CHAPTER 1

Introduction

Intimidating Conversations

You are working the night shift and it is 3 a.m. Your patient has just put on the call light and is complaining of shortness of breath. You freeze. You think to yourself, "This can't be happening. She was fine an hour ago. I've only been a nurse a few weeks. What is wrong with my patient? What should I do first? Did I do something wrong to cause this? Should I ask for help? Oh man, the doctor is going to be so mad at me when I call; they're definitely sleeping. What am I going to say first? What are they going to want to know?"

Does this situation sound familiar to you? As a new nurse, you may not feel confident in your ability to handle this situation and can become nervous about the upcoming conversation with the provider. You are not alone.

Differences in Communication Styles

Typically, nurses and providers communicate differently. As you are reading this guide, this statement should not come as a surprise. Nurses tend to be more narrative and descriptive, whereas providers prefer a bulleted, to-the-point description of a patient's condition. In so many situations, time is of the essence, and while attempting to be expedient, information can be lost in the process. Differences in communication styles can lead to strained interprofessional relationships, causing nurses to avoid contact with providers, and conversely, providers dreading their phone calls. It is a frustrating situation, but can be especially difficult for newer nurses, because they often lack confidence and may be unprepared to collect essential data about an acute clinical situation.

Ineffective communication among medical professionals is a leading contributor to adverse medical events, errors, and patient death. It can also lead to increased length of hospital stay,

diminished nurse and provider job satisfaction, and higher health care costs. Improving patient safety is a top priority, and a key component to addressing this issue is improving communication among caregivers.

How Do We Fix This?

The World Health Organization, The Joint Commission, and the Institute for Healthcare Improvement recommend using the SBAR communication tool to create a common language among all caregivers. SBAR can be used by anyone, but it is most widely used and initiated by nurses.

SBAR stands for:

Situation: Why are you calling the provider?

Background: What background information is pertinent to the situation?

Assessment: What do you think is wrong with the patient?

Recommendation: What is your recommendation regarding the patient's care, or what do you need from the provider?

SBAR was originally created by the United States military and was then adopted and developed by Kaiser Permanente to encourage standardized communication in the medical environment. It can be used in a variety of settings, including inpatient, rehabilitation, and long-term care. Studies examining the effectiveness of SBAR have found that it improves the perception of communication between nurses and providers; creates a safer environment; and reduces medical errors, incident reports, re-hospitalizations, and unexpected deaths. Using SBAR can reduce anxiety and allow the nurse to better prepare for the conversation with the provider and, accordingly, help to eliminate unnecessary or incomplete narration. The use of SBAR allows the nurse to deliver a thorough, concise report, which gives the provider enough information to ask additional meaningful and deliberate questions in order to develop a comprehensive plan of care. SBAR requires the nurse to critically think and use their clinical judgment in order to be a part of the decision-making process.

Why Aren't We Doing This Already?

Even though the use of SBAR has been shown to be effective, it is not always utilized in actual patient care settings unless required by the employer. Nursing programs are beginning to embed SBAR communication techniques into their curriculum, but it is not consistent nationwide. Another obstacle to the wider use of this communication tool is that there are many variations of SBAR; the most up-to-date variation is ISBARR, which adds *Introduction* and *Read Back Order* components. Giving the provider a professional introduction and reading back the given orders have been found to be simple, yet critical, strategies to improve communication within the standard SBAR model.

The ISBARR examples currently available may vary by author and do not usually provide specific descriptions for different clinical situations. While the concept of ISBARR is simple and easy to understand, the undertaking of the assessment that provides the content to complete the report may be challenging for a new nurse. Because utilizing ISBARR effectively takes experience and skill, novice nurses can have difficultly recognizing a patient's decline, formulating an action plan, and collecting the pertinent data needed to make the ISBARR report complete. *I-S-A-V-E-P-L-A-N* is an acronym that can be used to fill in the different components of the ISBARR tool.

I-S-A-V-E-P-L-A-N stands for:

Introduction: Introduce yourself and the patient.

Sign/Symptom: What is the main sign/symptom you are concerned about?

Associated Signs/Symptoms: What other associated signs/symptoms is the patient experiencing?

Vitals: What is the most recent set of vital signs (and trends if applicable)?

Exam: What are the pertinent physical exam findings you have assessed?

Past Medical History: What past medical history elements may be related to the sign/symptom?

Labs and Medication: What labs and medication may be affecting the current situation?

Assessment: What do you think is wrong with the patient?

