Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations

Situation–Background–Assessment–Recommendation (SBAR) communication has become the standard for communicating across disciplines. It has demonstrated its effectiveness at improving patient outcomes, enhancing patient and clinician satisfaction, and helping to control healthcare costs. It can help home healthcare clinicians with efforts to prevent avoidable hospitalizations. But how often and how well do home health clinicians use this method of shared communications with physicians? This article explores why communication between physicians and home health clinicians can be so problematic. It introduces the SBAR communication method, its origins, its features, and some of the published evidence that it provides effective and efficient communication, thereby promoting better patient outcomes.

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Communication—effectively getting your message across—is difficult. The higher the stakes, the more important the message, the more difficult efficient and effective good communication becomes. Consider Sentinel Event statistics reported by The Joint Commission (2005, 2013; Tjia et al., 2009). Over the past decade, The Joint Commission has reported the root causes of these events, and approximately 60% to 70% of the sentinel events they examined were related to communication problems. Analysis of the events shows that communication between healthcare team providers frequently was ineffective (did not get the attention deserved) or inadequate (did not include crucial information) resulting in patient deaths and injury (The Joint Commission, 2005).

Effective and appropriate communication is needed in the home healthcare setting as much as it is needed in acute care settings, not only to prevent sentinel events, but also to prevent hospitalizations and improve patient outcomes (Quality Insights of Pennsylvania, 2006). However, hospitalization rates remain too high and patient outcomes remain lower than desired. At least some, if not most of these undesirable outcomes, are related to the difficulties and complexities of interdisciplinary team communication, especially with physicians. What we have here is a failure to communicate!

This article explores why communication between physicians and home health clinicians can be so problematic. It introduces the Situation–Background–Assessment–Recommendation (SBAR) communication method, its origins, its features, and evidence that it provides effective efficient communication, which can promote better patient outcomes. It analyzes each of the SBAR components and provides concrete recommendations that home healthcare clinicians can use when preparing to speak with a physician about a patient problem and how to approach it. Finally, it presents a SBAR template for addressing a chronic obstructive pulmonary disease (COPD) exacerbation, with the goal of preventing an avoidable hospitalization (Figure 1).

Research in Interdisciplinary Communication

Researchers have realized that interprofessional communication—or the lack of it—has compromised patient safety and have investigated the reasons interprofessional communication can be so problematic. Several reviews in the medical and nursing literature have explored these communication barriers, especially between nurses and physicians. Because of historical and social factors, nurses and physicians have internalized a hierarchical structure for communication and decision making in which the physician is "in charge" (Hall, 2005; Leonard, Graham, & Bonacum, 2004; O'Daniel & Rosenstein, 2008; Shannon & Myer, 2012). However, this hierarchical model is not effective in the complex healthcare environment in which no one person can have all the knowledge needed for choosing the best course of action (Leonard, Graham, & Bonacum, 2004; Shannon & Myer, 2012). Healthcare has become too complex, each discipline has its own scope of expertise, and suboptimal outcomes occur when important perspectives are not voiced and heard (Leonard, Graham, & Bonacum, 2004; O'Daniel & Rosenstein, 2008).

In addition, nurse and physician professional education and training have tended to teach two different ways of communicating about patient issues. Nurses tended to learn to communicate using a timeline descriptive narrative communication method whereas physicians tended to learn to communicate via prioritized bullet points (Leonard, Graham, & Bonacum, 2004; Shannon & Myer, 2012). Because of this, physicians may have had a tendency to become frustrated with nurses' communication styles, subtly feeling the communication style is evidence of a lack of critical thinking. At the same time, many nurses report that they feel too many physicians are inpatient and rude, not valuing their input and insight into patients' problems (Leonard, Graham, & Bonacum, 2004).

Exploration of nurse decision making about when to call a physician about a patient problem reveals another barrier to nurse–physician communication. Nurses are less likely to call a physician if they fear it will result in a psychologically unsafe interaction (Leonard, Graham, & Bonacum, 2004; O'Daniel & Rosenstein, 2008). Psychologically unsafe interactions include ones in which the nurse fears anger, insult, or disapproval from the physician or feels that "the call won't make a difference because the doctor won't listen to me."

