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Implementation of SBAR Communication For Nurse Handover in Nursing Services at Manimeri Health Center, Teluk Bintuni Regency

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ABSTRACT

Ineffective communication poses significant risks to patients, with 30% of nurses failing to provide accurate information to doctors, although 70% do provide good information, reducing patient risk (Depkes RI, 2008). Communication impacts both patients and healthcare workers, with nurses facing difficulties due to the lack of handover communication guidelines, which can endanger patients (Watulangkow et al., 2020). According to Permenkes No. 11 of 2017, 79.7% of incidents in Indonesian health centers result from ineffective communication. Dewi et al. (2019) found that the SBAR (Situation, Background, Assessment, Recommendation) technique in patient care reduces adverse events, near-miss incidents, potential injuries, no-harm incidents, and sentinel events. This study examines the impact of SBAR-based nurse handover on nursing service quality at Manimeri Health Center, Teluk Bintuni Regency, West Papua. Using a qualitative method with an exploratory phenomenological approach, the study involves seven participants. Data is analyzed using the Collaizi method, which offers clear, detailed steps. Findings reveal that SBAR-based nurse handover implementation in nursing services is suboptimal. Limited nurse understanding hinders the improvement and optimization of SBAR handover communication. Despite these challenges, there has been a notable change in the rate of adverse events following the research.

Keyword: Nurse Handover, SBAR, Nursing Services

ABSTRAK

Komunikasi yang tidak efektif menimbulkan risiko besar bagi pasien, dengan 30% perawat gagal memberikan informasi yang akurat kepada dokter, meskipun 70% perawat telah memberikan informasi yang baik sehingga dapat mengurangi risiko terhadap pasien (Depkes RI, 2008). Komunikasi berdampak pada pasien maupun tenaga kesehatan, di mana perawat sering mengalami kesulitan akibat tidak adanya pedoman komunikasi saat serah terima, yang dapat membahayakan pasien (Watulangkow et al., 2020). Berdasarkan Permenkes No. 11 Tahun 2017, sebanyak 79,7% insiden di pusat layanan kesehatan di Indonesia disebabkan oleh komunikasi yang tidak efektif. Penelitian oleh Dewi et al. (2019) menunjukkan bahwa teknik SBAR (Situation, Background, Assessment, Recommendation) dalam pelayanan pasien dapat mengurangi kejadian yang merugikan, insiden nyaris terjadi, potensi cedera, insiden tanpa cedera, serta kejadian sentinel. Penelitian ini mengkaji dampak serah terima perawat berbasis SBAR terhadap mutu layanan keperawatan di Puskesmas Manimeri, Kabupaten Teluk Bintuni, Papua Barat. Menggunakan metode kualitatif dengan pendekatan fenomenologi eksploratif, penelitian ini melibatkan tujuh partisipan. Data dianalisis dengan metode Collaizi yang menawarkan langkah-langkah yang jelas dan terperinci. Hasil penelitian menunjukkan bahwa pelaksanaan serah terima perawat berbasis SBAR dalam layanan keperawatan masih belum optimal. Keterbatasan pemahaman perawat menjadi hambatan dalam peningkatan dan optimalisasi komunikasi serah terima SBAR. Meskipun demikian, terdapat perubahan yang signifikan dalam angka kejadian yang merugikan setelah dilakukan penelitian.

Kata kunci: *Serah Terima Perawat, SBAR, Layanan Keperawatan*

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Introduction:

SBAR is a technique used to convey information about a patient's condition from nurse to nurse and doctor, positively impacting the reporting on the patient's status (Watulangkow et al., 2020). This method has a relevant format applied by the Joint Commission International (JCI) or the accreditation team of health centers to provide information for effective communication and reduce potential errors (Primanita, 2020). According to the Hospital Accreditation Commission (2018), effective communication is essential during shift changes between nurses and healthcare workers and when transferring patients from one room to another.

