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Perceptions of Nurses Regarding Using the SBAR Tool for Handoff Communication and Patient Safety at Saudi Arabia, 2024

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ABSTRACT

Background: Communication failure has been reported in the literature as the primary source of medical errors and patient harm. Among various methods of handoff communication, Situation, Background, Assessment, and Recommendation (SBAR) is a reliable and efficient framework that nurses worldwide use.SBAR shift reports are used to make sure that patients' information is conveyed concisely and without unnecessary details.

The study aimed: To evaluate the perceptions of nurses regarding using the SBAR tool for handoff communication and patient safety.

Methods and Materials: Descriptive research design was used in Hospital at Makkah, Saudi Arabia.Convenient sampleinvolved of 50 nurse's works at inpatients department. There are two tools for data collection: The first tool consists of two parts Part I: Personal data sheet which gathered data about: gender, age, and years of experience, educational qualification, and marital status. Part II: Self-administer questionnaire about Nurse's perception related to (SBAR) situation, background, assessment, and recommendation. It included 25 multiple choice questions. The second tool: patient's safety audit checklist, the tool consists of 17 items with sub-items covering general patient's safety goal.

Results:all nurses had unsatisfactory knowledge score and no patient's safety activity.

Conclusion: Nurses are not active in connection to patient safety goals and have a low knowledge score regarding SBAR shift reports. Consequently, putting in place an in-services training program on SBAR shift report applications and doing additional research on the structure of SBAR shift reports and its effects on nurses' productivity and patient satisfaction

Keywords: Assessment, Background, Recommendation, Situation, Nurses and patient's safety

INTRODUCTION

Globally, excellent group dynamics, communication, and teamwork are acknowledged as key factors that influence patient safety. When vital information about patients' illnesses is shared between healthcare providers, this type of communication takes place[1].It can be difficult to communicate effectively, and workplace misunderstanding is likely to occur because of a number of obstacles and mistakes. The Institute of Medicine stated in 2007 that 98,000 patient fatalities per year due to medical errors should be averted and that misunderstanding was avoidable[2, 3].

The handoff process is an essential aspect of nurses' daily clinical practice. Standardized handoff communication in healthcare is defined as "a process in which information about patient, client or resident care is communicated from one health care provider to another in a consistent manner." [4].Routinely, nursing endorsements or handoffs occur three or more times a day, according to shift changes and as necessary. Moreover, nurses are legally liable and accountable for reporting essential information during handoffs[5].

The World Health Organization (WHO) and the UK National Health Service (NHS) recommend SBAR (Situation, Background, Assessment, and Recommendation), a standardized method for communicating important information, contributing to the effective escalation of management and the improvement of patient safety[6]. Nurses play a pivotal role in evaluating the clarity of the handoff communication process. Moreover, nurses' perception of the process improved for nurse-to-nurse accountability [7].

In order to address the problem of confusing and incomplete patient handovers, the Joint Commission (2017) [8] established the International Patient Safety Goal. However, insufficient patient handover continues to be a major challenge in healthcare organizations, and this aim is frequently not achieved. Implementing communication protocols and techniques like SBAR (Situation – Background – Assessment- Recommendation) is necessary to overcome this problem. To guarantee accurate and succinct reporting during patient handover, nurses must receive the necessary training on how to use these technologies. The SBAR tool gives nurses a framework for efficiently communicating patient information, which improves the caliber and effectiveness of reports[9].

SBAR is a straightforward and effective method that nurses can use to improve teamwork and exercise autonomy during shift reporting. It is made up of standardized questions that allow nurses and other medical professionals to communicate patient information in a clear and efficient manner. The SBAR framework enables efficient reporting and encourages the sharing of critical information by combining the communication styles of healthcare professionals[10].

Patient safety is a fundamental concern in continuous quality healthcare and has grown to be a top priority for healthcare companies. Using the SBAR shift report format will improve patient safety and decrease adverse occurrences[11].The administration of hospitals must create safer and more efficient healthcare in order to deliver high-quality medical care and services. Assessing patient safety in hospital nursing practice is one of the most important tasks[12].