For interdisciplinary communication to occur effectively, disciplines need to have a shared way to communicate that works for all the disciplines

SBAR Template Communication About Exacerbation of COPD Symptoms

Situation:
- Dr. (*name*), this is (*your name, discipline*) from (*name of your home health agency or hospice*).
- I am calling about (*patient's name*), who is experiencing increased dyspnea.

Background:
- Patient's age _____
- Primary diagnoses: COPD (GOLD stage, if known: A-Mild, B-Moderate, C-Severe, D-Very Severe); other primary/pertinent diagnoses.
- Recent important events. *Examples include:*
  - Admitted to home care on (*date*) for (reason for home care).
  - Discharged from the hospital on (*date*) after being treated for _____.
- Oxygen use: _____ liters/minute, intermittent or continuous.
- Current respiratory medications, and frequency of use; recent increased frequency.
- DNR status if applicable: _____
- Have available: medication profile, allergies, and phone number of pharmacy.

Assessment: (*Only report primary/abnormal/pertinent data*)
- Patient's current symptoms:
  - Dyspnea: Severity on Berg Scale: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 ❒ Intermittent ❒ Constant
  - Cough: ❒ Increased frequency ❒ Increased sputum ❒ Increased purulence description
  - ❒ Fatigue ❒ Restlessness ❒ Anorexia ❒ Difficulty sleeping ❒ Vomiting ❒ Anxious
  - When did symptoms develop? _____ How severe are symptoms? _____

- Physical assessment:
- Vital signs: Temp _____ Pulse _____ RR _____ BP _____ SaO2 _____
- Mental status changes: LOC _____ ❒ Confusion ❒ Anxiety
- Skin color: ❒ Cyanosis Location: _____ Capillary refill _____
- Breathing effort: ❒ Tripod positioning ❒ Pursed lip breathing ❒ Retractions ❒ Nasal flaring
- Sputum: Color: _____ Consistency: _____ Amount _____
- Lung sounds: ❒ Crackles ❒ Wheeze ❒ Diminished Location: _____
- Peripheral edema: 1+❒ 2+❒ 3+❒ 4+❒

- Analysis Examples
  - I believe the patient has developed a respiratory tract infection.
  - The patient's COPD symptoms may have exacerbated because of today's air quality alert.
  - The patient's COPD seems to have exacerbated but there are no signs of respiratory infection.

Recommendation: "We may be able to avoid hospitalization …" "We may be able to catch this early …"
- ❒ Antibiotic: Indicated for increase in dyspnea/sputum volume/sputum purulence.
- ❒ Systemic corticosteroid: Prednisolone, oral, 30-40 mg, daily for 10-14 days.
- ❒ Short-acting bronchodilators: ❒ Change route to via nebulizer. ❒ Change frequency to every 4 hours.
  - ❒ Change/add beta-agonist or anticholinergic to_____.
- ❒ Home oxygen therapy: Titrate to _____ liters/minute to reach oxygen saturation of _____ (88-92%).
- ❒ Increase visit frequency to _____ (every day x 2-3 days) to monitor treatment plan effectiveness.

Additional Interventions:
- ❒ No exposure to smoke/air pollution
- ❒ Force fluids to _____ (2 to 2 ½ quarts)
- ❒ Institute coughing/deep breathing/postural drainage
- ❒ Teach relaxation and energy conservation techniques

Figure 1. Situation–Background–Assessment–Recommendation (SBAR) communication about exacerbation of chronic obstructive pulmonary disease (COPD) symptoms.

Notes: BP = blood pressure; DNR = do not resuscitate; GOLD = Global Initiative for Obstructive Lung Disease; LOC = level of consciousness; Temp = temperature; RR = respiratory rate; SaO2 = oxygen saturation.
Source: Author.

