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MANAGING PATIENT PROGRESS REPORT THROUGH SBAR TOOL IN NON-CRITICAL CARE AREAS

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Abstract

Introduction: Managing patient progress report, although it is a routine task for all nurses in the hospitals but by managing it well through proper structuring, systematic and concise will avoid errors especially during the passing over report session. Effective and efficient of handing over the progress report is reported to promote high safety culture of care with good optimal outcomes of the patients. SBAR tool (Situation- Background- Assessment- Recommendation) was proven to be an effective instrument in managing the process of patient progress report. The aim of study was to manage patient progress report during the hand over session using the SBAR tool.

Method: A quasi-experimental study with pre and posttest conducted on 83 nurses working in non-critical areas. For post intervention strategies, one-day classroom training incorporated role play on issues of passing over reports and intensive usage of SBAR tool. Hospital quality audit set a formula, minimum. Forty percent of the respondent need to be assessed at regular internal after each training session. Forty respondents were observed and checked using checklists by recruited facilitators.

Results: Four components of SBAR were evaluated during handover report sessions. The reliability of a patient progress report improved from 54.5 % to 83.73 % with integration of the SBAR tool into a shift handover.

Conclusion and Implication: Acceptance and adherence of SBAR tool promote accountability among nurses towards promoting patient safety and quality of patient progress reports. SBAR is received positively by majority of nurses to manage patient progress report effectively and efficiently in the non- critical care areas.

Key Words: Managing, Handover, Patient Progress Report, SBAR, Nursing

INTRODUCTION

Managing a handover patient progress report is a routine task of nurses in the healthcare setting for power, containment and responsibility of nurses in patient care roles and responsibility [1]. For many decades, nurses are managing the handover report by reading the documented report from the clinical notes or by nursing cardex.

The traditional way of handover reports were found to be inconsistent from one nurse to another and it was restricted to nurses' role and hierarchies. A skillful, accurate communication and respectful interaction during handover between the nurses are critical in achieving optimization of quality patient care outcomes [2] was not emphasized. Communication failure often found in the traditional way during of the hand over report, that was due to the insufficient information given, ambiguous and unclear information as well as the lack of timely and efficient exchange of handover [2, 9].

Although, effective communication had been identified as key determinants of patient safety, many healthcare setting are still on the traditional way of handover process. This is due to lack of skills and poorly conducted handover skills and techniques among healthcare professions had resulted in the delay or inappropriate treatment and increased length of stay [22]. Besides, the traditional way of handover is said to be no longer in line with the current evidence-based practices.

Communication in the hospital is a complex process and seamless. Failure in the communication process was found to be mainly due to multi-tasking, different educational background, hierarchy & gender, communication style, lack of assertiveness and empowerments [24-25]. Those factors compromised the safety practices and clinical outcomes. Many research articles had quoted on the issues that communication is ironic and most of the people who received an understanding of basic good communication skills, but still, often, neglect and failed to put into practice. In fact, many relevant messages were omitted, missed or forgotten by the nurses during the transition of patient care due to unavailability of structured communication tool for handover [26].

The Joint Commission had reported about 2,445 sentinel events from hospitals across the United States,

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and 70% of the events were due to communication failures [8, 16-18]. It was estimated in the study that about 75% of the patients died yearly due to communication errors. Those incidences led to 98,000 deaths and cost the industry an excess of $17 billion annually [16]. Therefore, the change of shift handover becomes an integral part of clinical practice [19].

Nurses are certainly required to deliver clear, concise, relevant and appropriate informations for safe quality of care through effective management of the handover report. SBAR, as it stands for Situation, Background, Assessment, and Recommendation, **is** an effective technique that can be used to clarify and streamline information exchanges. It is an urgency for nurses to learn and embraced the new communication tool as a way to improve handover communication skills. There is an urgency for the healthcare providers to change and move towards evidence based practices such as SBAR communication tool, as report in a study, stating that "caregiver interactions involved a bi-directional communication where human factors serve as a prime source for errors and deletion" [23].

SBAR is a structured method of communicating on clinical information, it has been a practice in many health care system at handover patient progress report but to ensure the relevant information is passed in a concise manner. SBAR is a tool that has been potential to improve the quality of communication [5]. The handover begins with the Situation which highlighted the main reason for hospitalization. Then, moves on to Background as part of the assessment. With SBAR, nurses provides pertinent information about patient history including past medical surgical history, previous medication, allergic and other relevant information's followed by the communication is Assessment. The summary of the assessment findings pertaining to the patient will be necessary for the Recommendation to be developed on the patient care planning.

