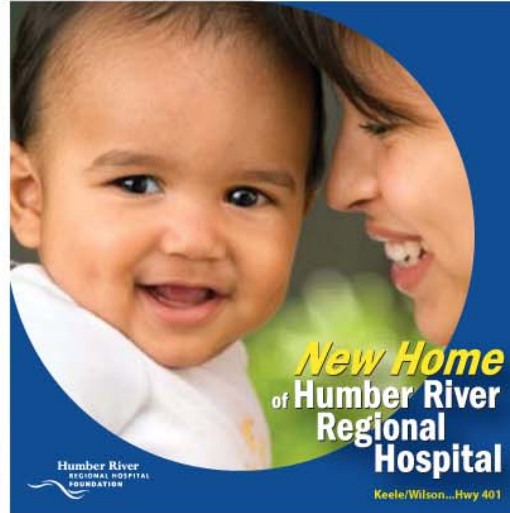
I-SBAR: a structured verbal communication tool



Purpose

- communication failure has been cited to be a factor in 60-70% of adverse events.
- communication techniques for doctors and nurses are very different, nurses describe, doctors diagnose.
- calls can be made when in crisis, without appropriate preparation

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Purpose

- healthcare environment has become increasingly complex, fast paced with multiple interactions.
- communication standards are not consistent among nurses and allied staff.
- on-call physicians or those in a consultant role may be notified and expected to make a decision based on what is communicated to them.

Purpose

- poor communication can have a negative impact on patient care and safety
- input is received from multidisciplinary teams comprised of clinicians with differing training, expertise and background, practicing in an increasingly complex healthcare environment

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I-SBAR REPORT TO A PHYSICIAN

BEFORE **Calling the Physician:**

1. Assess the patient yourself
2. Review the chart for the appropriate physician to call
3. Read the most recent Progress Notes and assessments by MD and nurse(s) from prior shift.
4. Discuss situation with resource nurse
5. Have ***available*** when speaking with the physician:
   Chart   MAR   Kardex   Access PCI (vital signs, lab values, orders)

I

IDENTIFY

Yourself, Patient and Room #:_______________________________________

S

SITUATION

The concern I am calling about is:_______________________________________

B

BACKGROUND

Admission diagnosis and date of admission_______________________________

State the pertinent medical history_______________________________________

Past treatments (EKG, CXR, Cultures, etc.)_______________________________

Current medications, IV's, Lab Values:___________________________________

A

ASSESSMENT

Most recent vital signs:

BP____ Pulse____ Respirations____Temperature____O2Sats____

Past vital signs:

BP____ Pulse____ Respirations____Temperature____O2Sats____

Any changes from prior assessments:

Neurological	Respiratory	Integumentary	Pain
Gastrointestinal	**Cardiac**	**Musculoskeletal**	**Genitourinary**

R

RECOMMENDATION

☐Allow MD to give their orders

************************AND/OR************************

☐If you don't receive all your desired orders, make your **recommendations**!

☐Clarify and/or repeat all orders received

If a change in treatment is ordered, then ask:

☐ How often do you want vital signs?________________

☐ If the patient does not improve, when would you want us to call again?______

This is not part of the Patients' Chart

Start · Transfer Repo... · ISBAR Augus... · 12 Microsoft... · groups on 'Hrr... · Least Restraints · Microsoft Excel · isbar october ... · 1:01 PM

I-identify

- -introduce yourself, your position and your location
- confirm that you are speaking to the appropriate person
- identify the patient by name, room number and diagnosis
- if the call is made to an on call physician ensure that the MRP is identified

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S-situation

- State the reason for your call, ensure that the doctor is aware immediately if it is urgent
- Clearly state the concerns
- Have all the relevant information readily available, pt's age, gender, current status
- Be brief but concise

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B-Background

- know the relevant history. The reason for their current admission, what the treatment plan is, including current medication and pertinent lab results.
- Give a comprehensive report, include details such as the presenting factors and complications

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A-Assessments

- What were the clinical observations and impressions that created concerns. What are the concerns, the risks and the needs
- remain focus on the reason for your call
- use appropriate terminology be clear and concise about your concerns and assessments.
- have all the current and relevant information needed for example vital signs