(The Joint Commission Center for Transforming Healthcare, 2010). One very effective answer is SBAR communication.

Evolution of SBAR Communication

In 2002, Kaiser Permanente Health employed David Bonacum (2008) to investigate patient safety. Bonacum was not a physician, but a quality expert who had worked in the nuclear submarine and aeronautical industries. On reviewing incident data from surgical, obstetrical, and intensive care units (ICUs), he discovered that many of the "events" seemed to be caused by communication failures. These incidents seemed to have something in common with nuclear submarine incidents and airplane crashes: a lack of effective communication in complex situations.

For instance, piloting a jet plane is always a complex endeavor, which becomes even more complex in unexpected or crisis situations. In reviewing data of air plane crashes, it was discovered that frequently copilots realized that a disaster was about to occur, which might have been avoided, except that the copilot was unable to convey the imminence of the disaster and the way to avoid it to the captain of the plane (Bonacum, 2008). The root cause of these communication failures was traced to erroneous assumptions about organizational hierarchy ("the captain must know what he is doing") and the ability to convey an urgent message in a way that captured the captain's attention, provided essential information quickly, and suggested the way to resolve the situation when an apparent solution was evident to the copilot.

To alleviate communication problems, the high-risk aeronautic industry adopted the Situational Briefing Model communication method from the nuclear submarine industry. This communication method is a practical structure for communicating critical information concisely, in which relevant, timely, crucial information is communicated succinctly. This method, as Bonacum and his Kaiser colleagues (Leonard, Graham, & Bonacum, 2004; Leonard, Graham, & Taggart, 2004) described it, consists of four steps: communicate the *situation* (the problem), provide essential *background* information (adequate context), state *assessment* of the situation (analysis), and provide a *recommendation* for resolving the situation ("the fix"). This communication framework is known as SBAR *communication*.

Imagine a copilot on a jet engine passenger plane who realizes that his plane is on a collision course with another plane. He uses SBAR communication to alert the plane's captain:

Situation:	We have an emergency!
Background:	We are in the path of another plane!
Assessment:	Crash imminent!
Recommendation:	Pull up; turn left!

Bonacum and his colleagues realized that this kind of communication method may be able to avert the kinds of sentinel events and incident reports that were coming across their desks from surgical, obstetric, and ICUs, and other acute care setting areas. Along with several other communication techniques, the Kaiser quality team instituted SBAR communication across multiple Kaiser Permanente inpatient settings as a way to convey important information effectively and efficiently. They were able to document a dramatic drop in the number of incidents in each setting (Leonard, Graham, & Bonacum, 2004; Leonard, Graham, & Taggart, 2004).

SBAR communication was adopted by many healthcare organizations, and it continued to demonstrate that it provided a framework for shared communication across disciplines, which decreased "incidents" and enhanced patient care (Beckett & Kipnis, 2009; Haig et al., 2006; Velji et al., 2008). Quality organizations promoted SBAR communication (Agency for Healthcare Research and Quality, 2012; Institute for Healthcare Improvement, 2011; The Joint Commission Center for Transforming Healthcare, 2010; O'Daniel & Rosenstein, 2008). Soon it spread from high-risk areas to a way for clinicians to communicate with one another in all situations (Beckett & Kipnis, 2009; Riesenberg et al., 2010). SBAR communication has demonstrated that it enhances efficient communication that promotes effective collaboration, improves patient outcomes, and increases patient satisfaction with care. SBAR is an evidence-based best practice communication technique. If your organization is not already using SBAR, this is the time to start (Table 1).

SBAR in Home Care

Several quality improvement projects describe using SBAR communication in home healthcare. The Home Health Quality Initiative (Home Health

Quality Initiative, 2010; Quality Insights of Pennsylvania, 2006) advocated its use for preventing avoidable hospitalizations and developed templates that clinicians could use when calling a physician about a patient exacerbation to avert an avoidable hospitalization. Several articles in *Home Healthcare Nurse* reported quality improvement projects in which SBAR communication helped to lower agency hospitalization rates (Evdokimoff, 2011; Kogan et al., 2010; Withey & Breault, 2013).