SBAR-Situation Background Assessment-Recommendation tool is said to be easy to remember. The mechanism can be used to frame up the conversations, especially during the critical situations that requires immediate attentions and actions. It clarifies what information should be communicated between members of the team. Many advantages are said about SBAR, it improves communication among healthcare professionals, besides helping the nurses exploring the patient's information in a structured manner and recommended solution to the problems. However, to acquire the SBAR skills, a training is a suggestion to it, in order to put SBAR in place and practice.

The purpose of this study is to adopt SBAR as tool in handing over report in ensuring patient safety culture and quality of nursing care in non-critical care areas.

Background

Although SBAR has been introduced in this hospital but effective implementation was not widely used and no studies had been conducted to determine the outcomes. The current process of handover report in the non-critical care units was mainly based on what is written in the nursing care plan and patient progress notes. The practice of communication from shift to shift needs was quite a general report pertaining to patient care. The focus is not on patients as individuals or the nursing needs, instead, it was merely on medical diagnosis treatment. Thus, the nature of handover report is more on passing over a routine report or recalled memory, based on information written in the patient notes. The information presented sometimes were irrelevant, repetitive, and speculative or contained other information sources. The time spent in handing over the report was often wasted for the incoming nurses who were not being given more useful information. As a result, the nursing handover report session, has attracted criticism from other health care providers on related issues such as, time expenditure, content, accuracy and the disparaging terms in which patients are sometimes being discussed.

Nurses need to undergo specific training on shift handover skills except for therapeutic communication that does not help much in the clinical handover of patient information. Handover skills is gained through observing the senior nurses handing over a report of the patient. The structured educational training on handover skills using standardized tools is becoming mandatory after health industries faced numerous medical negligence due to lack of communication skills among health care providers. Standardization brings everyone into the same format of reporting process which reduces potential harm to the patient [27].

METHODS

Design

This is one group quasi-experimental study on pre-test and post –test designed to evaluate the changes in the patient progress report after SBAR training.

Setting

The research study was conducted in a one of the private hospitals with 140-bed occupancy.

The hospital provides primary to tertiary level of care to the surrounding population.

Population and Sampling

The target population were nurses working in the non- critical care areas who gave direct care to patients. The non- critical care areas are Medical, Surgical, Pediatric, Mother and Baby Care. All participants were invited to participate in the research study on a voluntary basis. Purposive sampling is a type of non-probability sampling in which respondents are selected because they are identified as knowledgeable regarding the subject under investigation.The researcher establishes certain criterias and the respondents are selected accordingly. The sample size was adopted from a similar study done with 43 respondents [9]. In this study, a total of 83 nurses volunteered to participate in the research.

Instruments

For data collection, the Handover Assessment Checklist (hereinafter briefly referred to as SHAC). SHAC is a validated tool from the National Patient Safety Goals and Joint International accreditation body (2006). SBAR divided into four components that are situation, background, assessment and recommendation. The SBAR was used to evaluate the shift handover of patient progress report among nurses. Each components were sub-divided into elements. Each item was rated "Yes (1)" or "No (0)" during shift handover patient progress report. A total of 40 purposive samples of handover were evaluated using SHAC for baseline, second and fourth-month of the SBAR training. Nominal data are presented in frequency and percentage. Ordinal data are presented using Independent Sample t-test and Chi -Square Test.

Training

All respondents who consented voluntarily for one day training on SBAR, will be informed through the head nurses. This training had been repeatedly done until all nurses completed SBAR training. Each session conducted limited to 10-12 nurses in 2 sessions per week. The SBAR training session took one month to complete. Eight groups of nurses completed the SBAR training successfully within the targeted time frame.

The Training process

- The training session was incorporated with information giving on SBAR, video session on SBAR, role-play activities and hands-on session using SBAR tool.
- In a role-play session, respondents were given clinical scenarios on the implication of indigent handover report and improvement of handover report using SBAR.
- In the hands-on session, respondents observed in the process of handover skills and respondents used SBAR checklist to evaluate the performance.
- At the end of the session, respondents evaluated the usage of SBAR tool, and An SBAR pocket guideline was given to each respondent for reference as to support the SBAR practice at clinical areas.
- At the 2nd and 4th month after the SBAR training, assessment was performed using SBAR Handover Assessment Checklist (SHAC). The data was collected during shift exchange.

