

Using SBAR to communicate falls risk and management in interprofessional rehabilitation teams

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Research team

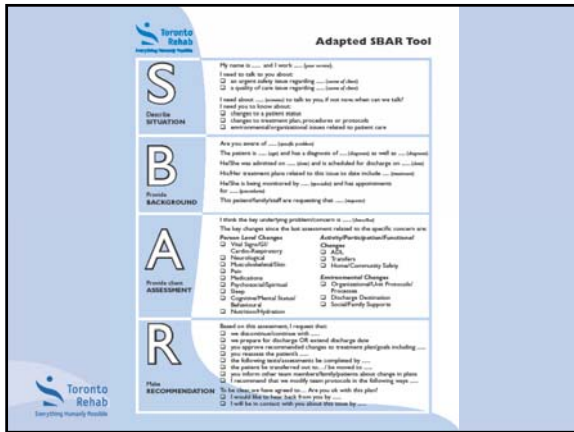
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 - Elaine Aimone
 - Dr. Gaetan Tardif
- Funding source:
 - Canadian Patient Safety Institute and the Toronto Rehabilitation Institute



Structured communication

- Sets up expectation for **what** and **how** a safety issue is communicated
- Provides appropriate assertion, awareness and education to a situation
- Growing support for effectiveness in high-risk care settings
- Primarily between nurses and physicians





Purpose of the study

- To track implementation of the adapted SBAR on two clinical units with high falls incidence rates
- To evaluate processes and outcomes related to falls incidence, severity, patient safety culture, and team communication

Methods

- Pre-post design; convenience sample
- n=50/55 (geriatrics); 35/50 (MSK)
- Three educational workshops (total=4 hours)
- Six month implementation phase
- Interviews and observations to track uptake of SBAR

Outcomes

- Three main indicators
 - Staff perceptions of patient safety culture and team communication
 - AHRQ culture survey
 - Team orientation scale
 - Safety reporting
 - falls incidence and severity
 - near miss reporting



Hospital Survey on Patient Safety Culture

- Developed by the Agency for Healthcare Research and Quality (AHRQ) in US (2004)
- Designed to evaluate changes in safety culture over time and the impact of safety interventions
- Intended for use with all types of hospital staff
- Used widely across the US and found to be valid and reliable
- 5% rule (suggests clinical change) and critical ratio test (statistical significance)



Study teams pre vs post

Dimension	Z-Score	% Change
Overall Perceptions of Safety	*	20%
Frequency of Events Reported		8%
Manager Expectations Promoting Safety		5%
Organizational Learning	*	14%
Teamwork Within Units	*	9%
Communication Openness	*	13%
Feedback & Communication About Error	*	15%
Non-Punitive Response to Error	*	13%
Staffing	*	16%
Mgmt Support for Patient Safety		8%
Teamwork Across Hospital Units	*	17%
Handoffs & Transitions	*	28%



Rest of organization pre vs post

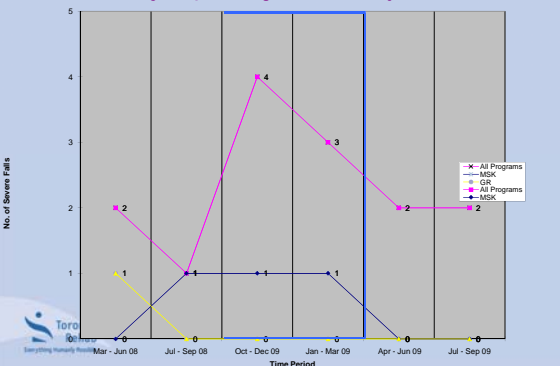
Dimension	2008	2009	Z-Score	% Change
Overall Perceptions of Safety	59%	63%	*	4%
Frequency of Event Reporting	53%	56%		3%
Manager Expectations Promoting Safety	76%	76%		0%
Organizational Learning - Continuous Improvement	72%	77%	*	5%
Teamwork Within Hospital Units	79%	81%		3%
Communication Openness	58%	56%		-2%
Feedback and Communication About Error	62%	64%		2%
Nonpunitive Response to Error	45%	48%		3%
Staffing	52%	52%		0%
Hospital Management Support for Patient Safety	76%	80%	*	4%
Teamwork Across Hospital Units	65%	67%		2%
Hospital Handoffs & Transitions	47%	51%	*	4%

Team Orientation Scale:

Study teams pre-post:
4 items significant
($p < 0.05$)

1. Team members act upon the information I communicate to them.
2. I am able to communicate effectively with team members.
3. This team has agreed methods for communication.
- R4. Communication between team members is unclear.
5. I regularly communicate with other members of the team.
6. I act upon the information that other members of the team communicate to me.
7. All team member's perspectives are important.
8. This team believes it is important to consider the perspectives of all team members.
9. I believe other team members value my contribution to our work.
10. Each team member plays a valuable role within the team.

Safety reporting: Total major falls



Conclusions

- SBAR widely and effectively used among interprofessional team, including both clinical and non-clinical staff
- SBAR champions on the unit helped to encourage, reinforce, and sustain the use of SBAR with colleagues
- SBAR use prevalent for both urgent **and** non-urgent situations, beyond issues of falls
- Improved communication has resulted in positive changes in staff perceptions of patient safety culture and team communication but not directly on patient outcomes





SBAR:
A Shared Structure
for Effective
Team Communication

Aligned for Rehabilitation and
Complex Continuing Care

An Implementation Toolkit
2nd Edition

Prepared by
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www.torontorehab.com/SBAR
