



How FAR can you get with SBAR?

Literature, Root Cause Analysis and common sense indicate that hand offs between shifts has a high correlation to increasing patient and resident safety. Unfortunately, the time between hand-offs and shift changes can often get lost in a flurry the leaving nurse trying to get home and the arriving nurse trying to get started. Having a structured and systemic approach to hand-offs can be an effective tool to helping reduce falls.

We know that a majority of falls happen in the evening and during the “lull” times of the day where human beings generally get sleepy after meals, need to use the restroom, or want to change environment and try to move independently. These times often happen right around or near a shift change. When care planning for a potential fall risk patient, consider using SBAR as an effective intervention to keeping that resident safe. This approach follows a systematic exchange of information between shifts where assessments between professionals is shared in anticipation that unplanned, adverse event could be possible.

Here is an example of how this approach can be used with the following case study:

Mr. Smith is a newly admitted 97 year old with a history of Insulin dependent diabetes, anxiety and shuffling gait pattern. He spends most of his time in a wheelchair, and participates in a few activities. He has been teary and expressed an overwhelming feeling of loss. He is very modest and has been upset at recent toileting accidents, which increase his anxiety. His is considered a high potential for falls and skin breakdown. During his third day, he refused to participate in Bingo, an activity his daughter said he would enjoy. He spent more time than usual in his room, and he has been complaining of being thirsty. Nancy, his day nurse is getting ready to leave her shift. She uses **SBAR** to inform Gail, the evening nurse of what to anticipate with Mr. Smith:

Situation: Mr. Smith has been complaining of being thirsty, refused to go to Bingo today and has staying in his room most of the day expressing a sense of loss.

Background: This is his third day here, he is an insulin dependent diabetic, has a shuffled gait and has shown signs and symptoms of depression. He has been assessed as both falls and skin breakdown. He has had some recent toileting accidents.

Assessment: His increased thirst could be indicative of uncontrolled diabetes and may increase his need to use the rest room. His depression might weaken his judgment and further exaggerate his shuffled gait.

Recommendation: Consider 1 hr checks and encourage him to use the bathroom to prevent a need for urgency that could result in a fall. Monitor glucose and document signs and symptoms of thirst to report to MD if evidence supports an issue with diabetes. Speak to him at the beginning of the shift to ask him about the issues that were just shared with the day nurse and to engage him in his own care plan.

Using SBAR can help staff problem solve, learn to respect each other’s opinions by understanding why and how recommendations are drawn, and set a proactive approach that individualizes a fall prevention model in the facility.