

IMPLEMENTATION OF A STANDARDIZED SHIFT TO SHIFT  
REPORT ON AN INPATIENT MEDICAL / SURGICAL UNIT

LATIFAT OKEKE

DNPV 767 – PROJECT III

TOURO UNIVERSITY NEVADA

DNP PROJECT CHAIR: DR. JUDITH CARRION

DNP PROJECT INSTRUCTOR: DR. DENISE ZABRISKIE

DNP PROJECT ACADEMIC MENTORS: DR. RHONNE D'ERRICO

DR. MARIA D'ERRICO

FEBRUARY 18, 2021



## PROJECT OVERVIEW



- ❖ The topic of the DNP project is the “Implementation of a standardized shift to shift report tool on an inpatient medical / surgical unit”
- ❖ Ineffective communication is one of the main causes of medical errors and sentinel events in healthcare settings (Trossman, 2019).
- ❖ Negative health outcomes related to poor communication is enormous, most of the adverse / sentinel events in the healthcare setting have been traced to poor communication (The Joint Commission, 2017; Institute of Healthcare Improvements, 2018)
- ❖ Staff training was implemented to improve change of shift report
- ❖ Project participants were 44 registered nurses on an in-patient medical / surgical unit.

## PROJECT INTRODUCTION & BACKGROUND 1

- ❖ Handoffs plagued with poor communication ultimately lead to patient harm (Arora & Farnan, 2019). Nurses who disseminate critical information must concisely communicate patients' pertinent clinical information.
- ❖ Staff training / implementation of SBAR (situation, background, assessment, recommendation) tool, enhances effective and efficient communication
- ❖ Project site is in an acute care hospital in New York city and 44 registered nurses are involved in this DNP project



## PROJECT INTRODUCTION & BACKGROUND 2



- ❖ One of the most challenging aspects job of a nurse is the high demand for communication with those around them, whether they are patients, doctors or other nurses, you always need to effectively engage with people.
- ❖ Poor communication is a patient safety issue (The Joint Commission, 2017)
- ❖ Effective and efficient communication can help create a culture of excellence, which in turn delivers values for patients, families and fellow caregivers.
  - Builds trust between the patient and the provider, nurse to nurse

## PROJECT INTRODUCTION & BACKGROUND 3

- Trust combats negative emotions and make it easier to reach clear understanding of relayed information
- Shapes the patient's experience
- Builds nurse -patient therapeutic relationship
- ❖ These values enhance outcomes, safety and efficient care.
- ❖ Effective communication between nurses fosters the ability to provide individualized patient plan of care which leads to better patient outcomes (Ofori-Attah et al., 2015).

## PROJECT PROBLEM



- ❖ Literature illustrates that unstructured and disorganized handoff patterns contribute immensely to medical errors and sentinel events in hospital settings (Starmer et al., 2017)
- ❖ Lack of a standardized communication tool at the project site
  - Project site does not have a structured, standardized shift to shift handoff process in place. Each of the nurses with different style of giving report
  - The current reporting process at the project site predisposes to sentinel events and compromises safety
  - TJC National Patient Safety Goals issued in 2019 require healthcare institutions to implement a standardized handoff communication tool such as SBAR
- ❖ Improving communication is dependent on the training of the registered nurses
- ❖ Implementing a standardized SBAR tool fosters effective communication, prevents sentinel events and medical errors. This ultimately leads to positive patient outcomes (Starmer et al., 2017).

## PURPOSE STATEMENT

The purpose of this DNP project is :

- ❖ To provide staff educational training on SBAR communication tool in order to foster effective communication
- ❖ To implement a standardized process of conducting handoff report for registered nurses at the project site
- ❖ To improve communication of pertinent patient information during the handoff process

## PROJECT QUESTION



The project question is:

- ❖ Would an educational training, implementation and monitoring adherence to the SBAR tool improve change of shift communication?



## IMPORTANCE OF COMMUNICATION IN NURSING



A critical component of nursing practice

❖ Effective and efficient communication

➤ It generate trust between nurses, nurses and other providers, nurse and clients

➤ It provides professional satisfaction

➤ It is a means of bringing about change, i.e. nurse listens, speaks, and acts to negotiate changes that promote clients optimal well-being.

## PROJECT OBJECTIVES

The objectives for this project are:

- ❖ To implement a standardized shift to shift report tool
- ❖ To educate nurses at the project site on the standardized shift to shift report (SBAR) tool
- ❖ To ensure 80% minimum staff compliance with the utilization of the SBAR tool by  
conducting observational audits of staff compliance (Appendix E)

## BARRIERS TO ADHERENCE

- ❖ Lack of knowledge / understanding
  - Awareness and Impact of SBAR tool
- ❖ Lack of the nurse's skill in assessment
  - Assessment of the SBAR tool elements
- ❖ Lack of sustainability of the utilization of the SBAR tool
  - Leadership buy-in of the project is very crucial