The SBAR tool has proven effective for preventing rehospitalizations of patients with chronic illnesses who have developed an early sign or symptom of exacerbation, or other acute problems. In other words, the patient has developed a "situation." The patient may have reported a worrisome symptom. For instance, the patient may have developed one of the "yellow zone" symptoms on one of the excellent zone tools (also known as "stoplight" or "green–yellow–red" tools) for heart failure (HF), COPD, diabetes, and other chronic health issues (Home Health Quality Initiative, 2010). Or the clinician may have picked up an ominous sign when performing a scheduled patient assessment. In any case, the situation requires collaboration with, and probably orders from, the physician to resolve the problem.

Before Making the Phone Call: Four Steps

Before calling the physician about a patient situation, it is important to engage in some in-depth data-gathering, critical-thinking and problem solving. First, assess the patient, anticipating what the physician will specifically want to know about that patient's status. Beyond obtaining the patient's vital signs, you need to perform a basic physical assessment and a focused system-specific assessment for the body system(s) (e.g., cardiopulmonary, neurologic, gastrointestinal) related to the presenting sign or symptom (Maison, 2006). Consider what measurements (e.g., blood glucose, weight) and specific assessment techniques—inspection, palpation, percussion, and auscultation—you can use to further investigate the body system(s) that could give clues about the nature or severity of the problem. For instance, if the problem seems to be a respiratory problem, besides the vital signs, what is the patient's color, capillary refill, pulse oximetry reading, respiratory effort, breath and adventitious lung sounds on auscultation, and so on.

If the patient reports a new or worsening symptom, such as dyspnea, diarrhea, and so on, use your symptom analysis questions—well-known from assessing pain—to analyze the symptom:

- Location: Where is it the worst?
- Quality: What is it like? What adjectives describe it?
- Quantity: How much of it is there? What is its severity on a 0-to-10 scale? What is its severity now, at its best, worst, after medication?
- Timing:
  - Frequency: When does it occur? How often?
  - Duration: How long does it last?
  - Onset: When did it start? What do you think caused it to start?
- Ameliorating/Aggravating Factors: What makes it better? What makes it worse?
- Other symptoms: Anything else bothering you?

The second step before calling the physician is to determine the urgency of the situation. "Situations" can be emergent, urgent, or routine

Table 1. SBAR About SBAR

Situation: Ineffective and inadequate communication, especially between home healthcare clinicians and their patients' physicians, increases patient hospitalizations, increases healthcare costs, and decreases the quality of patient care.
Background: Physicians and clinicians may have learned different ways to communicate about patient issues and problems. Home healthcare clinicians identify signs and symptoms, which, if not addressed early, can result in more costly care, including hospitalizations. Because patient care is so complex, every perspective needs to voiced and heard and clinicians must be able to speak with assertive confidence about their observations and recommendations about a patient's situation.
Assessment: Home healthcare clinicians need one effective shared communication method to assure effective communications with physicians.
Recommendation: Home healthcare clinicians should consider using SBAR communication when communicating with the patient's team members, especially physicians.

(Visiting Nurse Associations of America [VNAA], 2012). In home care, an *emergent situation* requires collaboration with the physician within 1 to 2 hours. Some situations require an immediate 911 call and immediate transfer to an emergency department. An *urgent situation* requires collaboration within 6 to 12 hours and a *routine situation* can wait until normal business hours (VNAA, 2012). (Your organization may have different times defined for emergent, urgent, and routine collaboration calls.) Some of the questions that help the clinician determine the urgency of the situation include:

- How does the patient's current status compare with the status on previous visits, as documented on progress notes?
- How severe is the sign/symptom? (Generally, the more severe the symptom the more urgent the situation.)
- How suddenly has the sign or symptom occurred? (Generally the more sudden the onset, the more urgent the situation.)
- Can something be done to resolve this situation? How urgently does it need to be done to keep the patient safe?
- What is the patient's risk of harm or hospitalization if this situation is not resolved within 1 to 2 hours? Within 6 to 12 hours? By the time of the physician's regular office hours?
- What is the best time/way to reach this physician? How much time is there before that time?