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R-Requests

- Based on your clinical observations what are you **requesting** from the physician
- Be **confident and assertive**, make your recommendations.
- Clarify and **repeat** orders received
- be **specific** about request and time frame
- **Document**

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Strengths

- Simple to use
- Generalized across any settings
- Easy to implement
- Relays relevant information in an efficient manner
- Make it a part of out everyday practice

Strengths

- **Improve** the quality of clinical communication
- *Reducing* adverse events in which poor communication played a key role.
- Ensures recommendation is **clear** and professional
- Focuses on the ***issue at hand*** and not the person delivering the message

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Weakness

- Not efficient when used for MRP because they know the patients well
- Doctors in a *hurry* to get to the point
- May be deemed as *time consuming* when in a crisis

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Opportunities

- Improving **<u>patients safety</u>** by standardizing communication between physician and nurses.
- Allows the expectation that relevant and necessary information will be shared among healthcare providers
- Enhances communication by acting as a simple and portable tool optimizing communications

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Opportunities-Cont

- Creates a set of **expectation** for what will be communicated
- Ensures accuracy and completeness of information therefore reducing the chances of *missed information*
- **Standardizes** communication
- Serves as improvement in the structure and **consistency** of communication.

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Opportunities-Cont

- Increases level of confidence in staff's abilities and skills to communicate efficiently and effectively.
- Minimizes the gap between optimal communication and patient safety

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Threats

- May be viewed as an unnecessary change, possible an obstacle to overcome.
- staff may disengage if they feel their time is being wasted.
- Might be deemed as increased workload, in a time of crisis.

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ISBAR- PRE & Post Training Evaluations

Observation Questions	Pre-Training Observation Findings (87 Completed)	Post Training Observation Findings (70 completed)
Does the nurse have patient information	17/87= 19%	61/70+87%
Does the nurse identify him/herself and the patient?	24/87=27%	67/70=96%
Does the nurse clearly describe the situation?	24/87=27%	68/70=97%
Does the nurse describe the patient's background?	38/87=43%	65/70=93%
Does the nurse provide a detailed patient assessment?	38/87=43%	66/70=94%
Does the nurse make requests/recommendations?	47/87=54%	53/70=76%
Was the overall conversation presented in an organized and professional manner?	27/87=31%	68/70=97%

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I-SBAR at HRRH

- Sept 2006, a quality improvement team introduced ISBAR at the clinical level.
- Physicians were encouraged to be active participants and would benefit by being the recipient of accurate and complete information on their patients
- Goal is to incorporate its use in conversations between nurses and physicians

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I-SBAR at HRRH

- Several units are currently using this tool independently or as a part of their physician communication form.

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Conclusion

- Listener knows what to expect and the speaker, knowing what is expected is able to deliver the information needed.
- I-SBAR provides a **framework** to ensure that information is being delivered amongst healthcare providers in a consistent and reliable approach
- When a standardized approach is implemented, evidence shows that the effectiveness of that approach increases.
- Enhances professional responsibility and accountability

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References

- I-SBAR: A shared Mental Model for Improving Communication Between Clinicians, March 2006, Vol 32, Number 3
- The Joint Commission Guide to Improving Staff communication, 2005, p.87 and 90.

Best Possible Medication History (BPMH)/ Medication Reconciliation

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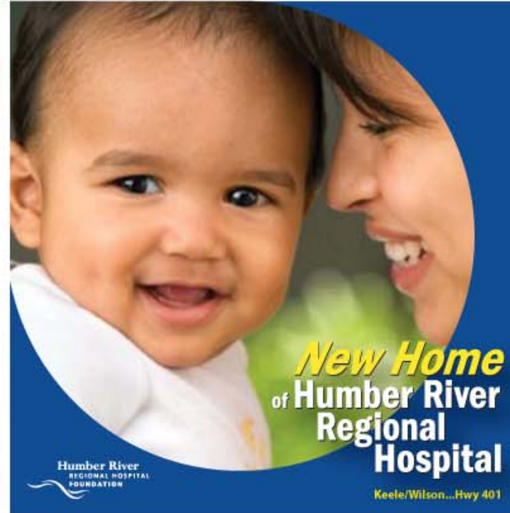
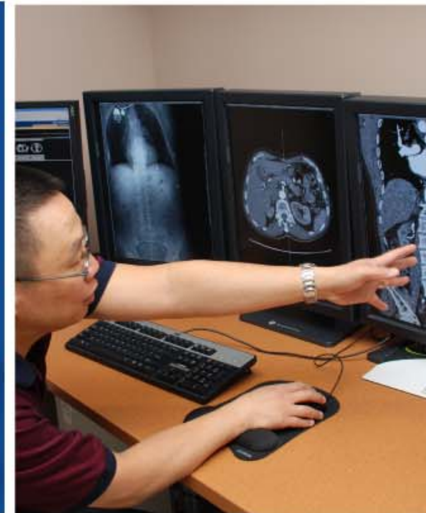
Proud of our diversity. Proud of our care.





