SCENARIO

SBAR Handover

LEARNING OBJECTIVES

Recognise that communication breakdown between healthcare providers can lead to avoidable patient harm

Concise hand over of patients leads to safe effective clinical care

Ensure a standardised approach to communicating important information

EQUIPMENT LIST

Paper based

PERSONNEL	FACULTY
MINIMUM: 1	MINIMUM: 1

TIME REQUIRMENTS
TOTAL 30mins

Set up:	5 mins	Simulation:	10mins
Pre Brief:	5 mins	Debrief:	10mins

MODULE MAPPING

Module 19: Developing Professionalism
Communication, Team Work

REFERENCES

Thomas, C. M., Bertram, E., & Johnson, D. (2009). The SBAR communication technique. *Nurse Educator, 34(4), 176-180*

INFORMATION TO CANDIDATE

You are the ST1 on the night shift covering obstetrics. You have the following clinical situations that you wish to discuss with the ST5 covering labour ward. Please use SBAR.

1. Mrs Kelly Hooks in bed 3 is complaining of abdominal pain. The midwife asked you to review her about an hour ago but due to workload you are just seeing her now. She is 34 weeks pregnant and she has been an in hospital for 2 days after having a small APH. This is her 3rd pregnancy; previously she had a normal delivery at 36 weeks and an emergency section at 35weeks for APH. She has a background history of thrombocytopenia. She is not on any medications and has no allergies. She had a growth scan yesterday and the baby is on the 10th centile with normal AFI/dopplers her placenta is right lateral clear of the os. Her blood group is A+ve. She states her pain has come on suddenly over the last hour and is getting worse, its right sided and constant. She is unsure if baby is moving due to the pain. She thinks she might have had some fresh bleeding as she feels damp but is unable to check because of the pain. The midwife gave her some co-codamol but that hasn't helped. She looks very uncomfortable and distressed you've asked the midwife to do some observations and attach a CTG. Her BP is 90/60, pulse 110, sats 99%, RR16 Temp 36.3 MEWS 3. The CTG looks normal. You palpate her uterus and it is very tender and contracted, she has some fresh bleeding on her pad approximately 100mls. You are concerned she is having an abruption you want her to be reviewed urgently by the oncall ST5.

2. Miss Cherrie Sloan has attended triage with a history of watery PV loss. You have been asked to review her. She is currently 28 weeks into her first pregnancy. She has been well up until now and has no medical problems or allergies. She is 32 years old and has never had a cervical smear. Her anomaly scan was normal and her placental was posterior and clear of the os. She noticed the loss yesterday and has been wearing a pad that is slightly damp. She denies any urinary symptoms. She has no abdominal pain and she feels her baby moving. Her observations are normal MEWS 0. Her abdomen is soft and non-tender and you think it is a cephalic presentation. You perform a speculum examination with the midwife as chaperone. You can see some clear fluid but are uncertain if it is discharge or something else. You can make out her cervix but think it has some nodules on it that you haven't seen before. You would like to ask your ST5 to review your findings.

INFORMATION FOR CANDIDATE

3. Mrs Katie Donaldson has attended the day assessment unit with lower abdominal pain. The ST5 is busy and asked you to review her. She is 39 weeks into her 4th pregnancy. She has previously had three SVD. She is 34yrs old with a BMI 37. Her pain is bilateral and radiates to the back and has not been relieved with paracetamol. She has had some irregular tightenings. There is no associated bleeding or discharge and her baby's movements are normal. She denies any urinary symptoms and her bowels have been regular. The pain has been getting worse throughout the pregnancy and she is finding it difficult to walk and get out of bed. Her observations are normal. Her uterus is soft and non-tender. The fetus is cephalic 3/5 palpable with a longitudinal lie. She is tender over the pubic symphysis and sacroiliac joints. The CTG is normal and she has 1+ ketones in her urine dispstick. Your clinical impression is one of symphysispubis dysfunction and you feel she is safe for discharge with simple analgesia and physio review but you wish to discuss with the ST5.

4. Mrs Chandra Singh, 22years old, is on the postnatal ward. She is day 2 after a category three emergency section for a failed induction of labour for post dates. This is her first baby. You have been asked to see her by the midwives who are concerned about her lack of engagement with the baby and her reluctance to mobilise and communicate with staff. Her section was routine and uncomplicated. Prior to pregnancy she was medically well, on no regular medications and NKDA. She was studying at university but has quit due to this unplanned pregnancy. Her family live overseas, although her mother is here presently, they disapprove of her partner. Chandra is reluctant to talk to you on the ward she makes no eye contact but appears comfortable, her baby is crying in the cot and she makes no attempt to attend to her. Whilst checking her MEWS chart (zero score) you notice she appears to be talking to somebody in the room in an aggressive manor. When you ask her what is the matter she suddenly laughs hysterically. You are very concerned about Chandra's behaviour. She is unable to answers simple questions regarding person place and time. You review he routine bloods from this morning and they are normal. You feel she may be experiencing hallucinations and an altered mental state. You want to request an urgent assessment from the psychiatric liaison service.

INFORMATION TO FACILITATOR

SCENARIO DIRECTION

Allow the candidate 10 minutes to review the information.
You act as the ST5: Ask them to discuss each case with you
Communicate to candidate how you felt about receiving their SBAR handover.

Were they succinct and focused?
Did they convey the urgency of the case?
Did they correctly use SBAR structure?
Were they clear and professional in their communication?
Did they convey the important clinical information to you?
Where you clear in what they wanted you to do?
Situation:
Identifies self and location
Identifies the patient and reason for call
Describes issue
Background:
Reason for admission
Significant medical background
Assessment:
MEWS score
Examination findings
Investigation Results
Clinical Impression
Recommendation:
Request actions needed gives appropriate time frame
Elicits pertinent facts from vignettes
Organises information into SBAR
Communicates in succinct manner
Delivers clear instructions

S Situation	Briefly describes current situation. Clear succinct overview of pertinent issues
B Background	States relevant history
A Assessment	Summary of the facts What is the problem? What has been initiated?
R Recommendation	What do you want to happen?