Currently, many research papers and articles are being published in both national and international professional journals. These publications primarily concentrate on the enhancement and advancement of communication and documentation of patient clinical data between nurses [13-15].The SBAR tool is used in organizations to make communication more effective and consistent. Therefore this study aimed toevaluate the perceptions of nurses regarding using the SBAR tool for handoff communication and patient safety.

METHODS AND MATERIALS

Descriptive study design was used amongall nurses working at inpatient units at the time of the study and excluded the five nurseswho participate in the pilot study total number =50 nurses. Ethical Committee was approved the present study. The hospital's responsible administrator granted formal approval to conduct the study. Every participant was made aware after explaining the purpose of the research that their involvement in the study was entirely voluntary and that they might leave at any time. Every participant received an assurance regarding the privacy of the study sample and the confidentiality of the data acquired throughout the whole research.

There are two tools for data collection: The first tool wasself-administering questionnaire consists of two parts Part I: Personal data sheet which gathered data about: name years of experience, age, gender,and years of experience, educational qualification, and marital status. Part II: Self-administer questionnaire to measure nurse's knowledge about SBAR. This tool was constructed by Said, (2014) [16], and some modification was done by the researcher, to evaluate nurse's knowledge related to situation, background, assessment, and recommendation.

It consists of 25 multiple choice questions (MCQ) divided into three main areas as following:

Communication skills: seven questions involves the definition of communication, effective communication, elements, sending message, verbal and legality of communication, and how to improve your communication.

SBAR shift report: twelve questions involves its definition, intradepartmental reports, definition of SBAR, its aim, what it must include, what it is considered as, signed by whom, writing person, place, time, responsible nurse, and what is a good report. SBAR shift report exchange: six questions involves exchange place characteristics, between whom, frequency, morning to afternoon, afternoon to night, and night to morning.

Scoring: every question about the knowledge, a correct response was scored 1 and the incorrect response was given zero. For each question about knowledge, the scores of the items were summed-up and the total divided by the number of the items, giving a mean score for the part. These scores were converted into percent scores. Knowledge was satisfactory if the percent score was 60% or more and unsatisfactory if the knowledge score less than 60%.

The second tool: patient's safety audit checklist, this is a standardized check list developed by the Ministry of Health and Population Egypt (2014)[17]. It was used to evaluate patient's safety activity.The tool consists of 17

items with sub-items covering general patient's safetygoal. Scoring: Each item was to be checked as: No activity: scored (1), starting the activity: scored (2), in progress the activity: scored (3) and established the activity: scored (4).The total score for the 17 items thus ranged from 17 to 68. These are categorized as following: 17- 34 mean no activity, i.e. there has been no activity implemented; 35- 50 means activity started, i.e. the related item has been formally discussed and considered and staff has been trained or has implemented it partially in some department; 51-60 means activity is in progress, i.e. the related item has been partially implemented in all department of the hospital or fully implemented in some department of the hospital ; 61-68 means established activity, i.e. the related item is fully implemented in all department of the hospital.

Face validity was done to assure accurate comprehension of the research tools statements. It was done through jury by nine expert opinions from Nursing Administration. Also content validity was checked and analyzed using confirmatory factoranalysis test to assure (importance, clarity, and accountability) all items of the research tools scored more than one so all of them were confirmed all items are ranged from 1.5 to 1.8. Reliability data was done using cronbach's alpha coefficient method and its results revealed that all statements of the study questionnaire were (0.90).

Pilot study was performed before collection of data in order to test understandability and applicability of the tools. To estimate the time required for filling the questionnaire form, and to detect any obstacles which may encounter during data collection phase. It was carried out on 5 nurses (10% of the total sample). Nurses chosen in the pilot study were excluded from the present study. Accordingly, the required adjustments were done.The data collection was done from January to June 2024.Statistical analysis and data entry were done using statistical software package for SPSS version 28. Data were presented in the form of frequencies and percentages for qualitative variables, means, standard deviations, and medians for quantitative variables.

RESULTS

Table (1): Displays that all study participants are females, more than two thirds of study participants were having Diploma of Technical Institute of Nursing (68%). Most of study participants were married (72%), also more than half of them (60%) aged 30 years or less. Regarding the unit they works in, most of the study participants works in tumor units (74%), while (26%) of them works in surgical units.