The third step to take before calling the physician is to access and review the patient's record. Compare your assessment data against the data in previous notes, to determine the trends that are occurring. Be sure to have at your fingertips all the information the physician may need from the patient's medical record. Think ahead: consider what information the physician may need or ask for from the client record. Unless the physician is familiar with this particular patient, your report may need to include information about the patient's:

- age and major diagnoses,
- why the patient is being seen by home healthcare,
- when and why the patient was last seen in the hospital or the emergency department,
- allergies and current medications,
- recent changes in the patient's treatment plan,
- recent laboratory test results,
- advance directive status, and
- pharmacy telephone number.

The final step is to organize the information into the SBAR format and into primary and secondary data (Arizona Hospital and Healthcare Association, 2007). *Primary data* are information about the patient's situation that you think is crucial to the physician's decision making. It is directly relevant to the reason you are calling the physician. It concentrates upon abnormal assessment data. *Secondary data* are assessment data that are normal and information not needed to make a decision about the patient's current situation. Secondary data are just "noise" when trying to convey crucial information; they hinder—and do not enhance—communication when trying to solve patient problems efficiently and effectively. However, secondary data are important to know, when the doctor has further questions. If the doctor asks about the patient's blood pressure, you want to have the answer, even if they were secondary data in your opinion.

Ideally, your SBAR report should be less than 1 minute, if possible, so part of your organizational preparation for the report is to determine how you will be as concise and as succinct as you can be, while conveying the critical information (Arizona Hospital and Healthcare Association, 2007). Consider a report based on the following 60-second timeline:

- Situation: 10 seconds
- Background: 20 seconds
- Assessment: 20 seconds
- Recommendation: 10 seconds

Giving the SBAR Report

During the actual SBAR call, communicate information using each of SBAR's four fundamental components: situation, background, assessment, and recommendation (Table 2).

Situation

In the initial statement made to the physician, convey who you are, the patient's name, and a very concise statement of the patient's problem.

Table 2. SBAR Communication: A Concise, Effective Communication Technique Used to Communicate With Physicians and Reduce Unnecessary Hospitalizations

	Meaning of Letter	Information	Data to Include	Example
S	**Situation**	What is going on?	• Patient's name • Current problem	Dr. Jones, I'm calling because Mrs. Jones has developed increased SOB over the past couple of days.
B	**Background**	What is the context and background?	• Patient's age, gender • Diagnoses • Other pertinent information, as appropriate to problem o Recent history o Medications, allergies o Etc.	Mrs. Jones is 72 years old, with diagnoses of heart failure and diabetes. • She was admitted to home care 5 weeks ago after being hospitalized for HF exacerbation. • She is supposed to be on Lasix 40 mg daily, but admits to forgetting to take it several times over the past couple of days.
A	**Assessment**	What physical assessment data will the doctor want to know? What do you think the problem is?	• Pertinent physical assessment findings • Perform a complete assessment *before* calling MD. • Name the problem	Physical assessment findings include: • Bilateral fine crackles at posterior bases. • 3+ pitting edema at ankles. • 7 pound weight gain since last week. • Respirations 28 with minimal activity. • P =104, BP =152/88, BG=normal. • She reports she is more SOB, but not severely SOB. Because she seems to be having an exacerbation of her CHF …
R	**Recommendation**	What do you think will correct the problem?	Suggestions to resolve the problem without ER/hospital.	I think if we increase her Lasix for a couple of days, we can resolve this situation without hospitalization—and I am working on a plan so that she remembers to take her medications.

Notes: BG = blood glucose; BP = blood pressure; CHF = congestive heart faliure; ER = emergency room; HF = heart failure; MD = medical doctor; SOB = shortness of breath.
Source: Copyright © 2008, Mary Curry Narayan. Adapted from "Guidelines for Communicating With Physicians Using the SBAR Process" (courtesy of Kaiser Permanente) and from "SBAR: A Home Health Package" (Quality Insights of Pennsylvania, 2006).