Ethical Considerations

Ethical approval for the research study obtained from the Ethical Research and Development Committee of KPJ Healthcare University College. All instruments used in the study were mentioned in the authorization request and after evaluation by the Ethic Committee.

RESULTS

This research included 83 nurses in the SBAR training but 40 nurses were chosen at each interval to assess patient progress report during shift handover. Refer to Appendix A.

Eight respondents were chosen from Surgical, Pediatric, Baby and Mother Care units. Sixteen respondent selected from medical as this is a combination of two wards. The researcher has used internal audit formula in selecting the responding. The hospital internal clinical audit requirement was forty percent from total respondent in the clinical areas. A total of 40 respondents were evaluated using SHAC for baseline, second and fourth-month of the SBAR training.

Table 5 showed the overall percentage of compliance of the SBAR handover at pre-test and post-test at second and fourth months after the SBAR training. There was an increase from 54.5% (pre-test) to 76.1 % and 83.73 % (post-test). Comparison the percentage of SBAR score by independent samples t-test showed that there was statistical difference between pre-test and post-test (P =0.001).

The SBAR training has improved the management of patient progress report. Independent sample t-test also used to compare the score of each four elements of SBAR. Element for situation did not show any statistical difference after SBAR training but for

background, assessment, recommendation, there were statistically differences after training (p= < 0.005).

situation is part of the patient safety verification and important identifier to ensure the right handover

Table 1 The overall result on Handover report on Situation before training, at 2 months and 4 months

Elements	Pre Test (N=40)		After 2 months (N=40)		After 4 months (N=40)	
SITUATION(S)	Yes	No	Yes	No	Yes	No
Patient Name	37 (92.5%)	3 (7.5%)	40 (100%)	-	40 (100%)	-
Medical Record Number (MRN)	31 (77.5%)	9 (22.5%)	40 (100%)	-	40 (100%)	-
Patient's room number	40 (100%)	-	40 (100%)	-	40 (100%)	-
Name of admitting consultant	40 (100%)	-	40 (100%)	-	40 (100%)	-
Patient's Diagnosis	40 (100%)	-	40 (100%)	-	40 (100%)	-
Date of admission (DOA)	40 (100%)	-	40 (100%)	-	40 (100%)	-
Reason for admission	40 (100%)	-	40 (100%)	-	40 (100%)	-
Overall compliance on Situation	**95.7%**		**100%**		**100%**	

Table 2 The overall results on Handover evaluation on Background before training, at 2 months and 4 months

Elements	Pre audit (N=40)		After 2 months (N=40)		After 4 months (N=40)	
BACKGROUND (B)	Yes	No	Yes	No	Yes	No
Summary of the patient's history	17 (42.5%)	23 (57.5%)	30 (75%)	10 (25%)	28 (70%)	12 (30%)
Patient status	1 (2.5%)	39 (97.5%)	19 (47.5%)	21 (52.5%)	21 (52.5%)	19 (47.5%)
Patient's past medical and surgical history	39 (97.5%)	1 (2.5%)	40 (100%)	-	40 (100%)	-
Patient's allergic	38 (95%)	2 (5%)	40 (100%)	-	40 (100%)	-
Intravenous Therapy	17 (42.5%)	23 (57.5%)	36 (90%)	4 (10%)	39 (97.5%)	1 (2.5%)
Previous Medication History	34 (85%)	6 (15%)	36 (90%)	4 (10%)	37 (92.5%)	3 (7.5%)
Discuss on Systemic Assessment	7 (17.5%)	33 (82.5%)	30 (75%)	10 (25%)	31 (77.5%)	9 (22.5%)
Lab result	6 (15%)	34 (85%)	8 (20%)	32 (80%)	30 (75%)	10 (25%)
Overall compliance on Background	49.69 %		74.69%		83.13%	

Table 3 The overall results on Handover evaluation on Assessment before training, at 2 months and 4 months

