SBAR for Patients

Charles R. Denham, MD

This article challenges caregivers to develop a new tool to improve communication between patients or families of patients and caregivers. Such a tool would be a derivative of an enormously successful existing tool, developed by a leading health care quality executive, using principles established in naval training on nuclear submarines. The communication principles provide structured language, reduce authority gradient impact, and apply discipline that fosters active listening between communicators. The developer of the original tool, known as SBAR, an acronym for "*s*ituation, *b*ackground, *a*ssessment, and *r*ecommendation" is interviewed, as are patient safety advocate experts who support the derivative tool that can be used by patients and families.

There are many well-known health care quality leaders; however, there are some who have made terrific contributions to patient safety who are not so well known.

Doug Bonacum, a quality and safety leader at Kaiser Permanente, is one such unsung hero. When caregivers meet him, they are immediately struck by characteristics that Jim Collins, the business guru, would describe as those of a level 5 leader: humility, will, ferocious resolve, and a tendency to give credit to others.[1]

Formerly a US naval submarine officer with a background in chemical engineering, he was posted on the USS George Washington Carver, a nuclear submarine and ballistic missile delivery system during the last stages of the Cold War.

On patrol in the North Atlantic from 1985 to 1988, he was a lowly ensign assigned to the least favorable watch, from midnight to 6 am. As such, he would be responsible for briefing the captain of the ship about potentially dangerous situations that might emerge during his shift. A captain always expected that, if such a call were made, a crisp briefing and strong recommendation would be delivered during that call.

The extremely steep power gradient or hierarchical relationship between an ensign and the captain of a submarine could be collapsed during verbal communication interchange when the ensign utilized clear briefing methods that captured the essence of the SBAR for further action to the captain. Although not formalized into the extremely successful SBAR tool we will discuss in this article, the experience in the US Navy allowed Doug Bonacum to develop it for the healthcare community when faced with a clinical communication challenge years later at Kaiser.

The empowerment of patients and families that may be attained through a derivation of Bonacum's tool is the subject of our discussion, expert interviews, and a challenge to providers to innovate and follow Bonacum's leadership.

THE PROBLEM: VERBAL INFORMATION TRANSFER FAILURES

Human factors, authority gradients, caregiver-to-caregiver communication breakdowns, health care literacy, and active listening have been identified as core concepts to understanding verbal information transfer between patients and their caregivers and between caregivers themselves.[2]

Nurses and physicians are trained to communicate differently. Nurses are trained to communicate by being descriptive, detailed, and narrative; physicians are trained to summarize, diagnose, and fix things.[3] Barriers to communication problems have been found to be the result of hierarchy, sex, ethnic background, and communication styles between nurses and physicians.[4–6] So too are there great differences between the

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communication styles of physicians and patients or families who do not have clinical training.

The Joint Commission notes that more than 60% of sentinel events in hospitals include communication as a contributing factor. On January 1, 2006, a requirement went into effect, associated with the Joint Commission's National Patient Safety Goal 2, which strives to improve the effectiveness of communication among caregivers. This requirement (2E) states that facilities must implement a standardized approach to hand-off communications.[7]

Communication that promotes safety includes both active communication and listening. Within clinical environments, there are often distractions and interruptions that make it difficult for clinicians and frontline caregivers to listen carefully. Often, there is so much information, and there are so many communications that it is difficult, if not impossible, to determine which communications are the most critical. Having a shared mental model that provides the most important information can promote effective communication and patient safety.[8]

Communication between patients or their families and caregivers suffers similar breakdowns for many of the same reasons that plague caregiver-to-caregiver communication.[2]

SBAR: A SOLUTION FOR CAREGIVER-TO-CAREGIVER COMMUNICATION

As described above, a briefing tool for nurse-physician communication was originally developed by Doug Bonacum, Kaiser Permanente's vice president of Safety Management. It was termed "SBAR," which stands for "situation, background, assessment, and recommendation." Bonacum originally implemented it in Kaiser Permanente's northern California regional risk management department's perinatal patient safety project. SBAR was designed as a situational briefing tool to convey, in less than a minute, vital information needed by the doctor or next caregiver.[9,10] It was designed to convey only the most critical information, eliminate excessive language, and allow staff to get immediately to the heart of every issue.[11]