Why is HRRH required to follow Medication Standards

- Ensures patient safety
- Reduce medication errors
- Required Organizational Practice (ROP) from Accreditation Canada
- Follow best practice guidelines
- To meet Ministry safety standards
- To comply with HRRH policies, procedures, and guidelines

Medication Reconciliation

- Medication Reconciliation is a process of obtaining a complete and accurate list of patient’s current home medications and comparing that list to the physicians admitting orders.
- Can decrease/eliminate patient’s receiving duplicate or incompatible medications or wrong doses

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Best Possible Medication History(BPMH)

- Ensures the patient receives all necessary medications while in hospital/upon discharge.
- Essential component of safe and effective patient care
- Essential component of medication reconciliation

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A complete and Accurate Medication List

- List should include information on ALL medications the patient was taking prior to admission, including prescription, non-prescription, herbal products, illicit drugs and supplements.

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Sources of information

- Patient
- Family/or Caregiver
- Ontario Drug Benefit (ODB) Drug Profile Viewer List
- Medication Vials/Blister packs
- Medication List
- Community Pharmacy
- Medication Profile from LTC/other hospital
- Family Physician
- Nurse/Nurse Practitioner

Note: Use the above sources when interviewing the patient to confirm the BPMH

Best Possible Medication History (BPMH)

The BPMH is:

1. Part of the secondary assessment

2. Completed within 24 hours of admission to all areas and points of transfer

BEST POSSIBLE MEDICATION HISTORY

Currently on medications>

Location of medications >

Type of Nicotine replacement product, if applicable>

Medication and Strength	Dose	Route	Frequency	Last Date/Time
1				
Comment:				
2				
Comment:				
3				
Comment:				

BPMH complete as possible at this time>

Sources used to achieve BPMH>

Sources required for further information>

Identified barriers in getting information>

Do not leave blank!

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Putting it all together!

Admissions

Step 1: Complete the BPMH

Step 2:Print Medication Reconciliation form and place in physician order section of the patient's chart.

Step 3: Medication Reconciliation form is reviewed by admitting physician who documents desired changes, meds to hold or discontinue, etc.

Step 4: Fax form to pharmacy

Medication Reconciliation Form

Humber River Regional Hospital
Emergency

MEDICATION RECONCILIATION
BEST POSSIBLE MEDICATION HISTORY
& ADMISSION ORDERS

ALLERGIES

NONE KNOWN ☐

Nurse/Physician/Pharmacist to document home medications
(non formulary medications should be indicated under "Reason for Change/Hold/Discontinuation")

DO NOT WRITE ORDER WITHOUT "PHARMACY COPY" IN PLACE

Height ____________ Weight ____________

BEST POSSIBLE MEDICATION HISTORY — PRESCRIPTION MEDICATIONS					Physician Reconciliation/ Admission Orders — Physician to Complete on Admission					
Medication Name & Strength	Dose (eg, mg)	Route (eg, PO)	Dosing Interval (eg, daily)	Last Taken (date/time)	Continue	Hold	Discontinue	Change	Reason for Change/Hold/Discontinuation (Please indicate any new orders in this section)	Use Patient's Own Medication (if available)
									Consider	
									Renal	
									or Hepatic	
									Dosing	
									& PO Status/	
									Surgical Status	
Non-Prescription Medications (eg, Over-the-Counter Products, Herbals, Other)										

SOURCE OF MEDICATION HISTORY

- ☐ Review of Patient Medication List or Medications
- ☐ Community Pharmacy
  - Pharmacy Name ____________
  - Phone ____________
- ☐ Drug Profile Viewer
- ☐ Family Physician List
- ☐ MAR from Another Facility
- ☐ Patient/Caregiver Recall
- ☐ Other: *specify*

