BEDSIDE SHIFT – SBART FRAMEWORK FOR COMMUNICATION

This technique provides a framework for communication between members of the healthcare team. SBART is an easy to remember and concrete mechanism useful for framing any conversation, including those held in front of the patient. It facilitates and easy, focused way to set expectations and relay important information—essential for developing teamwork and fostering a culture of patient safety.

SITUATION	 "I'm going home now. XXX will be your nurse today/ tonight. I've worked with XX for a long time and I can tell you I'm leaving you in good hands! (or some other managing up phrase, i.e. XX is one of our most experienced nurses, XX is going to take great care of you" State patient name, Age Diagnosis, Code status, Admit status Name of primary care MD
B BACKGROUND	 "I'm about to give report to XXX. Please listen so at the end you can ask any questions of fill in any additional information that XXX will need to know to take great care of you today (tonight)." Give a brief & pertinent past medical history; Explain any co-morbidities or events that led up to this hospitalization or that are having an effect on the patient at this moment in time Admitted for
A ASSESSMENT	 Inform the oncoming RN of what you have assessed and or noted during your shift Provide a review of systems (ROS) including: Neuron, cardio-pulmonary, GI, GU, peripheral, & skin, activity order, diet order, etc. Mention all tubes, lines, & drains that are associated with each body system assessed Include any information or tasks that you have completed in the patients care. Mention what the oncoming RN will need to complete or follow-up on Include anything that will be coming up for the patient in the near future (Procedures, Surgery, Lab test, diagnostic studies, etc.) Be specific on what is going on with the patient now.
R RECOMMENDATION	 I suggest that you (what needs to followed up on that shift, patient goals, etc.) Review the ordered nursing and medical plan of care with the oncoming RN (IV-therapy, antibiotic therapy, tube feedings, etc.) Include relevant medications that have been ordered and any ancillary support services that are working with the patient such as RT, PT, OT, Nutrition Services, Social Services, Discharge Planning, etc. In giving this portion of the report any and all plans for this patients care (Fall precautions, restraint usage, wound care, turning needs, level of acuity, etc.) Include treatments, consents needing signed, pre-op checklists, any education or psychosocial issues going on with the patient or family unit Inform the nurse on the current plan of care for the patient. "Do you have any questions? Is there anything else XXX needs to know about caring for you today?"
T THANKS	Thanks – to the patient Prior to leaving the room and in the presence of both nurses, ask the patient the following: Is their <u>pain</u> being well managed? Do they have any <u>concerns</u> you can address? Do they <u>understand</u> their plan of care for this hospitalization and their discharge plan? <u>Inform</u> the patient of any diagnostic testing to be completed and what they can expect during your upcoming shift. "You're in great hands. Thank you for allowing me to care for you today"