

Implementation of the Sbar Tool and its Influence on The Reduction of Adverse Events in Nursing Services

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ABSTRACT

Effective communication in nursing is critical to promoting patient safety and reducing healthcare-related errors in hospital settings. This study aims to discuss the impact and influence of implementing the SBAR (Situation, Background, Assessment, Recommendation) tool in nursing services, analyzing how language standardization among healthcare professionals mitigates adverse events, optimizes continuity of care, and enhances hospital management. This is a descriptive-analytical study grounded in an integrative literature and document review, addressing international guidelines from the World Health Organization (WHO), Joint Commission International (JCI), and resolutions from the Federal Council of Nursing (COFEN). The analysis demonstrated that the systematic use of the SBAR protocol significantly reduces communication failures during shift handovers, intra-hospital transfers, and rapid response team activations. It is concluded that the SBAR protocol constitutes a high-impact, low-cost lightweight management and care technology, essential for consolidating a strong safety culture in healthcare services.

Keywords: SBAR, Patient Safety, Health Communication, Adverse Events, Nursing, Hospital Management

Introduction

Effective communication among healthcare team members is globally recognized as one of the foundational pillars for promoting patient safety and ensuring clinical excellence in hospital institutions. Failures in transmitting clinical information—whether verbal, written, or electronic—represent one of the most frequent and severe root causes of preventable incidents and adverse events, in addition to causing detrimental discontinuities in nursing care.

In the hospital environment, characterized by high complexity, dynamism, and constant pressure for rapid decision-making, patient data flow often suffers from noise, omissions, or misinterpretations. Critical moments, such as shift handovers, transfers between care units, and the activation of multidisciplinary rapid response teams, concentrate high risks of losing pertinent data regarding the user's clinical evolution.

In light of this vulnerability, the World Health Organization (WHO) and Joint Commission International (JCI) established effective communication as the Second International Patient

Safety Goal, encouraging the use of structured communication tools. In this context, the SBAR (Situation, Background, Assessment, Recommendation) protocol stands out as a lightweight management technology capable of standardizing the transmission of clinical information between nursing staff and other categories of the multidisciplinary team.

The implementation of SBAR in nursing services aims to impart clarity, objectivity, agility, and logical consistency to exchanged messages, reducing subjectivity and ambiguity. Furthermore, strengthening standardized language directly contributes to consolidating the organizational safety culture, promoting nurse autonomy, and ensuring the effectiveness of clinical decision-making within the hospital setting.

OBJECTIVES

General Objective

To discuss the influence of implementing the SBAR tool in nursing services, analyzing its contributions to reducing adverse events, improving care quality, ensuring continuity of care, and enhancing hospital management efficiency.

Specific Objectives

- Describe the methodological steps constituting the SBAR

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tool (Situation, Background, Assessment, Recommendation) within the context of clinical nursing practice;

- Map high-vulnerability scenarios in clinical information transfer within hospital services, such as shift handovers and intra-hospital transfers;
- Identify the main impacts of standardized communication on preventing medication errors, early identification of clinical deterioration, and strengthening patient safety culture;
- Discuss the nurse's role as a leader and change agent in ongoing training and monitoring of communication quality indicators.

Methods

This is a qualitative, descriptive-analytical study based on an integrative literature review and document analysis regarding quality management, structured health communication, and patient safety. The descriptive-analytical methodology allows for detailing nursing work processes and critically analyzing the determinants connecting communication standardization to adverse event reduction.

The theoretical framework of the study was based on analyzing the four methodological steps of the SBAR instrument (Situation, Background, Assessment, Recommendation). Practical application scenarios of the instrument by nurses were investigated, including bedside shift handovers, patient transfers between units (such as the Emergency Department, Operating Room, and Intensive Care Unit), activation of Rapid Response Teams (RRT), and case discussions in multidisciplinary meetings.

The literature and document search was supported by national and international regulatory and scientific guidelines. Regulations from the Ministry of Health and the National Health Surveillance Agency (ANVISA) within the National Patient Safety Program (PNSP), resolutions from the Federal Council of Nursing (COFEN), accreditation standards from Joint Commission International (JCI), global goal reports from the World Health Organization (WHO), and scientific articles indexed in PubMed/MEDLINE, LILACS, and SciELO databases published between 2018 and 2024 were consulted [1-5].

Results and Discussion

Structuring the SBAR Tool in Nursing Practice

The SBAR tool organizes the flow of verbal or written communication into four sequential, logical steps, ensuring essential information is transmitted without distortion:

Situation (S): The professional identifies themselves, states the patient's name, bed number, and objectively describes the immediate problem or clinical change observed at the moment.

Background (B): The patient's relevant clinical context is presented, including admission diagnosis, past medical history, current treatments, administered medications, and invasive devices in use.

Assessment (A): The nurse provides a critical analysis and grounded clinical evaluation, covering updated vital signs, severity scale scores (such as Glasgow, Braden, Morse), and alterations in laboratory or imaging tests.

Recommendation (R): Proposal of clear actions, re-evaluation timelines, or specific requests for the medical or multidisciplinary team.

Impact on Adverse Event Reduction and Care Improvement

Scientific literature demonstrates that the systematic adoption of structured communication via the SBAR method exerts a direct and significant impact on reducing healthcare incidents. Communication failures historically rank among the leading root causes of medication administration errors, diagnostic delays, and wrong-site surgeries. Standardizing communication via SBAR ensures critical data-such as allergies, prescribed dosages, and administration schedules-are not overlooked during care transitions.

In situations of acute clinical deterioration, the nurse's application of SBAR reduces medical response times. By synthesizing the 'Assessment' and formulating a consistent 'Recommendation', the nurse accelerates decision-making by the Rapid Response Team (RRT), resulting in decreased hospital mortality and reduced length of stay in Intensive Care Units.

Management Challenges and the Nurse's Role

Consolidating SBAR requires a cultural transition within hospital organizations. Nurses play a strategic role as facilitators, educators, and managers of the implementation process. Continuous training through active learning methodologies, such as realistic simulation and debriefing, is essential to ensure staff compliance and overcome interpersonal resistance.

From a hospital management perspective, monitoring SBAR compliance indicators and auditing shift handovers enable the direct measurement of quality gains. Reduced rework, optimization of handover time, and mitigation of costs stemming from adverse event management demonstrate the tool's managerial and financial efficiency.

Conclusion

The SBAR tool is established as a lightweight technology and a management strategy of exceptionally high efficacy and low cost to qualify clinical communication in nursing services. Its systematic implementation minimizes ambiguities and noise in clinical data transmission, significantly strengthening patient safety and preventing the occurrence of avoidable adverse events.

It is observed that standardizing communication flows not only improves continuity of care across shifts and hospital departments but also promotes professional empowerment for nurses and harmonic integration within the multidisciplinary team. It is concluded that investing in ongoing training and auditing SBAR usage constitutes an indispensable guideline for healthcare institutions committed to quality, managerial efficiency, and eliminating avoidable patient harm.

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