DRUG COVERAGE /INSURANCE

To Be Completed by RN/Pharmacist

☐ No ☐ Private ☐ Other ☐ Provincial *eg ODB, Trillium, Monthly Card*

Pharmacy Consult ☐Yes ☐No Reason for Consult____________

Completed By: ____________ Date: ____________ Time: ____________

Completed By: ____________ Date: ____________ Time: ____________

Physician's Signature: ____________

Print Physician's Name: ____________ Date: ____________ Time: ____________

THIS IS A PERMANENT PART OF PATIENT'S CHART ☐ Indicate if Addendum Page ____ of ____

000000 WHITE - Chart YELLOW - Pharmacy Form # , version (00000)

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SWOT

- Strengths
- Weaknesses
- Opportunities
- Threats

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Strengths

- Promotes patient safety
- Decreases medication errors
- Prevent adverse drug events
- Eliminate medication discrepancies (errors/omissions)
- Improve communication at patient transfer points

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Weaknesses

- Language barriers and cultural barriers
- Multiple pharmacy use
- Multiple prescribing physicians
- Patient too ill to list medications correctly
- Rely on families
- Difficult to obtain information from other sources
- Admissions that occur off hours

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Weaknesses

- Required a lot of staff education
- Many physicians reported that the form was confusing
- Staff reported that the columns on the form are too narrow
- Any additional medications post printing are treated as a new order

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Opportunities

- Medication Reconciliation can save lives
- Medication Reconciliation can save hospitals millions of dollars
- Reduces Readmissions
- Reduces poly pharmacy use
- Encourages teamwork
- Increases patient satisfaction
- Empowers patients

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Threats

- Patient’s with low health literacy
- Look-alike/Sound-alike medications
- Staff time constraints and interview skills
- Time consuming for Educators and Managers
- Repeat educational sessions
- Buy in from physicians and staff

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Audit Results

- Went live November 3, 2010
- Weekly audits done on all new admissions
- Audit results were low in the beginning

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Audit

Copy of medication reconciliation audit April 19 K5E - Microsoft Excel

Medication reconciliation

Unit: K5E

uditor: Tina Colaros:

Total # of charts audited: 3

Total # of Med Rec signed by doctor: 3

Date: April 19/11

** Place a 1 in the applicable box	Chart 1		Chart 2		Chart 3		Chart 4		Chart 5		Chart 6		Chart 7		Chart 8		Chart 9		Chart 10		Chart 11		Chart 12	
STANDARDS	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met	Standard Met	Standard Not Met
BPMH Completed	1		1		1																			
Medication Reconciliation form completed	1		1		1																			
Medication Reconciliation form printed	1		1		1																			
Forms signed by doctor	1		1		1																			

Names of staff who did not complete and print Medication Reconciliation Form

Names of Doctors who did not sign medication reconciliation form

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Challenges

- How to get the nurses to consistently do medication reconciliation on all patients
- On-going education on how to use the form
- Low scores in the beginning- and the challenge of bringing the numbers up
- Education sometimes is not enough…

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Conclusion

- Medication Reconciliation is a powerful and effective tool in the fight against preventable adverse drug events.
- The goal of medication reconciliation is to provide correct medications to the patient at all transition points.

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Resources

- iHUMBER
- Micromedex- E-CPS
- HRRH - Medication Reconciliation Guideline - PC.267.2
- HRRH - Medication Reconciliation Admission through the Emergency Services (ER) – Procedure PC.270.1

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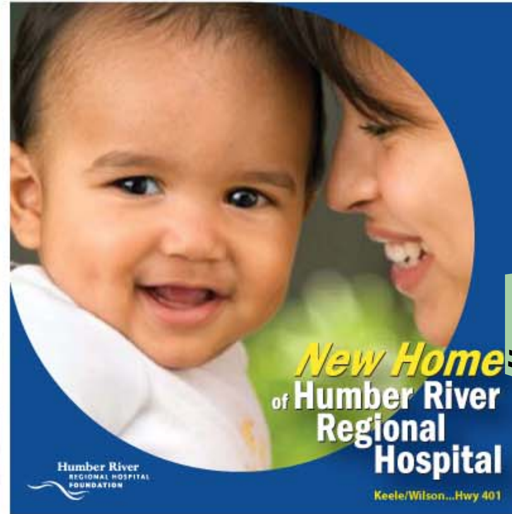
PCP- The Patient Care Profile



What is the PCP?