Communication using the SBAR technique (Situation, Background, Assessment, Recommendation) is very easy to apply to patients in critical conditions as well as those who are conscious. This technique is crucial in providing patient-related information, as incorrect delivery can lead to gaps in patient reports (Wang et al., 2017). Effective communication between nurses and other healthcare workers fosters professional collaboration in conveying information, preventing errors, and adverse events. Miscommunication accounts for more than 70% of errors in patient actions, with 75% leading to death and 65% stemming from irrelevant information (Panesar et al., 2014).

Ineffective communication poses risks to patients. Data shows that 30% of nurses do not accurately communicate information to doctors, while 70% do, thereby reducing patient risk (Depkes, RI, 2008). Communication influences both patients and other healthcare workers, and it can be challenging for nurses due to the lack of handover guidelines for the information that needs to be conveyed (Watulangkow et al., 2020). The quality of nursing services, as an indicator of healthcare quality, significantly impacts the public image of healthcare institutions. Implementing quality assurance activities in health centers can include quality control activities, with patient safety being a key clinical quality indicator (Nursalam, 2013).

Patient safety is a variable used to measure and evaluate the quality of nursing services, affecting overall healthcare services. In implementing patient safety systems in health centers, aspects such as the capabilities and attitudes of healthcare providers, as well as organizational systems, need to be developed or enhanced. Nursing services play a significant role in health center services, not only because of the large number of nursing staff but also due to continuous and sustainable care. Currently, health centers are required to implement patient safety systems, creating a safer and higher-quality patient care environment (Kemenkes, 2011).

The SBAR communication aims to assist healthcare workers in providing information related to the patient's condition and in developing relevant reports effectively. Information provided by nurses or doctors based on the benefits of nursing actions in handling patients must be conveyed accurately to be used for subsequent actions in accordance with the SBAR communication technique.

Methods:

The research design employs a qualitative method with an exploratory phenomenology approach. Participants are the term used in qualitative research to refer to individuals who can provide the necessary information relevant to the study (Creswell, 2014). The sample in this research was chosen based on purposive sampling, selecting individuals to understand their experiences concerning the phenomenon under investigation. In phenomenological research, the sample size ranges from 3 to 10 participants, with sample selection based on Focus Group Discussion (FGD) techniques.

Data analysis in qualitative research focuses on the relationships between the meanings of words and the significance of each phenomenon experienced by the participants. This analysis is conducted to derive meaningful relationships between variables that can be used to address the research questions formulated in the study.

Results:

Nurse Understanding

The results of in-depth interviews conducted before the focus group discussion with 7 participants during the research process revealed the first theme: participants expressed

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that nurses' knowledge about handover and SBAR communication was still lacking. Statements included: "I don't know which one is A and R, not fully understanding how to use SBAR, and the timing depends on the number of patients." Four out of seven participants said:

(P1) "Handover is done before we finish our shift, and SBAR communication is the format used for the handover."

(P2) "SBAR stands for Situation, where we report the patient's name, age, diagnosis, main complaints, vital signs, and the therapy given. Background is used in our ward according to the existing form. For A and R, we don't include them because they are not on the SBAR form."

(P5) "We follow the SBAR format provided here, but we don't fully understand its use; we do it because the head nurse instructed us to."

(P6) "We do handovers at the nurse station, and the time depends on the number of patients. If there are many patients, it takes longer; if few, it is quicker."

Nurse Understanding

The study's findings from 7 participants during the research process revealed the second theme: participants expressed that the understanding of nurses about handover using SBAR communication was still very poor. Statements included: "It's just like SOAP, we are used to it, we've always done it, I'm confused, there's no guideline, I don't know how to organize it." Four out of seven participants said:

(P1) "We write SBAR in the Implementation section of the nursing notes because it's similar to SOAP."

(P4) "We've always done handovers as per the existing example, and we understand it because we've always worked this way."

(P5) "Laughing... I used to be confused about the steps in the handover because we had no guidelines. With SBAR, we might have already been doing it because it's continuous."

(P6) "For handovers, we start by greeting, then report on patients under doctor A, M, and A, starting with the name, as written in the SBAR form. I agree with including age, name, bed number, doctor's name, diagnosis, fluids, injections, and vital signs as recorded in the nursing notes, but I am confused about how to organize it."