Table 1: Distribution of study participants Personal data (n=50)

Personal data	**Frequency**	**Percent**
Age:		
<30	30	60.0
30+	20	40.0
Range	21-40	
Mean±SD	29.1±4.6	
Median	28.5	
Educational qualifications:		
Secondary Nursing school diploma	12	24.0
Diploma of Technical Institute of Nursing	34	**68.0**
Bachelor degree in nursing science	4	8.0
Gender		
Female	50	**100.0**
Male	0	00.0
Marital status:		
Unmarried	14	28.0
Married	36	**72.0**
Unit name:		
Surgical department	13	**26.0**
Tumors department	37	**74.0**

Table (2): Shows nurses′ knowledge regarding communication skills, the majority study participants had unsatisfactory knowledge level about communication skills (92%) meanwhile only 8% of study participants' s had satisfactory knowledge level.

Table 2 : Percentage Distribution of Nurses' Knowledge Regarding Communication Skills

Nurses Knowledge regarding	**n=50**	
Communication skills:	**No.**	**%**
Communication terminology	4	8
Effective communication	6	10

Nurses Knowledge regarding Communication skills:	n=50	
	No.	%
Elements of communication	7	10
Sending message	8	16
Verbal communication	7	14
Legality of communication	6	12
Improving communication process	8	10
Satisfactory:	4	8
Unsatisfactory:	46	92

Table (3): Displays nurses′ knowledge regarding SBAR shift, the majority of study participants' had unsatisfactory knowledge level SBAR report (94%) meanwhile only 6% of study participants' had satisfactory knowledge level.

Table 3: Percentage Distribution of Nurses' Knowledge Regarding SBAR Shift Report

Nurses Knowledge regarding SBAR report:	n=50	
	No.	%
Definition of report	2	4
Types of reports	1	2
Definition SBAR	4	8
Aim of SBAR	1	2
Element of SBAR	1	2
SBAR as documentation tool	1	2
Signature	3	6
Types of SBAR	1	2
Who write SBAR	1	2
When SBAR can be written	1	2
Who will be responsible for shift hand off	1	2
Characteristic of good SBAR	1	2
Satisfactory:	3	6
Unsatisfactory:	47	94

Table (4): Indicates the nurses' knowledge of SBAR shift report exchange the table reveals that the majority of study participants' had unsatisfactory knowledge level regarding SBAR shift report exchange (96%) meanwhile only 4%of study participants' had satisfactory knowledge level.

Table 4: Percentage Distribution of Nurses' Knowledge Regarding SBAR Shift Report Exchange

Nurses Knowledge of SBAR Shift Report Exchange:	n=50	
	No.	%
Characteristics of SBAR exchange place	3	6
SBAR shift report is exchanged between	2	0
How many SBAR exchange through the day	1	2
Who attend SBAR exchange from morning to afternoon	1	2
Who attend SBAR exchange from afternoon tonight	2	4
Who attend SBAR exchange from night to morning	3	6
Satisfactory:	2	4
Unsatisfactory:	48	96

Table (5): Shows that study participants achievement of patient's safety goals. It illustrates that all study participants' achieve no activity level regarding all items of patient's safety goals total score (25).

Table 5: Audit of Patient's Safety goals Achievement

	General patient safety	Audit No
Ps.1	Presence of policies & procedures of patients safety in the organization	2
Ps.2	Policy of Patient's safety as recommended by ministry of health and population.	2
Ps.3	Policy and procedure for handling critical values/tests.	1
Ps.4	Nurses has training regarding the Egyptian patient's safety recommendations	1

	General patient safety	Audit No
Ps.5	Standards of patient's safety are posted in suitable area	1
Ps.6	Identify a patient with atleast two methods when providing any treatments or procedures	1
Ps.7	Update guidelines, regulations and laws are implemented.	4
Ps.8	Disposable injection and devices must be discarded after single use	4
Ps.9	Telephone, and verbal orders must be standardized process	1
Ps.10	Implement a systems to prevent tubing and catheter miss connection	1
Ps.11	Patients risk of falling, including the potential risk associated with the patients any potentia risk associated with medication regimen	1
Ps.12	Procedure were done to eliminate or prevent any risk of falling	1
Ps.13	Assessing and documenting any risk of pressureulcers	1
Ps.14	Procedure are taken to decrease the development of pressureulcers	1
Ps.15	Maintenance, implement, and document of critical alarm systems	1
Ps.16	Alarms are tested and must be audible with respect regarding to distances and noise within the unit	1
Ps.17	Approach to intershift communications, including ask and answer questions	1
	Total score	25
	Activity level=noactivity	

