado (Evergreen, Colorado, USA), developed a communication technique using the mnemonic SBAR-Situation-Background-Assessment-Recommendation. This communication tool has been successfully implemented in various health care settings to promote teamwork and a culture of safety.

Assessment:
SBAR communication technique provides a framework for communication between members of the health care team about a patient's current condition. This model allows an easy and focused way to set expectations regarding what and how information should be communicated and shared. It is especially helpful during high anxiety situations that require immediate attention and/or action.

- **S = Situation** (a concise statement of the problem)
- **B = Background** (pertinent and brief information related to the situation)
- **A = Assessment** (analysis and considerations of options — what you found/think)
- **R = Recommendation** (action requested/recommended — what you want)

SBAR is an easy and effective way to enhance communication between individuals. It provides a concise, yet comprehensive message reducing the probability of error.

Recommendation:

On September 12, 2017, the Joint Commission released a Sentinel Event Alert regarding inadequate hand-off communication.[2] In addition to SBAR communication, the alert included some of the following recommendations:

- Standardize training on how to conduct a successful hand-off – from both the standpoint of the sender and receiver.
- Engage staff in training using methods such as real-time observation and performance feedback, role-playing and simulation, and independent learning.
- Identify champions and coaches to promote quality improvement and serve as role models.
- Provide positive reinforcement to employees who perform hand-offs according to the standardized process.

References:

1. PSHQ. Patient Handoffs: The Gap Where Mistakes Are Made. Patient Safety Monitor Journal. November 2017. Accessed at: https://www.psqh.com/analysis/patient-handoffs-gap-mistakes-made/

2. Inadequate hand-off communication. Sentinel Event Alert. 2017 Sep 12;(58):1-6.