Patient Care Profile (PCP) is an inter-professional tool, which pulls together **up to date** information from the electronic patient record into a format that provides a **snapshot** of the patient's treatment plan.

The PCP includes:

1. Demographics (Allergies, primary/secondary Diagnosis
2. Resuscitation Status
3. Patient Status Review - <shift report>
4. Plan of Care
5. OE orders for T, T+1, T+2
6. All Consults & Referrals

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Patient Care Profile (PCP)

- Adopted hospital wide in 2007
- Meets accreditation standard requirements
- In line with HRRH corporate principles for inter-professional documentation
- Meets requirements to implement a documented shift report (shift to shift transfer of accountability)
- In line with HRRH plan for documentation to become fully electronic

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Goals for PCP

- To implement staff guidelines for giving and receiving report
- To improve the communication of pertinent patient data
- To improve organizational skills to keep report on track
- To enhance nurse’s critical thinking skills
- To improve quality care and best practices

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PCP

- Two components: PCP and Face to Face
- Before PCP, we had taped report or written report.
- The staff did not follow any consistent format for shift report

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The Patient Care Profile (PCP) Intervention

Patient AC000350/08 PCP,PATIENT 2 | Status ADM IN | Room F425M
Attend Dr SANI | Sanderson,Ian DR | Admit 23/08/07 | Bed 2
Start Date 27/08/07 at 1451 End Date 27/08/07 at 2359 | Age/Sex 27 F | Loc F4BMED
Include A,D,H,S AS,CP,MO,OE,PS 1:99 GRP INT | Med Edit | Unit# H000000542
Workload 0.42

Interventions	Sts	Directions	Doc	Src	D	C/N	KI	Prt
============ ASSESS/MONITOR ============								
-Patient Care Profile	A		54m	CP	D			*
************************************								
Document at end of every shift								
VIEW in PCI during shift report								
************************************								
-Resuscitation Status	A	.as ordered	55m	CP	D			*
************************************								
DNR Order Date: (ENTER DATE)								
************************************								

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Patient Care Profile (PCP)

Process Interventions

10/10 1437 NC | Int: 0✓ of 42

DN | Add Interv | Change Directions | Change Level | Change Status | Document Interv's | Document Now | Edit Admin Data | >More

Patient Care Profile

10/10 1437 NC | AC000368/08 PCP,BETTY

ADMISSION/DISCHARGE/TRANSFER -----------------------------

Primary Diagnosis: DKA AND MI

Secondary Diagnosis: diabetes, CHF, PNUEMONIA

Medication Allergies: METFORMIN

Food Allergies: SUGAR

Other Allergies: BEES

Language spoken > DUTCH | Translator Required? N

Notify in Emergency: Brad Pitt | Home Phone: 911-911-9111

Pre-Op? | Date of Surgery

Surgical Procedure:

CRITICAL EVENT -----------------------------

Resuscitation Status> NOCHCO

Physician> COOT

Any additional instructions: COMFORT MEASURES

** For Resuscitation Documentation - Review in PCI **

Verified?

PCP

/10 1345 RB

** Patient Status Review ** Shift to shift transfer of accountability **

Admission/Discharge/Transfer: Passes, Priviledges, Discharge Plan & Date

:

Mental Status: Clinically Significant Assessment Information

:

Safety/Restraints: Forms/MHA, Observation level, Restraints

:

Psychosocial: Inter-Professional Issues, Family Meetings

:

Medication (EPS, Changes to Medications, Long Acting Injection Dates

:

ADL/Hygiene:

:

PCP Reporting Screens

Physiological: VS, BM's, Pain, Focused System Assessments

:

Treatments/Diagnostics/Procedures: ECT, Glucometers, Specimens

:

Other

:

Standard Plan of Care >

Plan of Care:

The Plan of Care will automatically be pulled through and you can VIEW using View History or In PCI during Shift Report

Patient Care Profile

02/05 1515 NC

AC000051

OE: Card/Echo/Endo/Lab(all)/Neuro/Rad(all) Orders for Today

:

OE: Card/Echo/Endo/Lab(all)/Neuro/Rad(all) Orders for T+1

:

OE: Card/Echo/Endo/Lab(all)/Neuro/Rad(all) Orders for T+2

:

** WAIT for Yes to default** as system compiles then <Enter> Y

When the "Y" for Yes defaults in
Press <ENTER>
GO to Next Page

The Orders can be Viewed After filing using View History in PCI during Shift Report

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Process Interventions

02/05 1515 NC

Int: 0✓ of 30

DN | Add Interv | Change Directions | Change Level | Change Status | Document Interv's | Document Now | Edit Admin Data | >More

Patient Care Profile

02/05 1515 NC

AC000051/08 DECK,JANE

OE: Consults and Referrals (All)

CONS	PHYSICIAN CONSULT	19/04/07 0818 WHIL	BOWEL RESECTION SURG
CONS	PHYSICIAN CONSULT	19/04/07 0818 ZUPJ	TRANS ICU MED
REF	DIETITIAN CONSULT	19/04/07 0818	
REF	OCCUPATIONAL THERAPY	19/04/07 0818	
REF	PHYSIOTHERAPY	19/04/07 0818	

Consults – will show mnemonic of Physician, reason for consult as written in OE, and Specialty if indicated

** WAIT for Yes to default ** then press FILE <F12> Y

Yes/No Confirmation

File data. Intervention done. OK?

Yes No

Note ALL Consults and Referrals will default in for the ENTIRE PATIENT VISIT

SWOT

- STRENGTHS
- WEAKNESSES
- OPPORTUNITIES
- THREATS

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Strengths

- Audits shows compliance
- Enhances patient care, is patient specific
- Minimizes amount of time spent searching for pertinent patient information (one stop)
- All staff follow **consistent format**
- Orders, consults and referrals automatically get generated (don’t have to rely on memory)
- Replaces the manual Kardex

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Weaknesses

- Some staff were recalling information that wasn't pertinent. Simply repeating the previous information
- Some staff were putting in information that was not relevant

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Opportunities

- The PCP is stored electronically each time and this allows staff to look for **trends**
- It is a good guide for new nurses
- *Allied Clinical Staff have a place where they can quickly review patient's status instead* of sorting through patient care notes.
- Good format for when giving report during clinical rounds
- Challenge behavior patterns

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Threats

- Only few nurses are trained on smart board
- Electronic *malfunctions*
- Fiscal concerns of OT
- Need a **leader** to keep everyone on track
- According to surveys, few staff still are not on board
- *Common concern* was that PCP would take longer than tape report

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PCP Audit

PCP Audit

Audit 10 Charts for Each Audit

below indicating Audit and Month)

Date: | Name of Auditor:

# of Staff coming on Duty:				
# staff completing face to face report:			
face to face verbal report compliance			0%

	Chart 1		Chart 2		Chart 3		Chart 4		Chart 5		Chart 6		Chart
STANDARDS Met / Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met
Is there a documented PCP report for every shift?													
PCP consists of Pertinent info only													
Does info accurately reflect status of patient													
If trending indicates problem, were actions documented to correct/adjust trending?													
Was PCP documented last hour of shift?													
Is Edit Text info under appropriate intervention?													
Is info transcribed form order sets to Edit Text on Plan of Care													
Total Each Column	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent Met/ Percent Not Met	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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PCP Safety Calendar 2011

PCP Safety Calendar
2011

			January 83%			
			February 73%			
Mar 73%	Apr 100%	May 96%	June 93%	July 93%	Aug 90%	Sept 90%
			October 0%			
			November 0%			
			December 0%			