DISCUSSION

The healthcare organization is comprised up of a variety of individuals, including doctors, nurses, pharmacists, laboratory scientists, nutritionists, and social workers. Administrators and healthcare professionals work together to provide patients with high-quality care. But based on the statistical data, a lot of human error occurred during the handover procedure, particularly when it came to communication between healthcare professionals[18].

One of the main duties of the nursing profession is facilitating efficient communication between health care providers, which is essential for harmony, safe and effective patient care, and improving ongoing care. The most crucial way to share vital information with other healthcare professionals while providing patient care is through shift reports. Nurses must include the scenario, background, evaluation, and suggestions in all nurse-to-nurse communications while using SBAR shift report communication[19].

In order to provide safe patient care, effective communication is crucial. The rule that one of the patient's safety objectives is good communication lends credence to this assertion. The ideal option for nurses to use in order to explain and transfer information more harmoniously and succinctly is the situation, background, assessment, recommendation (SBAR) framework. The primary objective of the SBAR is to identify the growing conditions and obtain feedback on existing solutions. In order to minimize and prevent errors when providing patients with critical information, the SBAR shift report uses a structured communication strategy[20].

The present study aimed to evaluate the perceptions of nurses regarding using the SBAR tool for handoff communication and patient safety. The current study findings illustrated that all study participants were females, most of them were married and more than two thirds of them have diploma of Technical Institute of Nursing.This might be due to in the past the nursing profession accept only female students.These findings were consistent with the research conducted by Abdel-latif (2018)[21], who discovered that the majority of nurses under examination had degrees from Technical Institutes of Nursing.

The present study findings revealed that the majority of study participants' had unsatisfactory knowledge level regarding communication skills. According to the study, this outcome might be explained by nurses who had not received prior communication skills training. This result was consistent with study conducted by Said, (2014)[16] findings that most nurses were unaware of the components of communication skills expertise. According to Taiye (2015)[22], simulation participants had a poor opinion of their communication abilities. This finding was consistent with that finding.

The current study findings revealed that the lowest percentages of study participants' have knowledge about SBAR shift report and the majority of study participants' had unsatisfactory knowledge level SBAR report. This might be due to SBAR was a unclear and stranger term for nurses. They didn't study it before in their under graduate courses so when evaluate their knowledge about SBAR shift report also nurses document patient care from the beginning of their employment on narrative notes not using any standardized format. This finding went in the same line with Inanloo, et al., (2017) [23] who found that the mean score of nurse's knowledge of SBAR shift report was very low.

The majority of study participants had inadequate awareness of SBAR shift report exchange, according to the current study. This could be attributed to the fact that SBAR shift report sharing is a relatively new idea in the nursing sector. According to Shahid and Thomas (2018)[10], almost two-thirds of the nurses demonstrated "good to high" competency with SBAR shift report exchange, which contrasted with this outcome.

According to the current study's overall score activity level (25), study participants showed no activity in relation to the patient's safety aims. This might be because nurses are not dedicated to implementing patient safety goals because head nurses neglect ongoing supervision because of their busy schedules, and the hospital does not have any motivational strategies in place to encourage nurses to do so. These results were inconsistent with a research by Cornell et al. (2014)[24], which discovered that patient safety goals were better achieved and that the SBAR shift report had a good impact on communication and patient safety, leading to improved patient safety outcomes.

CONCLUSIONS

The outcomes of the current study allow for the following deductions to be made: According to the researcher's observations, all nurses did not record any activity pertaining to patient safety, and the majority of nurses had inadequate knowledge scores in the areas of communication skills, SBAR report, and SBAR report exchange (92, 94, 94, respectively) (25). The study's findings will lead to the following recommendation: Create a training curriculum for nurses in communication. Create and implement an in-service training program to enhance patient safety and nurses' awareness of SBAR reports, communication techniques, and SBAR report exchange.

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