## REVIEW OF LITERATURE 1

- ❖ Articles published between 2014-2020 describing the impact of ineffective communication in nursing
- ❖ Articles published between 2014-2020 describing the impact of educating nurses on the inpatient units on the use of a standardized shift to shift report tool (SBAR)
- ❖ Communication during change of shift should be organized, to enhance effective communication (Starmer et al., 2017)

## REVIEW OF LITERATURE 2

- ❖ Theme of education and its outcome on adherence with the utilization of the SBAR tool
- ❖ Sub-theme of the effect of poor, ineffective communication among nurses during change of shift report
- ❖ Educational training and implementation of the SBAR tool foster adherence and reinforce effective communication during change of shift report (Achrekar et al., 2016)
- ❖ Outcome evaluation by conducting adherence observation of nurses utilization of the SBAR tool

## THEORETICAL MODEL

- ❖ The theory of quality improvement or carrying out change by Edward W. Deming
- ❖ This model is a four-stage problem solving cycle Plan-Do-Study-Act (PDSA)
- ❖ Used for improving a process or carrying out change in healthcare and other allied professions (Coury et al., 2017)
- ❖ The use of this theory will provide structure for staff to focus on improving practice and test the desired change (Coury et al., 2017)
- ❖ Allows the nurse to engage in using the standardized SBAR tool to effect change in communication pattern during change of shift report
- ❖ To test a change by developing a change process to support safe, timely, effective, equitable and cost effective care delivery (Reed & Card, 2016)



## PROJECT DESIGN

- ❖ The design for this project utilized a quality improvement process
- ❖ The design focused on establishing a standardized shift to shift report tool on an inpatient medical / surgical unit
- ❖ Also focused on providing education and conducting adherence observations to the utilization of the SBAR tool and reinforce effective communication during change of shift

## PROJECT PLAN

- ❖ The DNP project was implemented during a six-week time frame
- ❖ The implementation phase included:
  - Implementing the intervention
  - Data collection
  - Analyzing and Evaluating the project results



## IMPLEMENTATION



- ❖ Implementation for this DNP project will involve educational training and implementing the SBAR (situation, background, assessment, recommendation) tool
- ❖ A PowerPoint educational training and handout on the SBAR tool will be used for implementation

## DATA COLLECTION



Data collection procedure included:

- ❖ Adherence assessment checklist conducted by the project lead
- ❖ The participants utilization of the SBAR tool were observed
- ❖ Data was compiled by project lead, analyzed using both  
SPSS version 25 and VassarStats

## RESULTS 1



The purpose of monitoring the adherence with the SBAR tool during handoff at the project site was because the factors that affect quality of service is ineffective communication of patients' condition and non-adherence to procedures by the health practitioners (Bussell et al., 2017).

- ❖ Project was successfully implemented at the project site
- ❖ Participants were compliant with the SBAR tool utilization  
after the educational training and implementation

## RESULTS 2

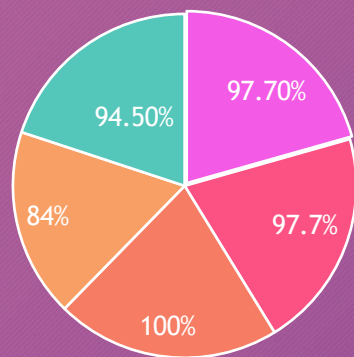


- ❖ Findings show a mean score of 3.80 adherence
- ❖ Overall adherence to the SBAR tool was 94.5%
- ❖ Intervention yielded well above 80% adherence rate predicted by the project lead
- ❖ General prediction, questions and objectives were met
- ❖ Training and implementation of the SBAR tool supported effective communication between shifts

## RESULT 3

### SBAR Tool Elements & Overall Adherence in Percentage

SBAR Tool Elements & Overall Adherence in Percentage



■ Situation ■ Background ■ Assessment ■ Recommendation ■ Overall Adherence

- 97.7% participants adhered to situation (43 out of 44 n)
- 97.7% participants adhered to background (43 out of 44 n)
- 100 % participants adhered to assessment
- 84% participants adhered to recommendation (37 out of 44 n)
- 94.5% participants overall adherence to SBAR tool post educational training and implementation of SBAR tool
- Fall outs (scores less than 100%) are due to assessment skill of the participants e.g. providing recommendation.

## EVALUATION

- ❖ An adherence observational checklist was used for evaluation by the project lead
- ❖ Evaluation entailed the assessment of the four elements of the SBAR tool
- ❖ Evaluation entailed the assessment of the overall adherence to the SBAR tool  
based on findings from each element

## PROJECT LIMITATIONS 1

There were two limitations identified for this project:

- ❖ The data collected was on a single unit at one project site:
  - Implementing the project on one unit limits the chance of large data collection on many units. It may affect the validity of the project results (Dove et al., 2016). This limitation leads to reduction in the power of the project and limits the generalizability (Faber & Fonseca, 2014).

## PROJECT LIMITATION 2

### ❖ Project time frame:

- The six weeks time frame for this project was inadequate to truly measure sustainable change at the project site. Minimum of six months would have allowed for greater application of knowledge into practice, a true measure of adherence and permanent change.
- COVID-19 did not impact this project.



## FUTURE DISSEMINATION 1



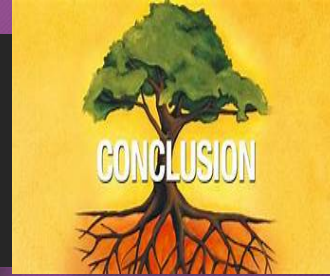
- ❖ Project results will be disseminated to the stakeholders at the project site through written and oral communication.
  - SBAR tool educational training and implementation on other units in the hospital
  - Incorporation of project into the orientation curriculum of newly hired nurses.
- ❖ Dissemination will also include presenting the DNP project results as a DNP presentation to Touro University Nevada (TUN) nursing faculty and peers of the DNP program followed by the submission of the project to the DNP Project Repository.

## FUTURE DISSEMINATION 2



- ❖ Professional organizations in nursing and medical practice
- ❖ Abstract and other requirements will be provided to the American Journal of Nursing, Journal of Nursing education, and other evidence-based nursing journals for possible publication.
- ❖ Additional venues for dissemination include the American Nurse Association, Institute of Medicine (IOM), and the American Association of colleges of Nursing (AACN), for a possible podium or poster presentation during conferences.

## CONCLUSION



- ❖ SBAR tool established at the project site
- ❖ Registered nurses monitored for adherence
- ❖ The project demonstrated the importance of educational training of the staff in SBAR tool and its adherence as:
  - Culture change in order to foster effective communication during change of shift.
  - Project offered a solution to the lack of standardized communication tool at the project site.

## REFERENCES 1

- ❖ Achrekar, S. M., Murthy, V., Kanan, S., Shetty, R., Nair, M., & Khattry, N. (2016). Introduction of situation, background, assessment, recommendation into nursing practice: A prospective study. *Asia-Pacific Journal of Oncology Nursing*, 3(1), 45-50. doi:10.4103/2347-5625.178171
- ❖ Arora, V., & Farnan, J. (2019). Patient handoffs. Retrieved from [www.uptodate.com/contents/patient-handoffs/print?Search=SBAR TOOLS&sou](http://www.uptodate.com/contents/patient-handoffs/print?Search=SBAR%20TOOLS&sou).
- ❖ Bussell, J. K., Cha, E., Grant, Y. E., Schwartz, D. D., & Young, L. A. (2017). Ways health care providers can promote better medication adherence. *Clinical Diabetes*, 35(3), 171-177.
- ❖ Coury, J., Schneider, L. J., Rivelli, S. J., Petrik, F. A., Seibel, E., D'Agostini, B.,... Coronado, D. (2017). Applying the plan-do-study-act (PDSA) approach to a large pragmatic study involving safety net clinics. *BMC Health Services Research* 17(1), 411. doi 10. 1186/s12913-017-2364-3



## REFERENCES 2

- ❖ Dove, E. S., Townend, D., Meslin, E. M., Bobrow, M., Littler, K., Nicol, D.,... Shabani, M. (2016). Ethics review for international data-intensive research. *Science*, 351(6280), 1399-1400.
- ❖ Faber, J., & Fonseca, L. M. (2014). How sample size influences research outcomes. *Dental Press Journal of Orthodontics*, 19(4), 27-29.
- ❖ Institute for Healthcare Improvement. (2017). SBAR Toolkit. Retrieved from
  - <http://www.ihl.org/resources/Pages/Tools/SBARToolkit.aspx>
- ❖ Ofori-Attah, J., Binienda, M., & Chalukpa, S. (2015). Bedside shift report: Implications for patient safety and quality of care. *Article in Nursing* 45(8), 1-4. doi:10.1097/01.NURSE.
  - 0000469252.96846.

## REFERENCES 3



- ❖ Reed, E. J., & Card, J. A. (2016). The problem with plan-do-study-act cycles. *BMJ Quality Safety* 25(3), 147-152. doi: 10.1136/bmjqs-2015-005076
- ❖ Starmer, A. J., Schnock, K. O., Lyons, A., Hehn, R. S., Graham, D. A., Keohane, C., & Landrigan, C. P. (2017). Effects of the I-PASS nursing handoff bundle on communication quality and workflow. *BMJ Quality & Safety*, 26(12), 949. doi:http://dx.doi.org/10.1136/bmjqs-216-006224.
- ❖ The Joint Commission. (2017, September 12). Inadequate hand-off communication. Retrieved from [https://www.jointcommission.org/assets/1/18SEA\\_58\\_Hand\\_Off\\_Comms\\_9\\_6\\_17\\_FIN\\_AL\\_\(1\).pdf](https://www.jointcommission.org/assets/1/18SEA_58_Hand_Off_Comms_9_6_17_FIN_AL_(1).pdf)
- Trossman, S. (2019). Consistent, quality communication: Nurses help lead efforts on safe patient handoffs and transfers. *American Nurse Today*, 14(1), 28.