Nursing Recommendations, Interventions, and Read Back: What nursing interventions have you implemented so far? What interventions are you recommending for the situation? What other interventions does the provider want done? Any orders given by the provider should be read back to the provider to verify.

I-S-A-V-E-P-L-A-N can be used to ensure that you are gathering all the pertinent data regarding the patient's issue before calling the provider. It was developed by the author from *The Guidelines for SBAR Use* by Kaiser Permanente. The complete ISBARR template is described below.

How Do You Use the Rest of This Book?

The next 29 chapters provide common clinical signs/symptoms that you might encounter as a nurse. You may not need to use all the information from the chapter for the ISBARR, and it will not replace clinical judgment or your institution's policies, but you will know the information if the provider asks, and it will help prompt questions during the conversation.

The chapters are meant to guide you through the complaint, ensure that you are collecting comprehensive information that the provider may need, and organize it utilizing the ISBARR format. Each chapter has the following: a brief overview of the sign/symptom; a description of differentials for the sign/symptom; questions you should ask your patient, family member, witness, or yourself; the physical exams that should be completed; and the past medical history (including medications and labs) that should be assessed. The chapters also provide evidence-based nursing interventions that can be initiated before (or while) you call the provider and plan-of-care recommendations to discuss with the provider.

As a reference, an example of an ISBARR conversation is given for the sign/symptom at the end of each chapter, along with

ISBARR Template	
I **Introduction**	**Introduce Yourself and the Patient** • Patient name/room number/location • Brief HPI if the provider is not familiar with the patient • CODE status (if applicable)
S **Situation**	**Sign/Symptom You Are Concerned About** • Brief description of the sign/symptom you are concerned about and why you are calling **Associated Signs/Symptoms** • All associated signs/symptoms the patient is experiencing

B
Background
	Vitals
	• Blood pressure (orthostatic if applicable), pulse, respiratory rate, O_2 sat, and temperature
	Exam
	• Pertinent physical exam findings
	Past Medical History
	• Past medical history that may be related to the sign/symptom
	Labs and Medications
	• Recent labs that may be related to the sign/symptom
	  • Date/time the lab was done
	  • Trends of the lab (if available)
	• Medications that may be contributing or used to treat the sign/symptom
	• Know the times they were last taken

A **Assessment**	**Assessment** • What do you think is wrong with the patient, or what are you concerned about? • Let the provider know if you are unsure what is wrong.

ISBARR Template	
R **Recommendation** **R** **Read Back**	**Nurse's Recommendations, Interventions, and Read Back** • What nursing interventions have already been done or are in progress • Give order recommendations to the provider (if appropriate) • Make the provider aware if you want them to assess the patient STAT • Ask what other orders the provider wants • Read back orders and ask the provider to put the orders in the electronic medical record (if available)

a brief overview of select common or emergent differentials (for the sign/symptom) and how they may present. It is the provider's job to determine the diagnosis and plan of care; however, it is important that the nurse is able to develop an idea of what may be causing the patient's issue. It is also important to remember that nothing in medicine is exact and that presentations of each disease can vary with every patient.

References

Arora, V., Auerbach, A. D., & Sokol, H. N. (2017). Patient handoffs. In J. A. Melin (Ed.), *UpToDate*. Retrieved from https://www.uptodate.com/contents/patient-handoffs

Ashcraft, A. S., & Owen, D. C. (2014). From nursing home to acute care: Signs, symptoms, and strategies used to prevent transfer. *Geriatric Nursing, 35,* 316–320.

Beckett, C. D., & Kipnis, G. (2009). Collaborative communication: Integrating SBAR to improve quality/patient safety. *Journal for Healthcare Quality, 31*(5), 19–28.

Blom, L., Petersson, P., Hagell, P., & Westergren, A. (2015). The situation, background, assessment and recommendation (SBAR) model for communication between health care professionals: A clinical intervention pilot study. *International Journal of Caring Sciences,* 8(3), 530–535.

Boaro, N., Fancott, C., Baker, R., Velji, K., & Andreoli, A. (2010). Using SBAR to improve communication in interprofessional rehabilitation teams. *Journal of Interprofessional Care, 24*(1), 111–114. doi: 10.3109/13561820902881601

Compton, J., Copeland, K., Flanders, S., Cassity, C., Spetman, M., Xiao, Y., & Kennerly, D. (2012). Implementing SBAR across a large multihospital health system. *The Joint Commission Journal on Quality and Patient Safety, 38*(6), 261–268.