The essence of this technique is that caregivers (1) provide a brief overview of the medical situation at hand, (2) offer background on the patient and their condition, (3) give an assessment of the situation, and (4) make a recommendation about the course of action needed. The standardized structure makes it easier for nurses and physicians to convey patient information without digressing, omitting key information, or worrying about how a physician may react. At the same time, the technique quickly gives physicians the key points they need to make an appropriate decision.[9]

The SBAR provides a standardized framework representing a hybrid of medical and nursing communication styles intended to enhance nurse-physician communications to help bridge the interdisciplinary communication gap. Especially in emergency situations, immediate understanding could be lifesaving for a patient, so this information tool helps ensure that the other provider hears critical information.[12]

Just as SBAR was found in the military to be a way to flatten the hierarchy between junior officer and senior officer, SBAR in the hospital was found to be a way to provide quick communication between nurses and doctors, in the "facts only" mode that doctors are trained to hear, thus reducing the hierarchy between doctors and nurses.[13]

EVIDENCE FOR SBAR EFFECTIVENESS

SBAR is sweeping the country. Its use is spreading within hospitals and may become so commonplace that it will be recognized as close to if not an actual standard of care.[14] SBAR has been found to be a very effective tool that provides a common and predictable structure to the communication. It can be used in virtually any clinical domain and has been widely applied in obstetrics, rapid response teams, ambulatory care, the intensive care unit, cardiac arrests, and other areas.[15] SBAR has found its way into perinatal care, emergency rooms, level I trauma centers,[16] and labor and delivery.[12]

It has been found to help clinicians understand and recognize clinical situations and act in an effective manner.[8] At Kaiser Permanente, the use of SBAR was so successful, it quickly spread throughout the organization, including one of the most problematic areas, patient hand-off.[13]

Evidence-based reports show that adverse events have been decreased through use of SBAR. As an example, the rate of adverse events at OSF St Joseph Medical Center (Bloomington, IL) was measured using a Global Trigger Tool, which contains a list of multiple triggers appropriate for general care, surgical care, intensive care, emergency department, medication, laboratory, and perinatal care, which prompts the reviewer to look further for evidence of an adverse event. The rate of adverse events was reduced from a baseline of 89.9 per 1000 patient-days in October 2004 to 39.96 per 1000 patient-days overall in FY 2005. Adverse drug events identified decreased from a baseline of 29.97 per 1000 patient-days to 17.64 per 1000 patient-days.[4,17]

Example Implementation Strategies

Introductions

1. Identify yourself and your specialty or practice.
2. State the reason for the call: "I'm calling to ask for your opinion or advice;" "I'm calling to ask you to see the patient and make recommendations for care;" or "I'm calling to ask you to assume the care of this patient for this problem, this hospitalization," and so forth.
3. Identify patient's name, age, and sex.
4. The patient's chief complaint and initial signs and symptoms.
5. A brief, pertinent history of the present illness or injury.
6. Relevant medical history.

Situation

1. Chief complaint/working diagnosis.
2. Current status.
3. Goals: A concise statement of the top 1 to 3 medical problems/ items to be resolved on the table.
4. Alignment: A statement of the patient's needs and wants as currently understood.

Background

1. Quick summary of other pertinent issues.
2. Pertinent findings of your examination (current signs and symptoms).

3. Pending laboratory, consults, and clinical test results (and their implications).
4. The care you have provided and the patient's response to your care.

Assessment

1. What is your working hypothesis; what has been ruled both in and out?
2. An invitation to develop a more accurate theory of situation and plan of care is made: "What have I missed? Any questions? Is there anyone else who needs to be consulted?"

Recommendations

1. Critical orders—what needs to be done until follow-up or consult?
2. Draw the box—establish parameters of when and how a physician or other provider needs to be contacted—and establish who that is.
3. Your estimated time of arrival (if transferring from another unit) or timeline for follow-up/consults.

Resolution

1. Summarize your understanding of the plan.
2. Do you both agree on the plan, timeline, and follow-up communications?

(List adapted from Monroe, 2006)[10]

WHY DO WE NEED SBAR FOR PATIENTS?