Elements	Pre audit (N=40)		After 2 months (N=40)		After 4 months (N=40)	
ASSESSMENT(A)	Yes	No	Yes	No	Yes	No
General status	2 (5%)	38 (95%)	12 (30%)	28 (70%)	22 (55%)	18 (45%)
.Recent vital sign and Pain Score	36 (90%)	4 (10%)	36 (90%)	4 (10%)	39 (97.5%)	1 (2.5%)
Other clinical information	5 (12.5%)	35 (87.5%)	26 (65%)	14 (35%)	29 (72.5%)	11 (27.5%)
Fluids/Medications	2 (5%)	38 (95%)	32 (80%)	8 (20%)	40 (100%)	-
Intake/output	10 (25%)	30 (75%)	36 (90%)	4 (10%)	36 (90%)	4 (10%)
Intravenous Line Monitoring	19 (47.5%)	21 (52.5%)	33 (82.5%)	7 (17.5%)	33 (82.5%)	7 (17.5%)
Fall Risk Assessment	31 (77.5%)	9 (22.5%)	36 (90%)	4 (10%)	37 (92.5%)	3 (7.5%)
Overall compliance on Assessment	45.71 %		73.36%		84.29%	

Table 4. The overall results on Handover evaluation on Recommendation before training, at 2 months and 4 months

Elements	Pre audit (N=40)		After 2 months (N=40)		After 4 months (N=40)	
RECOMMENDATION(R)	Yes	No	Yes	No	Yes	No
Nursing Care Plan(NCP)	3 (7.5%)	37 (92.5%)	28 (70%)	12 (30%)	27 (62.5%)	13 (32.5%)
Follow up orders	30 (75%)	10 (25%)	32 (80%)	8 (20%)	40 (100%)	-
Discharge Plan	2 (5%)	38 (95%)	8 (20%)	32 (80%)	33 (82.5%)	7 (17.5%)
Pending Result/Treatments	39 (97.5%)	1 (2.5%)	40 (100%)	-	38 (95%)	2 (5%)
How to improve pt condition/situation	1 (2.5%)	39 (97.5%)	14 (35%)	26 (65%)	17 (42.5%)	23 (57.5%)
New problem identify	-	40 (100%)	5 (12.5%)	35 (87.5%)	10 (25%)	30 (75%)
Is there anything else you want to know	-	40 (100%)	25 (62.5%)	15 (37.5%)	28 (70%)	12 (30%)
Overall compliance on Recommendation	26.79%		54.29%		67.5%	

Table 5 Summary of the Handover using SBAR tool before and after training

Elements	Pre Test (N=40) Percentage (%)	After 2 months(N=40) Percentage (%)	After 4 months(N=40) Percentage (%)	p Value
SITUATION	95.71%	100%	100%	0.07
BACKROUND	49.69%	74.69%	83.13%	0.01
ASSESSMENT	45.71%	75.36%	84.29%	.0015
RECOMMENDATION	26.79%	54.29%	67.5%	0.03
SBAR Compliance	54.5%	76.1%	83.73%	0.001

DISCUSSION

Situation

Effective record-keeping and documentation is crucial to good communication. The element from the process takes place. Situation is part of patient Safety Goal number one "Identify a patient correctly. There were no significance differences with or without SBAR tool for element's situation. The safety check includes medical registered number (MRN), patient's

full name, primary consultant, and reason for admission before the handover process begins. These elements are easily available from the patient progress notes and did not require any skills. These practices must be avoided as to prevent a possibility for unwanted events to be occurred among the patients. The finding from the pre assessment of handover before SBAR training revealed that there was still a 5.3% of respondents who missed safety check during handover. The implementation of SBAR handover checklist, ensure respondents comply with the elements. The use of a pre-prepared handover sheet that is passed on to the next shift in conjunction with a verbal handover maintains extremely good data integrity [27].

Background

The eight elements listed in the background such as patient history, including medical, surgical, allergic, previous medication and others. The result shows that only 49.69 % of the elements were handover by the respondents. The remaining data pertaining to patient status, systemic assessment and laboratory result were found to be missed during the shift handover. Some of this information were not given the priority according to patient's need during handover. The gap can be seen especially on the patient's past medication. There were few occasions where the researcher observed nurses had informed patient's previous medical history such as hypertension, but they missed the list of medication which needed to be followed through with a patient. Providing verbal handover only risks: identified in the literature linked to engaging in verbal handover only highlight the vagaries of human memory and the loss of information across each/every handover [32].The study revealed that the SBAR tool facilitated the respondents in organizing the information's. There was a big differences in the background after SBAR training. Respondents even though slow in handover report but improved the contain of handover.

Assessment

All information available in the patient assessment form but not highlighted as an important message during a handover report. The nurses have all the information about the progress of patient but unable to organize in a systematic order. This was the weakness that was observed during the shift handover by the researcher. Nurses do many assessments for the patient but during handover, they were unable to recall by memory the important observation that they had made for the patient. Nurses may forget some of the important clinical finding due to many interruptions such as disturbance from the team members and unplanned doctors around during shift handover.

Therefore, many of the critical points were not included in the handover by the nurses. The researcher believed this could be prevented if there was a structured checklist for nurses to counter check what needed to be passed and shared to others during handover of the patients report. The use of structured handover checklist is strongly recommended [29] and the researcher has proven the effectiveness in the shift handover.

Recommendation

For the element's recommendation, it was observed that nurses discussed less on the related clinical finding to make the optimal decision for the patients. The nursing care plan for a patient was not routinely discussed during shift handover. The nurse is reading doctors plan of care based on written notes in the patient progress report and very few clarification takes place during handover. The nurses write all patients' information on a piece of blank paper without addressing the important points according to the SBAR tool. Each handover process did not end with a question such as; Is there anything else you want to clarify? Respondents were found to be silent and did not raise any questions about patient care.

Summary

Patient progress report is one of the important strategies of communicating patients. Handover communication is an inevitable process and important factor in clinical decision making [10]. In this study, the handover process was disorganized and did not include all the pertinent data that required for managing patient progress report from outgoing nurses to incoming nurses. The handover was totally based on written information and recall memory from a nurse. During this process, there were a lot of barriers that nurses had to be encounter such as interruption from doctors, patients, peers and complexity of the operational process. Overall finding reveals that a passive handover did not encourage for two-way communication between nurses. The researcher believes that taking report on a blank paper may not help nurses to identify important patient data as it does not follow a standard even though it had been a common practice for centuries. Therefore, the handover process needs to be well organized and standardised, and the practice must be at par level with the current evidence-based practice. Effective Communication skills are the first-line defense mechanism to safe guard nurses and the patient from any potential harms in the hospital.

The change in the PPR was seen among nurses after they had used structured handover checklist compared existing process. The result of this study suggested that nurses who received one-day education training on the SBAR tool demonstrated a better quality of a handover report during shift exchange among respondents in the working units. The quality of the handover gradually improved at four months compared to before the SBAR training. The result revealed that the compliance rate on the SBAR tool was increased from 54.4% before training to 76.1% at two months. At the 4th month of the training, it was reported as 83.7%. Haig et al., also reported the similar finding from their research study whereby the utilization of SBAR tool during shift handover was increased after an educational training to nurses [11].

Therefore, in this study it was proven by the SBAR utilization among nurses, when handover skills rate increased to 83.7%. The result was statistically significant ($P < .005$). A structured training, continuous monitoring and guidance to the respondents have given a great impact on the improvement.

The additional tool that was provided to an SBAR handover sheet and MEMO pad had assisted respondents toward changes in their perception about the SBAR tool. They have adopted and adapted the SBAR tool as the communication medium in the non - critical care units. The change in management process during training has shown the willingness of nurses to accept the SBAR as one of the communication tools during any transition of patient care in the hospital. An educational activity that incorporated various interventions such as classroom simulation using role play and clinical scenario opened their mind-set for new knowledge based on evidence-based practices. Therefore, the use of structured communication techniques such as SBAR framework can help streamline information exchanges, and promote patient safety [30-31].

The respondents also could excerpt more relevant patient data from the patient chart, initial nursing assessment form, intake output chart, observation chart, nursing care plan, medication chart and physical assessment compared to before training. The changes may be due to impact of training during simulation exercise using a role play and video among respondents. The researcher believed that the time spent with respondents during the education session could create an awareness on the safety culture practices among respondents. The discussion on what information is critical and why it is important could result in the changes in the process of handover among respondents. The impact from the video on safety culture with the emphasis on the relationship between errors and data omission to adverse events and negative patient's outcomes that was shared during training had created a positive assertiveness among respondents.

The researcher believes that a change in management has to take place effectively by giving a continuous feedback and reminders to staff by the colleagues furthermore, by the leaders in the respective units. The busy working schedule and poor time management prevent nurses from spending more time in discussion with their peers about a patient's care. Nurses also give less priority to their request. After the SBAR training, there was a considerable improvement in the way respondents communicate on patient information. Nurses participated actively during shift handover by asking a question using SBAR elements. The structured handover helps nurses to recall all patient information compared to the old tradition of handing over progress report which depend more on recall memory. The SBAR tool guided nurses accordingly during handover process and many advantages were seen such reduced repetition, omission and others. This is the most significant finding from the research study.

As we know that the contributing factor for most medical errors was ineffective communication [2]. The leaders must continuously promote and encourage nurses to use tools that support the evidence best. The use of the SBAR, somehow has reduced the incidence of omission of patient information during the care which may comprise the safety of the patient. This tool has improved the way handover process and reported most of the message in a timely manner. The SBAR technique has helped the respondents verify the information that they received from one another. After receiving the intensive SBAR training in the classroom teaching with clinical role play, the respondents have appreciated the SBAR technique and start to realize the uniqueness of the tool. The respondents become competent users after the training, and their improvements were discovered during the shift handover.

From the outcome, there were areas for improvement, especially in taking a history from the patient and relate it to the clinical finding to identify the best care plan for the patient. The researcher found that nurses are not ready and comfortable to give recommendation based on their assessment to the consultants. The similar finding was reported that nurses felt the same situation [10]. To get over this problem, medical director of the hospital participated in the SBAR communication [10]. They

encourage staff to provide the "R" recommendation to the doctors during handover [10].

The researcher finds this a proper initiative to enhance standardised communication in the hospital. Good handover skills are essential for staff to be efficient in anticipating problems and be always aware of what is happening in the unit. From the finding, it indicates that the respondents have gained some knowledge and skills on using the SBAR tool in the clinical areas. This research finding supported that the communication domain has most significant statistical changes after adaptation of the SBAR communication tool [9]. The researcher found that each had a different adaptive level during the learning process to achieve the perfect handover communication in patient transfers.

The results from the study have some limitations. The study was only focused on the afternoon shift handover, and the researcher did not include morning and night shift handover. This may affect the SBAR compliance among nurses, and in a future similar, study should be conducted involved three working shift in the hospital. In future, demographic comparison need to be includes to identify a group for educational training. One of the five factors that inhibited communication was due to multiple transfers of patients who confuse the nurses [1]. As a result, nurse was rushed to complete a handover and many important messages were left behind. The healthcare organizations are cannot run from this complexity and resolution needed to solve the problems. Lack of a standardised tool that exists to help nurses but also nurses to be comfortable and be thorough in their shift reporting [28]. The management identify SBAR tool as a way to improve and managing patient progress report effective for nurses in a non-critical care areas. Nurses were trained on the SBAR through one day intensive workshop. Education is a way to improve communication and enhance patient care in the hospital [1].

As the result of this study, the compliance for situation was scored 100 % and was the highest mark compared to background (83.13 %), assessment (84.29%) and recommendation (67.5%). Average compliance of the respondents to the SBAR tool was 83.73%.

Limitations

There are many challenges inherent to effective communication contributing to difficulties, including, low health literacy, cultural diversity, contradicting or confusing health information, and lack of training for health care providers. These aspects of training were not a part of the research study. The research also focused on afternoon session and sustainability of implementation need to investigate in the future.

Implications

This research study demonstrated a significant result on the managing of patient progress report using a structured format among nurses working in the non-critical areas. This study may produce similar results hospital –wide implementation. The enhancement of the SBAR may help reduce the number of incidents and improve patient outcomes. The power of handover communication encouraged teamwork coordination and boost staff satisfaction.

CONCLUSION

Communication is the key to provide optimal care and prevent unnecessary harm to a patient during hospitalization. SBAR is one of the tools that are available to help nurses to streamline the important message that needs to be shared between healthcare providers. The old tradition of handover did not support for effective management of a patient progress report. Thus, the introduction of the SBAR tool brought a big change in the nursing practices. SBAR works well and assists in the provision of safe care is an invaluable asset for both healthcare professionals and patients. Thereby, communication should be taught in a standardised form to all health care. The SBAR training should be incorporated in a nursing syllabus as a stepping stone for high - quality care to patients.

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