Cornell, P., Townsend-Gervis, M., Yates, L., & Vandaman, J. M. (2014). Impact of SBAR on nurse shift reports and staff rounding. *MEDSURG Nursing, 23*(5), 334–342.

Crawford, C. L., Omery, A., & Seago, J. A. (2012). The challenges of nurse-physician communication. *Journal of Nursing Administration, 42*(12), 548–550. doi: 10.1097/NNA.0b013e318274b4c0

De Meester, K., Verspuy, M., Monsieurs, K. G., & Bogaert, P. V. (2013). SBAR improves nurse–physician communication and reduces unexpected death: A pre- and post-intervention study. *Resuscitation, 84*, 1192–1196.

Enlow, M., & Guhde, J. (2010). Incorporating interprofessional communication skills (ISBARR) into an undergraduate nursing curriculum. *Nurse Educator, 35*(4), 176–180. doi: 10.1097/NNE.0b013e3181e339ac

Hart, P. L., Brannan, J. D., Long, J. M., Brooks, B. K., Maguire, M. B., Robley, L. R., & Kill, S. R. (2015). Using combined teaching modalities to enhance nursing students' recognition and response to clinical deterioration. *Nursing Education Perspectives, 36*(3), 194–196.

Institute for Healthcare Improvement. (2014). *SBAR: Situation-background-assessment recommendation.* Retrieved from http://www.ihi.org/Topics/SBARCommunicationTechnique/Pages/default.aspx

Institute of Medicine. (1999). *To err is human: Building a safer health system.* Retrieved from https://iom.nationalacademies.org/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf

Joffe, E., Turley, J. P., Hwang, K. O., Johnson, T. R., Johnson, C. W., & Bernstam, E. V. (2013). Evaluation of a problem-specific SBAR tool to improve after-hours nurse-physician phone communication: A randomized trial. *The Joint Commission Journal on Quality and Patient Safety, 39*(11), 495–501.

The Joint Commission. (2012a). *Improving patient and worker safety: Opportunities for synergy, collaboration and innovation.* Retrieved from http://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf

The Joint Commission. (2012b). *Transitions of care: The need for a more effective approach to continuing patient care. Hot topics in health care*. Retrieved from http://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

Kaiser Permanente. (n.d.). *Guidelines for communication with physician using the SBAR process*. Retrieved from http://bcpsqc.ca/documents/2012/12/SQAN-Teamwork-Communication-SBAR-Guidelines-Kaiser-Permanente.pdf

Kostiuk, S. (2015). Can learning in ISBARR framework help to address nursing students' perceived anxiety and confidence levels associated with handover reports? *Journal of Nursing Education, 54*(10), 583–587. doi:10.3928/01484834-20150916-07

Lancaster, R. J., Westphal, J., & Jambunathan, J. (2015). Using SBAR to promote clinical judgment in undergraduate nursing students. *Journal of Nursing Education, 54*(3), 31–34.

Narayan, M. C. (2013). Using SBAR communications in efforts to prevent patient rehospitalizations. *Home Healthcare Nurse, 31*(9), 504–515.

Nasarwanji, M. F., Badir, A., & Gurses, A. P. (2016). Standardizing handoff communication. *Journal of Nursing Care Quality*, *31*(3), 238–244. doi:10.1097/NCQ.0000000000000174

Randmaa, M., Martensson G., Swenne, C. L., & Engstrom, M. (2014). SBAR improves communication and safety climate and decreases incident reports due to communication errors in an anesthetic clinic: A prospective intervention study. *BMJ Open, 4*(1), 1–8. doi:10.1136/bmjopen-2013-004268

Renz, S. M., Boltz, M. P., Wagner, L. M., Capezuti, E. A., & Lawrence, T. E. (2013). Examining the feasibility and utility of an SBAR protocol in long-term care. *Geriatric Nursing, 34*, 295–301.

Scotten, M., LaVerne-Manos, E., Malicoat, A., & Paolo, A. M. (2015). Minding the gap: Interprofessional communication during inpatient and post discharge chasm care. *Patient Education and Counseling, 98*, 895–900.

Townsend-Gervis, M., Cornell, P., & Vardaman, J. M. (2014). Interdisciplinary rounds and structured communication reduce re-admissions and improve some patient outcomes. *Western Journal of Nursing Research, 36*(7), 917–928. doi: 10.1177/0193945914527521

WHO Collaborating Centre for Patient Safety Solutions. (2007). *Communication during patient hand-overs*. Retrieved from http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf