Implementing a Structured Nurse-to-Nurse Communication Strategy: A Practice Change Pilot

Kathleen A. Morris, DNP, RN  
Wendy M. Woith, PhD, RN, FAAN  
Mennonite College of Nursing, Illinois State University, Normal, IL, USA

Background: At a Midwestern 221-bed hospital, results from a 2017 Agency for Healthcare and Research Quality (AHRQ) survey identified that nurses perceived ineffective communication during patient handoffs and transitions in care were a safety concern. Their concerns prompted hospital leadership to make nurse to nurse communication a 2018 nursing strategic priority. A qualitative research study examining nurses’ perceived barriers to effective communication was conducted to more clearly delineate the problem, enabling appropriate interventions aimed at addressing nurses’ safety concerns to be selected. Results from this study indicated that nurses desired a structured and standardized report process to improve communication during patient handoffs. Evidence from that study supports addressing the communication process at patient handoffs. Engaging nurses in learning and implementing an evidence-based, structured communication strategy during patient handoffs will help meet the organization’s strategic priority of improving nurse to nurse communication.

Literature Review: An estimated 251,000 patients die, and more than one million patients are injured in the U.S. annually due to medical errors, and ineffective communication is a major underlying factor. Approximately 80% of serious errors occur because of poor communication between care providers during patient handoff. At one 400-bed hospital studied, there were 2.9 million nurse hand-offs annually, equating to as many opportunities for communication failures. The transfer of information from nurse to nurse during patient handoff is, therefore, a significant practice concern. Effective communication is integral to the clinical practice environment and in the transfer of care from one nurse to the next. Evidence demonstrates that effective handoff communication occurs with the adoption of standardized structures and processes. Using effective structures and processes could help nurses develop skilled communication, thereby reducing gaps and inconsistencies that leave patients vulnerable to harm. Situation-Background-Assessment-Recommendation (SBAR) has been demonstrated to be an effective communication process that had positive effects on all measured outcomes, including reducing patient falls and adverse outcomes and increasing nurse and patient satisfaction. Using structured tools, such as SBAR-Q, I PASS the BATON, or the SHARE tool, cued nurses to critical issues or findings.

Purpose: The purpose of this evidence-based practice project was to pilot a change in practice that is intended to improve communication between nurses at patient handoff.

Intervention: Use of a Situation-Background-Assessment-Recommendation (SBAR) process supported with use of a SBAR tool to facilitate effective communication between nurses at bedside shift report during patient handoff.

Methods: In this evidence-based practice project, the Iowa Model was used to guide implementation of a standardized communication process, using SBAR, supported with a SBAR tool to facilitate effective communication between nurses during patient handoff. All RNs in the intensive care unit (ICU) and the cardiovascular care unit (CVCU), and those competenced to float to those units at a Midwestern 221-bed hospital completed an online pre-intervention survey, participated in a 30-minute training session on use of a SBAR tool to facilitate effective communication between nurses at handoff, and will complete an online post-intervention survey after the 4-week pilot period. The SBAR tool was also used as a competency checklist to monitor nurses’ use of the SBAR process during patient handoff. The project team leader-developed Rounding Questionnaire was used to assess RNs’ perceptions related to implementing the SBAR process and using a SBAR tool to facilitate effective communication during handoff. The Communication Satisfaction Questionnaire (CSQ) survey and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey will be used to evaluate outcome
measures of patients’ and nurses’ satisfaction. Changes in patient satisfaction will be measured pre- and post-intervention using the HCAHPS survey, a standardized survey routinely sent to randomly selected patients after discharge. Changes in nurse satisfaction will be measured pre- and post-intervention using the CSQ survey, a survey measuring nurses’ satisfaction with communication.

**Human Subjects Protection:** The Institutional Review Board determined this evidence-based practice project is not research involving human subjects. Findings will be available in September 2018.

**Preliminary Findings:** Thirty-nine nurses participated in the pre-intervention Communication Satisfaction Questionnaire (CSQ) survey. Although data from this survey are still being analyzed, preliminary findings show of those who responded to the survey, 43% reported that they were somewhat satisfied with the effectiveness of nurse to nurse communication. Forty-one percent reported they were satisfied with current communication methods at patient handoff on their unit, while 49% reported they were willing to change current handoff communication methods and 46% were willing to change their current methods of performing handoff. At this time, thirty observations have been made of patient handoffs at shift change observing use of the SBAR process and SBAR tool. Of the nineteen observations on the CVCU, fifteen (79%) of RNs used the SBAR process and 26% used the SBAR tool. Of the eleven handoff observations on the ICU, six (55%) of RNs have used the SBAR process; the SBAR tool was not used in any of the eleven observations made on the ICU. At present, the project team leader rounded on nine RNs in the CVCU and three nurses in the ICU. Although responses to the rounding questions are still being analyzed, many RNs on both units reported they utilize another type of SBAR tool for handoff, so they felt they did not need to use the pilot SBAR tool. Some RNs on the CVCU stated they use the pilot SBAR tool as a reference. Several RNs on the CVCU made recommendations to add to or modify the pilot SBAR tool. RNs on whom the project team leader rounded in the ICU, reported they already use a SBAR process or a SBAR tool for patient handoff.

**Preliminary Conclusions:** Although the pilot period is not complete, preliminary data analysis demonstrate nurses were willing to adopt a structured handoff process, but compliance with the change is below anticipated levels. More opportunities may exist to improve consistent use of an SBAR process with a supportive SBAR tool prior to expanding the process and tool to other nursing units.

**Title:**
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**Keywords:**
Nurse to Nurse Communication, Patient Handoff and SBAR

**References:**


**Abstract Summary:**
An evidence-based handoff process was piloted on two nursing units at a 221-bed hospital in the Midwest. The pilot consisted of nurses using a structured and standardized report process (SBAR)
supported with use of a SBAR tool to facilitate effective communication between nurses at bedside shift report during patient handoff.

Content Outline:
Introduction

- Effective communication is a vital link in daily exchanges between people, including healthcare professionals and patients.
- Implementing effective communication structures and processes at the bedside could help nurses develop skilled communication that when used during patient handoffs, reduce the gaps and inconsistencies that leave patients vulnerable to harm.

Background

- At a Midwestern 221-bed hospital, results from a 2017 Agency for Healthcare and Research Quality (AHRQ) survey identified that nurses perceived ineffective communication during patient handoffs and transitions in care was a safety concern.
- Results from qualitative research study indicated that nurses desired a structured and standardized report process to improve communication during patient handoffs.

Literature Review

- An estimated 251,000 patients die and more than one million are injured in the U.S. annually due to medical errors.
- Ineffective communication is a major underlying factor in preventable medical errors causing patient death and injury.
- Breakdowns in communication are the third leading root cause of sentinel events in United States hospitals.
- Approximately 80% of serious errors occur because of poor communication between care providers during patient handoff.
- Using structured tools, such as SBAR-Q, I PASS the BATON, or the SHARE tool, cued nurses to critical issues or findings.
- Implementing effective structures and processes at the bedside could help nurses develop skilled communication that when used during patient handoffs, reduce error, and improve patient and nurse satisfaction.

Intervention

- Use of a Situation-Background-Assessment-Recommendation (SBAR) process supported with use of a SBAR tool to facilitate effective communication between nurses at bedside shift report during patient handoff.

Methods

- In this evidence-based practice project, the Iowa Model guided implementation of a standardized communication process (SBAR) supported with use of a SBAR tool to facilitate effective communication between nurses during patient handoff.

Human Subjects Protection

- The Institutional Review Board determined this evidence-based practice project is not research involving human subjects. Findings will be available in September 2018.
Preliminary Findings

- Thirty-nine nurses participated in the pre-intervention Communication Satisfaction Questionnaire (CSQ) survey. Although data from this survey are still being analyzed, preliminary findings show that of those who responded to the survey, 43% reported that they were somewhat satisfied with the effectiveness of nurse to nurse communication. Forty-one percent reported they were satisfied with current communication methods at patient handoff on their unit, while 49% reported they were willing to change current handoff communication methods and 46% were willing to change their current methods of performing handoff. At this time, thirty observations have been made of patient handoffs at shift change observing use of the SBAR process and SBAR tool. Of the nineteen observations on the CVCU, fifteen (79%) of RNs used the SBAR process and 26% used the SBAR tool. Of the eleven handoff observations on the ICU, six (55%) of RNs have used the SBAR process; the SBAR tool was not used in any of the eleven observations made on the ICU. At present, the project team leader rounded on nine RNs in the CVCU and three nurses in the ICU. Although responses to the rounding questions are still being analyzed, many RNs on both units reported they utilize another type of SBAR tool for handoff, so they felt they did not need to use the pilot SBAR tool. Some RNs on the CVCU stated they use the pilot SBAR tool as a reference. Several RNs on the CVCU made recommendations to add to or modify the pilot SBAR tool. RNs on whom the project team leader rounded in the ICU, reported they already use a SBAR process or a SBAR tool for patient handoff.

Preliminary Conclusions

- Although the pilot period is not complete, preliminary data analysis demonstrate nurses were willing to adopt a structured handoff process, but compliance with the change is below anticipated levels. More opportunities may exist to improve consistent use of an SBAR process with a supportive SBAR tool prior to expanding the process and tool to other nursing units.

First Primary Presenting Author

**Primary Presenting Author**
Kathleen A. Morris, DNP, RN
Illinois State University
Mennonite College of Nursing
Instructional Assistant Professor
Normal IL
USA

**Professional Experience:** My area of interest is healthy work environment development in the acute-care and academic settings. I participated in a qualitative research study aimed at identifying nurses’ perceptions of barriers to effective communication. Currently, I am in the process of finishing my DNP scholarly project, which aims to improve patient and nurse satisfaction through a pilot implementation of an SBAR process to facilitate effective communication at patient handoff.

**Author Summary:** Ms. Kathleen Morris’ area of interest is healthy work environment development in the acute-care and academic settings. Ms. Morris’ work with a pilot to implement a SBAR process during patient handoffs in an acute care setting to improve patient and nurse satisfaction is the focus of her DNP scholarly project.

Second Author

Wendy M. Woith, PhD, RN, FAAN
Illinois State University
Mennonite College of Nursing
Professor
Normal IL
USA
**Professional Experience:** I have been conducting research for several years and have experience with both quantitative and qualitative design. I have conducted several studies on civility, including studies of nursing students, new nursing graduates, and homeless peoples' interactions with nurses. I have published manuscripts on these topics and given peer-reviewed presentation at national and international venues.

**Author Summary:** Dr. Wendy Woith has been conducting research for 15 years and has experience with both quantitative and qualitative research design. Her research areas include tuberculosis, civility, and wound management. Dr. Woith has published 25 manuscripts on these topics and given 30 peer-reviewed presentations at national and international venues.