As mentioned above, the SBAR technique is gaining favor in healthcare organizations nationwide and is being used in a variety of communication tools, including e-mail. Some have already suggested that the template could be harnessed for use by physicians when communicating with patients,[9,13] and we suggest that it could further be of use as a guideline when patients need to communicate with the caregiver. There is a need for effective communication exchange between caregiver and patient, where the patient is guided to present important health-related information in a way that the caregiver can "hear." The following concepts have been identified as crucial in health care communication.

Human Factors

Human factors issues present a major challenge in health care communication. Caregivers work in settings in which illness assessments are expected to be completed in limited amounts of time; there are many professional tasks to be performed besides listening to the patient, and interruptions are rampant. However, the data that are generated from patient-centered communication can result in substantially enriched patient information, which can lead to more accurate working diagnoses and a better understanding of specific approaches that may or may not work best for an individual patient.[18] Physicians, who are under increased pressure to see several patients per hour, were found, in one study, to interrupt 69% of patient interviews within 18 seconds of the patient beginning to speak. As a result, in 77% of the interviews, the patient's true reason for visiting was never elicited.[19]

Caregiver-to-Caregiver Information Exchange

It has been well-documented that, due to many factors, there are caregiver-to-caregiver exchange problems.[2] If the original data coming from the patient are not clearly articulated, there is a much greater chance of miscommunication as the information is passed up the line, similar to the "Whispering Game" in which information passed up the line is degraded to the point of incomprehensibility.

Authority Gradients

In a culture that has authority or power gradients of "high status" and "low status" relationships, there is clear reluctance for "lesser-status" individuals to speak up. Hierarchical relationships and status differentials between patients and health care providers can hinder effective listening and communication, which puts patients at risk.[2]

Health Literacy Gap

Hundreds of studies have revealed that the skills required to understand and use health care–related communications far exceed the abilities of the average person.[2] For even the most health-literate, the high literacy demands of health care delivery provide a considerable challenge, and it has been suggested by the Institute of Medicine that it is important to make written materials and verbal communications as simple as possible for the patient.[20] Managing the clinical-patient relationship is extremely important for the management of patients, especially those who have rare or complex health care conditions.[21] It stands to reason that providing a structured set of communication tools for the patient to communicate in the language of physicians might help lessen the literacy gap in that the patient will have a guide in information gathering and thought process geared toward successful communication with the physician.

Active Listening

Active listening, attentive listening, or patient-centered interviewing, of which active listening is a large component, is a fundamental process for developing effective long-term therapeutic relationships with complex patients and or complex medical situations.[18] The Institute of Medicine report, *Crossing the Quality Chasm*, has determined that excellent listening skills used in managing the clinical-patient relationship are especially important in patients who have complex health care conditions.[21]

Due to human performance factors mentioned above such as time pressures, multitasking and interruptions, inability of the patient to communicate to the caregiver because of health literacy and authority gradient issues, and dropped ball health care hand-over issues, active listening often is often not used at all or impossible to do because of "upstream" mistakes, including an ill-prepared patient with respect to information needed by the caregiver.[2]

When doctors do not use good active listening skills, their ability to gather information is compromised and they fail to engage patients in their own care (and thus have some responsibility for poor compliance with treatment regimens).[18]

Patient as a Team Member

Fewer errors occur when teams effectively combine active listening skills and the consistent use of structured communication tools such as read-back, SBAR, and standardized hand-off report forms for communicating critical information among team members. Standardized systems can help avoid the use of memory and systematically organize important patient information.[2]

It has been suggested that it is important to make written materials and verbal communications between patients and caregivers as simple as possible.[2,20] It would follow that giving patients a guide to communicate effectively with the caregiver, such as SBAR, could be very helpful.

Proposed SBAR Tool for Patients

The following is just one version of a proposed formulation of an SBAR tool for patients. It is presented to prompt discussion by caregivers regarding development of such a tool for use in their organization. It is provided as an example that may be dramatically morphed to meet the needs of individual care settings.

The major difference from the original tool is that *recommendation* has been replaced by *request*. This recognizes the fact that SBAR is used to provide a briefing between caregivers that are recommending next actions.

In the case of patients and families using such a tool, they would be making a request of their caregiver. We would expect that they would typically provide a short written note set, or they might use the SBAR notes to verbally brief physicians or nurses.

Situation

- We can instruct patients and families to briefly describe the current situation of concern or the status regarding the request for help or information from the caregivers.
- We can instruct them to describe "active medical problems" as those requiring treatment.
- The situation information can be provided about the purpose for the visit, admission to the hospital, or a problem for which there is a need of the caregiver's attention.
- We might instruct patients or families to describe the current status of their care or of their condition.

Background

- We can ask patients to provide a brief summary of what led to the current situation with a priority on facts important to the situation as they describe it.
- The background information could include prior treatment and a brief description of how the current diagnosis was made and how the treatment evolved.
- One critical issue is to make sure to allow patients and families to express information they feel is important to the situation and important for the caregivers to know for their request to be served. This might include other conditions that the patient may have had or include information that they may have become aware of through the press or other sources.

Assessment

- Patients and families should not be expected to come up with a clinical assessment; however, they should be encouraged to provide an assessment of their status pertinent to the request below.
- We can enlist them to be brief and sum up the situation in the assessment section of a proposed tool.

Request

- The requests that patients and families may make may include reassurance regarding concerns or risks, requests for additional treatment or testing, or follow-up actions.
- More often than not, we miss the opportunity to learn from patients and families. Once they feel empowered to communicate with us in a structured fashion, their requests may have real logic and prevent inappropriate or unsafe care.
- When structured information can be provided to clinical assistants and support staff, we can maximize the time spent with patients collecting baseline information. Furthermore, many issues can be fielded without requiring a wait for a physician's interventions when clinical staff can follow up on details and assemble missing information that may have been identified by patients and families during the process of preparing SBAR notes.
- The framework above is merely a starting point for discussions in the development of a structured tool approach for specific care situations.

SBAR EXPERT INTERVIEW

The following interview with Doug Bonacum was conducted by the author, Charles Denham, MD, about the origins and use of SBAR in the health-related setting (oral communication, December 9, 2007).

***Charles Denham**: The SBAR tool has had a phenomenal adoption rate. We understand we owe its origin to your experience with rapid communication on a nuclear submarine, which you transferred directly to patient safety communication at Kaiser Permanente. How so?*

***Doug Bonacum**: Correct. It has its roots in perinatal patient safety training at Kaiser Permanente in 2002, when I heard doctors and*

nurses who were training together for the first time. They discussed their disappointment with the type of communication that was occurring between them in clinical scenarios. Nurses would call physicians in the middle of the night with a need that often elicited an inadequate response from the physician. Doctors complained that nurses, calling in the middle of the night, would provide a long rambling dialogue that left the doctor without a clear idea of what the nurse wanted. Both sides recognized that there was an opportunity for communication and performance improvement.

We didn't have any tools like SBAR at the time at Kaiser Permanente; however, I reflected on my military experience in the submarine force, where there was a hierarchical gradient between, in my case, the ensign and the captain. We would flatten the hierarchy with a situational briefing. We at Kaiser came up with the acronym ''SBAR,'' which stands for situation background, assessment, and recommendation.

C. Denham: *So, it was originally focused on a structured conversation between two people at different levels in the hierarchy. Had you any idea that it would grow to be what it is today…used in so many different ways?*

D. Bonacum: *No. I was thinking that the perinatal training was about as far as it was going to go. I didn't really imagine that it would be used in other circumstances, during hand-offs, and even as far as engaging the patient, as you are proposing. It was originally intended just to flatten the hierarchy between a nurse and a doctor who were trying to deliver a baby safely in the middle of the night and it's grown quite extensively since then.*

C. Denham: *We're very excited about applying the concepts of SBAR to the patient side of the communication circuit. We have explored a derivation of SBAR, such that for patient use would mean situation, background, assessment, and request (instead of recommendation). This allows a patient or family to organize the information within a structure and then make a clear request of caregivers. What is your reaction?*

D. Bonacum: *Giving patients permission to make their request is vital. Patients need to know that that's part of their role in the process. That they can make the kind of request that they know is right for them and that their family knows is right for them. If we are giving them the structure of something like SBAR, changing the recommendation to a request is even more empowering because it's something that they can*

quickly learn, quickly apply, and probably get the results they need to be met.

***C. Denham**: So, it's reasonable to presume that we'd be able to flatten the hierarchy between patients and families and caregivers?*

***D. Bonacum**: Exactly right. I think that a real hierarchy exists between physicians and patients. By providing a tool like SBAR and empowering them to use it with the appropriate reinforcing feedback when they do use it will flatten the hierarchy.*

***C. Denham**: Have you been impressed with how SBAR has also helped combat the performance challenges we have with human factors such as degraded performance with distractions and fatigue?*

***D. Bonacum**: I think one of the human factors benefits that SBAR particularly addresses is it generates a pause. It causes the deliverer of the information to take a moment and really think about what the vital information is that he or she wants to communicate. It does so in a way that they can then communicate the situation more clearly to the person receiving the information. So, I think SBAR can actually overcome some of our human factors issues such as over-reliance on memory, the impact of fatigue, interruptions, and distractions. One can stop and say to himself, ''Let me just think about the vital elements I need to communicate and then communicate them in a way that's going to get the action I need to get the patient or my family member safe care.''*

***C. Denham**: One of the concepts that we've been exploring in the listening domain is that of ''active listening.'' Listening with more than just your ears and taking in the entire ''movie,'' if you will. The SBAR tool appears to allow us to make sure that more of the basic factual information is transferred so that we can put more attention to active listening. Is that a fair statement?*

***D. Bonacum**: I think that's fair. The active listening piece is critical. I think it always should be tested in the form of a read-back or a teach-back, which can be coupled with the SBAR to make sure the receiver and the transmitter are on the same page.*

***C. Denham**: How about the issue of health care literacy? Do you think applying the new SBAR tool for*

patients would help from a health care literacy perspective? Do you think it would help the caregiver understand how healthcare-literate their patients are when they see how they have organized their thoughts and put their situation it in writing?

***D. Bonacum**: I think SBAR for patients can help address some of the literacy challenges that our patients face and also allow the practitioner to have some insight, not only into how well the patient can really communicate their condition and what their needs and requests are…but how well the practitioner really understands the situation himself, which is another insight from which the practitioner could benefit.*

***C. Denham**: Finally, as we consider implementation of SBAR for patients, how would you recommend deploying it with patients and families who have not been exposed to the discipline of the military?*

***D. Bonacum**: The way we introduce SBAR in hospitals is against a backdrop of information about human factors and human error. We try to get everybody to understand this is really about a team and not about a group of individuals. We discuss formal communication tools we've seen in other industries such as a preflight briefing in aviation. We practice the process in training sessions and teach leaders to positively reinforce the use of the tool when at work. So for patients, a little bit of education and an opportunity to put it to work might be very helpful. If one were to provide examples of its use—for instance, establishing how one could optimize a hospital stay by helping us keep our staff focus on issues important to the patient might help get traction.*

SBAR FOR PATIENTS: INTERVIEWS WITH PATIENT ADVOCATES

Patti O'Regan, ARNP, NP-C, BC, MS, LMHC, Adjunct Faculty Member, College of Public Health, University of South Florida

How important are tools such as the SBAR tool for patients?

The SBAR tool for patients can provide a critical prompt for caregivers to engage in active listening. Listening to patients' and family members' concerns can offer providers a barometer of change in a patient's medical status or condition that can impact diagnosis, treatment, and even survival of the patient.

What message do you have for leaders of health care organizations regarding the implementation of tools that promote such active listening?

Patients are the beginning and end of care; without focusing on the critical information conveyed by patients and families at every step along their care path, we cannot deliver safe and optimal outcomes. I would encourage leaders to

do whatever they can to ensure that accountability is assigned and resources are allocated to implement such tools at their organizations. They must recognize the vital importance of listening to patients and families [oral communication, December 16, 2007].

JENNIFER DINGMAN, FOUNDER, PERSONS UNITED LIMITING SUBSTANDARDS AND ERRORS IN HEALTHCARE (PULSE), COLORADO DIVISION; COFOUNDER, PULSE, AMERICAN DIVISION

How important would SBAR for patients have been in the case of the loss of your mother due to medication management errors?

The caregivers would have addressed ALL of the critical issues that concerned us. In her case like many others, the care was very fragmented, and use of such a tool would have allowed the caregivers to look at all of the issues. I believe she would not have crashed and that she would have had a far different outcome. The issue of fragmented care is a major reason for adverse events, and an organized approach to listening to the concerns of family members would have had a huge impact.

What message do you have for patients and families regarding adoption of such tools such as the SBAR tool for patients?

It is imperative that patients and families be trained in improving their communication with caregivers. When such tools such as SBAR for patients are offered to them, I pray that they take the time to adopt them and use them throughout their health care journey. This kind of tool can be used with their primary care physicians, specialists, and even pharmacists. Such tools are the building blocks of partnership and will put caregivers and patients on the same plane and in the same conversation. These tools can build a bridge to close the health care literacy gap we have in this country. In my work with families that have sustained adverse events, the common denominator is communication failure between patients and caregivers or between their caregivers [oral communication, December 16, 2007].

MARY E. FOLEY, MS, RN, ASSOCIATE DIRECTOR, CENTER FOR RESEARCH AND NURSING INNOVATION, THE UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO

What role could a listening tool such as SBAR mean for patient-centered care?

It means partnerships, and it means using the right information at the right time and in the right way to empower the patients and the families to make the kinds of decisions they need to make about their care…to make informed decisions and for us as providers to listen to them [oral communication, December 16, 2007].

BECKY MARTINS, FOUNDER, WWW.VOICE4PATIENTS.COM

From your experience as a patient advocate, how would an SBAR tool impact patient care?

Such a tool would have a huge impact. It would invite the patient and family to be a participant in

care and empower them in a positive way. Sometimes if the information is provided in a positive way rather than a negative way as a complaint, caregivers are more likely to step in and change the course of treatment. When caregivers are dealt with in a manner whereby requests can be made without polarizing them, we will have safer care.

What message do you have to physician and administrative leaders regarding implementation of such a tool?

Please put such tools on a fast track and make them a priority. They will deliver great benefits to you while creating safer care for patients and families that you serve [oral communication, December 16, 2007].

DAN FORD, MBA, VICE PRESIDENT, FURSTGROUP; CONSUMER MEMBER OF PATIENT SAFETY, QUALITY AND PATIENT- AND FAMILY-CENTERED CARE COMMITTEES OF AZHHA, APIPS, AND CHN IN ARIZONA, AND CHP, INSTITUTE FOR HEALTHCARE IMPROVEMENT, AND THE JOINT COMMISSION NATIONALLY

What message do you have for leaders regarding authority gradients, and do you believe that the SBAR for patients will help address this issue?

We have to address authority gradients between patients and caregivers. All stakeholders have to understand that such gradients exist AND that they serve as barriers to communication and a threat to safety. The SBAR for patients tool, properly employed, will definitely allow caregivers to focus on the real issues and keep them from naturally migrating back to a condescending approach that is only too frequently at play.

How would the SBAR tool have helped you in the case of the adverse event suffered by your wife and family?

In my family's case, my wife had a hysterectomy with accidental bowel perforation, followed by a medication overdose that caused permanent brain damage. Had I been able to communicate with caregivers using the SBAR tool, I would have been able to help focus the caregivers on key issues rather than being encumbered by barriers that came up after an accidental adverse event. We would have been able to avoid the classical obfuscation that occurred. We definitely could have had much better communication with the risk manager who took a very condescending approach to working with our family [oral communication, December 16, 2007].

ARLENE SALAMENDRA, PAST BOARD MEMBER AND STAFF COORDINATOR, FAMILIES ADVOCATING INJURY REDUCTION

Your admission to the hospital as a patient, with subsequent medical errors, revolved around the fact that physicians in the emergency department did not listen to you or your family. Had you had some form of an SBAR tool available to you, would you have used it or would your family have used it? Would it have changed the course of your health care journey?

We definitely would have used such a tool both at the time of the admission and during subsequent

interactions with the doctors. Numerous errors were made because of mistakes early in the admission that remained unchanged. We definitely would have been spared a tremendous amount of suffering. Ultimately, the main physician paid a price for his mistakes. Therefore, the use of the tool would not only have protected us from medical errors causing harm, but it would have spared the physician difficulty and negative impact on his reputation for perpetuating the communication problem.

What message would you have for emergency department staff?

When patients come to the ED, they are very vulnerable and fragmented in their thinking. An organized structural approach to communication could speed up and make more accurate the decisions that are made in a very stressful environment. I would like to make a plea to caregivers to give such a tool a chance. At the very least, we can all learn more about communicating such vital information [oral communication, December 16, 2007].

A Challenge to Provider Leaders

The existing SBAR tool has been battle-tested in the war on communication failures between caregivers. It has had unprecedented success. This tool deserves the opportunity to be applied to a broader loop in health care information circuitry—that of patient and family communication with caregivers. Clearly, this author and the patient advocates supporting this expanded role would be presumptuous to propose our own version of the SBAR tool, when there are so many worthy organizations that know so much more than we do about implementation of such innovations. That said, we want to issue an encouraging challenge to the great provider organizations of our country that routinely take risks on innovations in pursuit of performance.

Leaders in Health Care Are Risk-Takers for the Common Good

A careful analysis of the successful spread of SBAR in this nation reveals that it was not just the intrinsic merits of the tool that drove its success; it was people, people like Doug Bonacum who shared their genius so willingly and humbly. People like the phenomenal teachers such as Michael Leonard[14] and Allan Frankel[22] who cross-pollinate great ideas in the fertile fields of our leading hospitals. Quality leaders at frontline institutions, such as John Whittington,[17] are willing to take risks on testing such innovations. And people like Carol Haraden,[23,24] a force of good nature at the Institute for Healthcare Improvement (IHI), are willing to create a place for new innovations like SBAR to be shared generously. The IHI culture of "all teach–all learn" creates an environment where implementation techniques can catalyze a nuclear reaction of adoption.

Using the "4A" adoption framework we have applied to the National Quality Form Safe Practices and the Leapfrog Group survey as a context for discussion, we close with observations about the opportunities for provider organizations to seize the challenge of implementing some form of SBAR for patients at their institutions.[25]

Leverage the 4 A's of Innovation Adoption: Awareness, Accountability, Ability, and Action

The successful launch of SBAR at Kaiser Permanente and other organizations such as OSF St Joseph Medical Center was in no small part due to the "awareness" of the performance gap in caregiver-to-caregiver communications that leaders revealed AND the recognition that other industries had the same problems in communication, authority gradients, and human factors impact that had successfully applied similar tools with great success.

Secondly, leaders of early adopters of SBAR made sure that clear accountability was assigned to key actors in their organizations to implement such tools with real forethought to acknowledge use of the tool when and where appropriate. They tied measurement of performance improvement to measurement of the use of SBAR.

Third, successful adopters of the SBAR tool invested dark green dollars of real line-item budgeted financial resources, and light green dollars of internal resources, to implementation. They paid for education, workshops for practice, and reinforcement of use. They did not allow such performance improvement programs to be neutered by finance and operations cuts.

Finally, they took direct action to affect line of sight improvement targets and led by example at the front line.

We encourage our great provider organizations to develop their own derivations of the SBAR tool for patients to serve them better and fulfill their real potential as caregivers.

In the spirit of Will Rogers, we propose that leaders lead, follow, or get out of the way of those who will take the risk to innovate to close the communication gap with the patients and families we serve.

TOOLS AND RESOURCES FOR SBAR

Creating Safety Partnerships With Patients: "A Leadership Guide." Available at: http://www.marylandpatientsafety.org/html/education/documents/PtPartnersFall07.pdf

Patients as Partners: How to Involve Patients and Families in Their Own Care. Available at: http://www.jcipatientsafety.org/24112/

Tools for health care providers to use to improve health literacy with patients. Available at:http://www.cal.org/caela/tools/instructional/health_literacy.html

A Web site devoted to improving care by engaging patients and their families: http://www.newhealthpartnerships.org/default.aspx

SBAR Resource Toolkit and SBAR training DVD. Available at: http://www.safer health care.com

Laminated SBAR Pocket Cards (25 Per Pack) by HcPro. Available on amazon.com

Book: *Partnering With Patients to Reduce Medical Error: Guidebook for Professionals*. Available at: http://www.pohly.com/books/partneringwith.html

Pfizer Clear Health Communication Initiative. Available at: http://www.pfizerhealthliteracy.com/physicians-providers/stats-at-a-glance.html

SBAR information. Available at: http://www.hcmarketplace.com/prod-3936.html

SBAR Made Easy. Available at: http://www.homehealthquality.org/shared/content/hhqi_campaign/bpip_physrelations/SBAR_Made_Easy_pub_.pdf

TMIT Video. Are You Listening? Video produced by the Texas Medical Institute of Technology. 2007. Austin, Texas. Available at: www.safetyleaders.org

DOD and AHRQ partnership for SBAR education in building teamwork in the health care environment

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