The goal here is to capture the physician's attention in 10 seconds or less. Do not waste those 10 seconds apologizing for the call. Get right to the point: "Hello Dr. Brown. This is Mary White. I am a nurse from Best Home Care Agency. I am calling about Mrs. Green." Then capture the physician's attention by stating the situation, such as:

- Mrs. Green is having increased dyspnea.
- Mrs. Verde has developed a cough and fever.

Background

In giving the physician background information about the patient, use your critical thinking and clinical reasoning and judgment skills to determine how much context the physician needs about the patient. If you and the physician discussed this patient three times in the last week, you may need to provide less background information than if you have reached an on-call physician who has never met this patient. If the physician knows nothing about the patient, or if

the physician is in the middle of a chaotic day, more contextual information may be necessary to "orient" the physician. Background information that may be needed for the patient report includes:

- patient's age and major diagnoses that could impact the situation and how it is resolved;
- why the patient is being seen by home healthcare;
- when and why the patient was last in the hospital (or emergency department);
- current medications the patient takes that are directly related to the patient's situation;
- allergies, especially if medication orders are anticipated;
- recent laboratory test results related to the situation; and
- advance directive status.

Examples of important background information include:

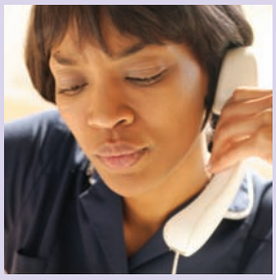
- Mrs. Green is a 72-year-old woman with COPD and HF. She was admitted to home care 3 weeks ago after a 4-day hospitalization for HF.
- Mrs. Verde is an 88-year-old woman with Stage IV COPD. She has an advanced directive, indicating future care should be palliative and she does not want to go back to the hospital.

Assessment

Report current signs and symptoms, and physical assessment data that are pertinent to the problem in concise, bullet-point statements (see Box 1). Using clinical judgment and critical-thinking skills, report only the "primary" data—the abnormal and crucial patient assessment findings. If all vital signs are normal except the blood pressure, just report the blood pressure, along with the other abnormal or significant data. A statement at the end of your assessment report, such as, "All other assessment findings were normal," may be appropriate, if indeed you did a good problem-oriented assessment of the patient. Examples include:

- Currently Mrs. Green's pulse is 108, respirations are 28 and temperature is 100.1 orally. Pulse oximetry is 91%. On auscultation, breath sounds are diminished, and with course crackles throughout her lung fields. She has a productive cough with gray-green thick mucous, which she reported started earlier today. I believe she is having a COPD exacerbation related to a lower respiratory infection.
- On assessment Mrs. Verde's pulse is 124, respirations are 32, and pulse oximetry is 87%. She is unable to use her bronchodilator inhaler due to her dyspnea and is very anxious. I believe the biggest problem interfering with the patient's palliative goals is her anxiety.

To alleviate communication problems, the high-risk aeronautic industry adopted the Situational Briefing Model communication method from the nuclear submarine industry. This communication method is a practical structure for communicating critical information concisely, in which relevant, timely, crucial information is communicated succinctly.



Analysis

After reporting assessment data of the patient's status, include an analysis or summary statement of what you think the problem is, as shown in the two examples above. Some home healthcare clinicians may find it hard to offer their opinions about what is wrong with the patient and what should be done about it to the physician, despite having a good sense what is wrong and how it can best be resolved. Remember that because the physician is totally dependent on your eyes and ears to evaluate the patient, the doctor's analysis of the patient's situation is only enhanced when you offer your insights. Part of professional practice is to determine

nursing diagnoses and identify problems after collecting assessment data.

For clinicians who have a difficult time providing an analysis statement or articulating an assessment of what the findings indicate, start by saying:

- *I think* the patient has developed a lower respiratory infection.
- *Do you think* the patient has developed a lower respiratory infection?
- *The patient seems to* have developed a lower respiratory.