Nurse Challenges

The study's findings from 7 participants during the research process revealed the third theme: participants expressed that the challenges faced by nurses in implementing handover with SBAR communication included statements such as: "No one wants to help improve it, there's a reluctance to use SBAR, lack of support from colleagues and superiors, it takes too long." The statements from the participants were:

(P1) "We want to use SBAR in this ward to improve, but it's useless if we do it alone without help from others."

(P2) "We want to implement it here, but some colleagues are reluctant to use SBAR, so we follow suit and become lazy to do it."

(P3) "SBAR implementation is somewhat good here because we use the SBAR form for handovers, but many colleagues are still unaware of it."

(P4, P6, and P7) "The challenge is we want to improve but lack support from others and superiors."

(P5) "Handovers take a very long time, especially when writing in SBAR and nursing notes if we have many patients."

Benefits of SBAR Communication

The study's findings from 7 participants during the research process in the inpatient ward revealed the fourth theme: participants expressed that proper handover using SBAR communication

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has benefits, including "making our work easier, understanding the patient's condition comprehensively, reducing incidents, and helping patients with activities during their stay." However, nurses have not yet mastered SBAR, so they only perform what is routine in their ward. Six out of seven participants stated:

(P2) "It helps us by making our work easier, but the content is still partial, so it's the same information repeated."

(P3, P5, and P6) "We understand the patient's condition comprehensively from the handover."

(P4) "This technique can reduce incidents if we understand handover using SBAR."

(P7) "SBAR handover makes it easier to assist patients with activities, transfer them to other rooms, and more, but in this ward, it's just routine SBAR."

Discussion :

Nurse Knowledge

The findings of this study indicate that nurses' knowledge related to handover using SBAR communication is not optimal because nurses do not understand how to use SBAR. Participants stated, "I don't know which one is A and R, not fully understanding how to use SBAR, and the timing depends on the number of patients." Participants described SBAR as using a form provided for handovers during shift changes and not understanding the A and R sections of the SBAR form, leading them to only report what is written and resulting in prolonged handovers if there are many patients. Nurses' lack of understanding in using SBAR communication techniques is due to insufficient knowledge and information about SBAR.

This study explains that nurses have suboptimal knowledge in performing handovers using SBAR, understanding each item in SBAR, and effectively applying the SBAR communication technique. The extent to which nurses use SBAR is determined by their knowledge, which is derived from experience based on observed facts. Implementing the SBAR technique requires nurses to have a thorough understanding to effectively use it in patient care.

Based on this study's findings, aligned with Hildegard E. Peplau's theory emphasizing interpersonal relationships, Peplau suggests that nurses should have comprehensive knowledge in providing patient care and develop new methods as guidelines for nursing actions, as well as critical thinking in decision-making during SBAR handovers with colleagues.

Nurse Understanding

This study's findings related to nurses' understanding of handover using SBAR communication revealed that participants perceived it as "the same as SOAP, we are used to it, we've always done it, I'm confused, there's no guideline, I don't know how to organize it." Participants expressed this because they did not understand SBAR communication during handovers and equated SBAR with SOAP in nursing notes, as they were accustomed to performing handovers that did not align with the theoretical framework. Nurses continue to use the form implemented long ago without fully comprehending its purpose. Some nurses also stated that they lack an easily understandable and clear form, making implementation difficult.

Understanding and using SBAR in handovers requires professional nurses. The researcher analyzed participants' statements, highlighting the need for standard operating procedures to help nurses improve their understanding and implementation of SBAR in conveying patient information to colleagues and other professionals.The findings align with Peplau's interpersonal relationship theory, which emphasizes nurses' ability to understand and identify issues to comprehend SBAR communication during patient care. This research, based on Peplau's four stages—orientation, identification, exploitation, and resolution—indicates that nurses should first agree with colleagues during shift changes.