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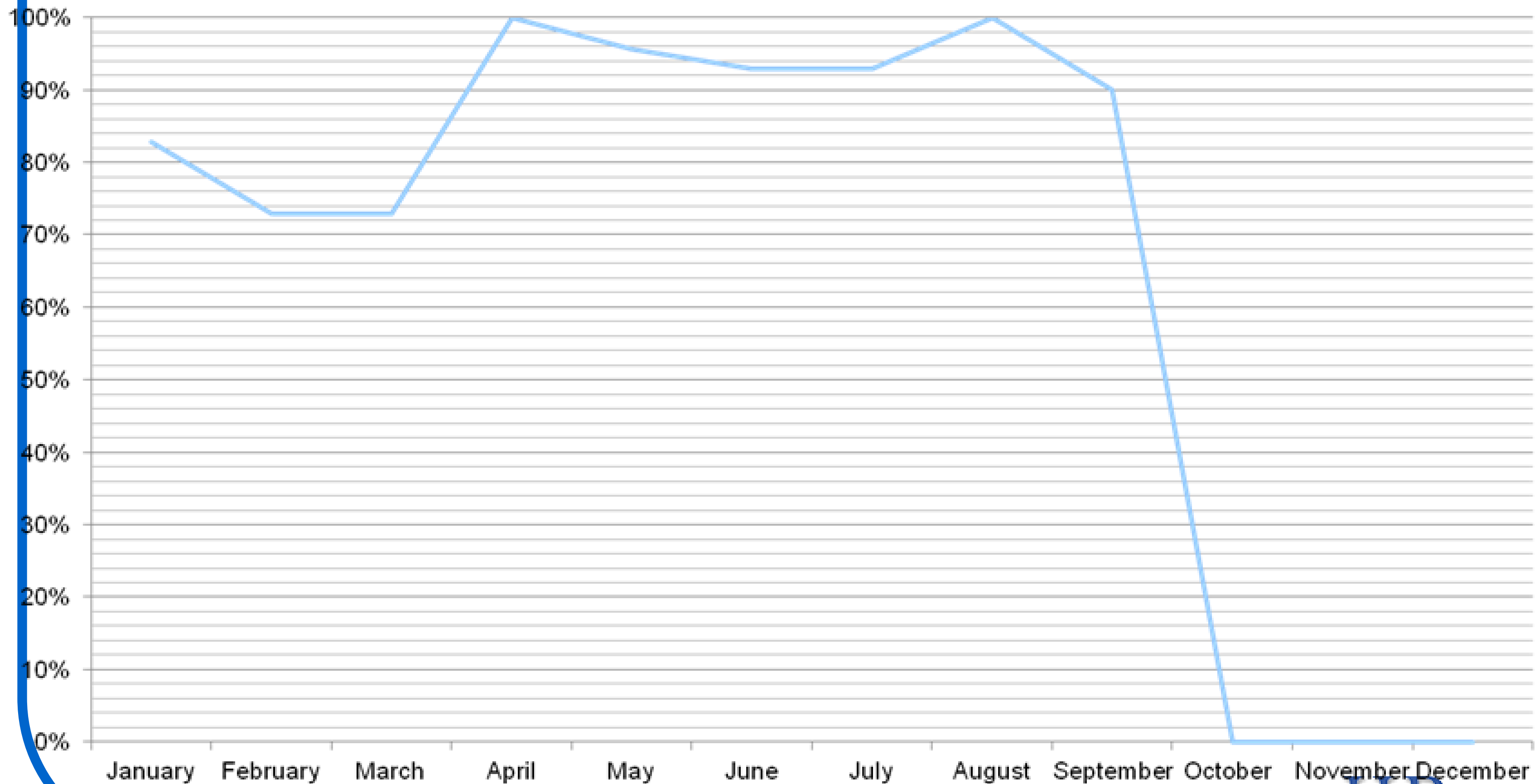
PCP Audit Percent of Compliance



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Questionnaire on PCP Reporting for Staff

1. The quality of care has improved since implementing PCP reporting
2. PCP allows me to get pertinent data that I need to care for my patients
3. I like having PCP and face to face reporting in order to clarify information
4. The format that we follow for PCP gives me the information that I need
5. PCP reporting is more thorough than taped reports
6. I would like to go back to taped reports
7. PCP report takes as much time as taped report did
8. PCP report has cut down on nurses socializing at the time of shift reporting
9. PCP reporting is more accurate than taped reports because it reducing the chances of misinterpretation and errors
10. PCP reporting ensures patient safety and continuity of care

Comments
How would you improve PCP

Measuring tool: 1. Strongly Agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

Where do we go from here?

- **Support** for staff by reinforcing thinking patterns
- Enhance professional leadership by identifying more **champions**
- Keep *communication open*
- Clinical Practice Leader or Manager to be *present* during shift report
- **Reinvent a shared vision**

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Questions?

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