Sometimes clinicians may not be able to determine a specific reason for the signs and symptoms the patient is showing. This may mean the patient needs medical evaluation. At this point you need to determine the urgency of the situation: Must the patient be seen by a physician on an emergent, urgent, or routine basis? When this happens it is appropriate to summarize the patient's situation with a statement like:

- The patient seems to be having some sort of acute respiratory event.
- I am not sure what is going on, but I think the patient needs medical evaluation, in your office and, if possible, today.

Recommendations

Some clinicians may feel as intimidated providing the physician with recommendations as they do about providing a "diagnosis" (analysis) about what is happening with the patient. Remember that it is a "best practice" to provide these recommendations when you have them and that research shows that, in general, physicians want to know what you think should be done. It is the physician's responsibility to also analyze the data reported, to ask additional questions if the physician has concerns about your analysis or recommendations, and to decide whether the course of action you have recommended seems appropriate. It is your responsibility to state clearly what you think is best for the patient. Making recommendations is part of the collaborative process that is the standard of quality interdisciplinary discussions (Arizona Hospital and Healthcare Association, 2007).

Box 1. Clarifying Terms

One small discrepancy in the healthcare literature about Situation–Background–Assessment–Recommendation (SBAR) communication is what to include in "B: Background" information from what to include in "A: Assessment" data (Arizona Hospital and Healthcare Association, 2007). This issue is related to two different definitions of the word *assessment*. One definition of *assessment* is an appraisal or summary statement of a situation (e.g., "My assessment is that the situation is serious."). However, to most clinicians an *assessment* is the steps the clinician performs—the targeted interview questions and physical assessment techniques—to help identify the patient's diagnoses or problems. Some SBAR authors include the interview and physical assessment data in the "Background" section of the templates they propose for using the SBAR method. Others consider the "Background" section to be only the contextual information that is known from what has happened to the patient in the past—age, diagnosis, advance directives, recent significant history, and so on—saving symptom and physical assessment data for the "Assessment" section.

From experience, I have found that most home healthcare clinicians more intuitively grasp the later method as a way to categorize data, which helps them to first set the context in adequate detail—age, diagnosis, significant medical history, and so on as the "background," and then the patient's current status via assessment techniques in the "assessment" section. A brief analysis statement is included before addressing the "Recommendation" section of the SBAR communication method. (I use this way of categorizing "B: Background" and "A: Assessment" findings in this article.)

As you think about what recommendations you should suggest to the physician, ask yourself the following questions:

- What action do I think the physician should take?
- What option(s) should the physician consider?

- How quickly do I need the physician to act to keep this patient safe?

When formulating your recommendations, keep in mind the goals of care and what is best for the patient. One of home healthcare's most important goals is to prevent unnecessary hospitalizations and emergency department visits. Therefore, consider if there is an intervention that may prevent the need for such expensive options. What medications or treatments could be initiated in the home?

For instance, several options are available to intervene in the early stages of a COPD exacerbation:

- If the patient has signs/symptoms of respiratory viral or bacterial infection—increased dyspnea and increased sputum volume or purulence—an antibiotic is indicated (Global Initiative for Chronic Obstructive Lung Disease [GOLD], 2013).
- Short-acting bronchodilators—beta$_2$ agonists and anticholinergics—can be added or combined or can be given on a regular, instead of on an "as needed," basis (GOLD, 2013).
- Home oxygen therapy can be titrated to reach a target saturation level of 88% to 92% (GOLD, 2013).
- Oral corticosteroids should be considered. Recommendation: prednisolone, orally, 30 to 40 mg each day for 10 to 14 days (GOLD, 2013).
- Patients relying on metered-dose inhalers may benefit from using a spacer or nebulizer to increase medication delivery to distal airways (Registered Nurses' Association of Ontario [RNAO], 2005/2010).
- Breathing and coughing techniques (e.g., pursed lip breathing, double coughing, and huff coughing) promote better oxygenation and help to expel excessive mucous interfering with gas exchange. (Huff coughing is a technique that moves airway secretions despite the inability to take the deep breaths needed for effective coughing. Instruct the patient to take a medium breath in, and then to make a sound like "ha," while pushing air out as fast as the patient can with mouth slightly open. The patient repeats this 3 or 4 times, and then coughs.) (RNAO 2005/2010).