Consistent with Soliyanti et al. (2020), the study emphasizes that effective handover requires consideration of flow elements, SBAR communication, and time efficiency. Hariyanto (2018) argues that nurses' ability to perform

effective communication using SBAR is still lacking and needs improvement to avoid patient safety risks. Athanasakis (2013) states that effective communication during handovers between nurses and other healthcare workers requires understanding and knowledge development to improve the quality of nursing care.

Nurse Challenges

The study findings reveal that the challenges nurses face in the inpatient ward during handovers using SBAR communication include statements such as, "no one wants to help improve it, indifferent to using SBAR, no support from others, no support from supervisors, it takes a very long time." Nurses expressed these sentiments because some wanted to make changes to the SBAR form but did not receive the necessary support to improve nursing care quality. Consequently, nurses lacked motivation to update the SBAR form for proper and effective use.

Challenges are factors that hinder achieving goals and trigger the implementation process. Nurses continue to perform handovers using SBAR communication despite the lack of support to enhance patient safety. The researcher analyzed that understanding each SBAR item is essential for effective communication with colleagues and supervisors, who should support the changes related to SBAR implementation. Standard operating procedures should be in place to gain support from peers and supervisors.

The study's findings indicate that nurses face challenges in performing handovers using SBAR communication. According to Peplau's theory, solving problems requires support and knowledge from supervisors, colleagues, patients, and their families. This support helps nurses focus on SBAR communication.

Research by Safrina (2019) indicates that handovers between shifts can lead to adverse events, worsening patient conditions. Implementing SBAR communication during handovers can improve nursing care delivery. Similarly, Ilmi (2019) emphasizes the need for support from nursing management to overcome challenges and facilitate changes related to SBAR.

Benefits of SBAR

The study found that participants highlighted several benefits of handovers using SBAR communication: "making our work easier, understanding the patient's overall condition, reducing incidents, and helping patients with activities during their hospital stay." Using the SBAR form during shift handovers helps nurses improve nursing care quality by providing comprehensive care that aids patients in faster recovery, enhances patient safety, and reduces the risk of errors.

This study explains that SBAR communication significantly assists in handovers and simplifies communication. Some nurses noted that using SBAR effectively during handovers results in more systematic and detailed communication of patient conditions to colleagues and doctors. It also allows nurses to keep track of each patient's progress, reducing errors in care delivery.

The findings align with Peplau's interpersonal relationship theory, which emphasizes that using SBAR helps nurses communicate relevantly and focus on providing nursing actions to address patient problems and needs, allowing patients to perform activities independently.

Research by Arenas (2014) suggests that using SBAR communication during patient transfers between healthcare providers during handovers improves nursing care and reduces miscommunication during patient transfers within or between hospitals. Mahvar (2020) states that incorrect communication can be resolved by guiding nurses to provide quality information about planned nursing actions to patients.

Conclusions:

The study conducted on nurses explored the implementation of handover using SBAR communication in nursing services at the Manimeri Health Center in West Papua Province. Five themes were identified: nurse knowledge, nurse understanding, nurse challenges, benefits of SBAR communication, and nurse experience.

These themes were categorized and explained based on the participants' experiences found by the researcher.

The study results indicate that the implementation of nurse handovers using SBAR communication in nursing services is still suboptimal, based on the five themes identified from the nurses who performed handovers using SBAR communication. The ongoing practice involves continuing with the existing form, a lack of understanding among nurses, and challenges in improving and optimizing the implementation of SBAR communication in nursing services at the Manimeri Health Center in West Papua Province. However, there has been a change in the rate of adverse events following the study.

Limitation of the Study

This study has several limitations. First, the research was conducted in a single healthcare center, which may limit the generalizability of the findings to other settings with different policies, resources, and organizational cultures. Second, the sample size was relatively small, as the study involved only seven participants, which may not fully represent the diverse experiences of nurses in various healthcare settings. Third, the study relied on self-reported data from participants, which may be subject to recall bias and personal interpretation. Future research should include larger and more diverse samples and explore quantitative approaches to complement qualitative findings.

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Conflict of Interest Statement

The authors declare that there is no conflict of interest regarding the publication of this article.

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