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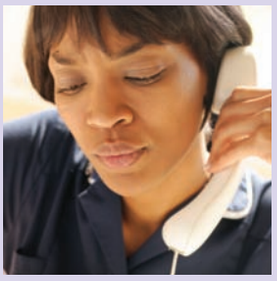

- Increase fluid intake (if no fluid retention) to thin and help clear excessive sputum production (RNAO 2005/2010).
- Avoid sources of smoke and air pollution to lessen respiratory burden (GOLD, 2013).
- Increase home visit frequency to every day for 2 to 3 days to monitor the effectiveness of the treatment plan.

Some examples of recommendation statements to be made to the physician include:

- To try to avoid hospitalization, should we initiate a course of antibiotic therapy? I have the pharmacy number, and the patient's son can pick up the prescription. I can monitor the patient's response over the next 2 to 3 days.
- Would you recommend starting the oral prednisolone the patient has available for COPD exacerbations?
- I think we might be able to treat the patient at home with more aggressive therapy by delivering his inhaled drugs via nebulizer instead of metered-dose inhalers.

Once the physician responds, giving orders, repeat the orders back to the physician, and ask when the physician would like you to call back to report the efficacy of the instituted interventions.

What to Do When SBAR Communication Fails

Have you been in a situation where a physician did not respond appropriately to your report? For instance, you felt that patient needed an emergency medical evaluation and diagnostic testing, and the doctor said to have the patient make a routine appointment during office hours? Or, conversely, the physician said to send the patient to the emergency room when you felt the patient could be appropriately treated at home with a change in medications? Situations like these—where clinicians feel the patient would be better served by a different course of action—require clinicians to speak up and express their concerns.

To express these concerns in an effective way, advocating for the patient and the best care, remember to CUS. CUS is an acronym that helps you know what to say when you think that the physician is not listening to you or is making a bad decision (Leonard, Graham, & Bonacum, 2004). CUS stands for:

- C: I am *concerned* because …
- U: I am *uncomfortable* because …
- S: The *safety* of the patient is at risk because … (Leonard, Graham, & Bonacum, 2004)

Although initially used in healthcare to prevent errors, such as wrong site surgery, or to assure a timely medical evaluation, CUS can also be used to prevent rehospitalizations. For instance, saying something like, "I am *concerned* that this plan is not going to adequately meet the patient's needs, and that he will end up in the emergency department if we don't have a plan for a COPD exacerbation in place now" or "I am *uncomfortable* with this plan, because unless we address the patient's respiratory infection this afternoon, I fear he may require rehospitalization."

Expanding SBAR Use

Although SBAR communication has proved highly effective in interdisciplinary communications, it has also proven effective during "transitions" and "patient hand-offs," when transferring the patient from one clinician, level of care, or setting to another (Riesenberg et al., 2010). SBAR communication can also be used to organize coordination of care reports, between a patient's case manager and team members (VNAA, 2012). It can even be taught to patients and their caregivers as an effective way to communicate with their physicians about "early warning signs" of exacerbation and to prevent emergency care and hospitalizations (VNAA, 2012).

Conclusion

The SBAR communication method is an evidence-based strategy for improving not only interprofessional communication, but all communication. It is particularly effective when hierarchical positions or critical situations (high-stake situations that require quick communication and decision making) make effective communication difficult. SBAR is not a stand-alone technique. It must be combined with excellent physical assessment skills and good clinical judgment and critical-thinking skills to effectively accomplish the goals we seek. However, SBAR communication is a communication framework that can promote patient safety and enhance outcomes while helping to control healthcare costs and decrease hospitalizations. ☗

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