SITUATION, BACKGROUND, ASSESSMENT, AND RECOMMENDATION (SBAR) MAY BENEFIT INDIVIDUALS WHO FREQUENT EMERGENCY DEPARTMENTS: ADULTS WITH SICKLE CELL DISEASE

Authors: Coretta Jenerette, PhD, RN, AOCN, and Cheryl Brewer, MSN, RN, Chapel Hill, NC
Section Editors: Reneé S. Holleran, APRN, PhD, CEN, CCRN, CFRN, CTRN, FAEN, FNP-BC, and Andrew D. Harding, RN, MS, CEN, NEA-BC, FAHA

Evidence-based research supports the use of situation, background, assessment, and recommendation (SBAR)—a collaborative communication strategy—to improve communication among health care providers.[1-3] SBAR has been found to assist with structuring and standardizing communication and is considered an easy-to-remember technique that provides for consistent, structured communication between members of the health care team.[4] However, there has been no published support for the usefulness of SBAR as a communication technique between health care providers and patients. We present a vulnerable population, individuals who frequent the emergency department, and an example of how SBAR can be used to improve communication and perhaps satisfaction with the care-seeking experience.

Sickle Cell Disease

Sickle cell disease (SCD) refers to a family of inherited autosomal recessive genetic disorders that affects about 1 in 365 African Americans, with approximately 89,079 persons having the disease in the United States.[5] The clinical manifestations of SCD often lead to unpredictable episodes of pain and feelings of inadequacy regarding patients' care.[6] For these reasons, many adults with SCD avoid the health care system whenever possible and manage their pain at home.[7] Using the iceberg analogy, Smith and Scherer[7] note that most of the iceberg of SCD pain is submerged at home whereas only the tip of the iceberg is seen by health care providers. However, for individuals with SCD who do seek acute care, the majority of visits are related to painful crises.[8,9] The extent of treatment for a painful SCD crisis depends on the health care provider, who assesses the SCD patient's presentation and ultimately decides whether the individual's report of pain is credible and deserving of treatment.[10,11]

Individuals with SCD are often labeled as "frequent flyers." Frequent flyers are individuals who frequent the emergency department, visit several emergency departments to obtain pain medication, or are thought to frequent the emergency department for nonurgent health concerns.[12] Individuals who need to frequent the emergency department need skills to navigate the system to have a positive care-seeking experience.

SBAR and SCD

Currently, adults with SCD who seek care in an emergency department with complaints of an acute pain episode may wait an average of 90 minutes for the first analgesic to be given.[13] Delays may be due in part to the fact that the pain of SCD is poorly understood and it is difficult to objectively assess a pain crisis. Additional barriers to adequate pain management include the fact that most individuals with SCD in the United States are African American and many are of lower socioeconomic status.[14] For these reasons and perhaps others, when young adults with SCD seek treatment for acute pain in an emergency department, there is great potential for racial stereotyping, mistrust, and problematic physician-patient communication.[15]

These factors may result in a negative pain management experience. Individuals with SCD are concerned

Coretta Jenerette is an Assistant Professor, School of Nursing, The University of North Carolina at Chapel Hill, Chapel Hill, NC.

Cheryl Brewer is a PhD Candidate, School of Nursing, The University of North Carolina at Chapel Hill, Chapel Hill, NC.

This work was supported by a grant from the National Institute of Nursing Research (K23NR011061) to C.J.

For correspondence, write: Coretta Jenerette, PhD, RN, AOCN, CB # 7460, School of Nursing, The University of North Carolina at Chapel Hill, Chapel Hill, NC 27599; E-mail: coretta.jenerette@unc.edu.

J Emerg Nurs 2011;37:559-61.

Available online 5 May 2011.

0099-1767/$36.00

Copyright © 2011 Emergency Nurses Association. Published by Elsevier Inc. All rights reserved.

doi: 10.1016/j.jen.2011.02.012

TABLE 1
Sample SBAR dialogue between provider and patient with SCD

SBAR	Dialogue
Situation	Provider: Hello, Naomi. I am Dr Johns. You are in the emergency department with a pain level of 7? You couldn't take care of this at home? When I see sicklers, they are usually complaining about level 9 or 10 pain. Patient with SCD: Well, Dr Johns, I try to seek care early for my pain. I know my body, and I am pretty good with managing my pain at home. I tried my usual pain medicines at home, but I'm hurting more and don't want it to get any worse. This pain in my legs began a couple of days ago, and it is now a 7 on a scale of 1 to 10. It feels like I am headed for a bad crisis and I want to avoid that if possible. Provider: Well, I'm going to have to examine you and see what I think is best.
Background	Patient with SCD: I understand that you need to examine me, but I would like for us to talk about the treatment plan. I had a lot of additional stress at work this week. Some of it was just unavoidable with a new boss. So, I have been trying to get additional rest and drink more fluids. I took 2 Percocet last night and 2 this morning. When the pain began to get worse, I decided that I would come in.
Assessment	Provider: So, the Percocet is not working. Do you feel like this is your typical pain crisis? Patient with SCD: No, the Percocet was not working, and that is all I had. It does feel like I am headed for a crisis.
Recommendation	Provider: OK. I am pretty sure that we will start with some gentle hydration and some pain medication that is a little stronger than Percocet. Does that sound like a plan? Patient with SCD: I hope that I can get something a little stronger and some fluids. I want to avoid a worse crisis if at all possible. I didn't want to be in the hospital, but my normal regimen did not work. Provider: What usually works for you? Patient with SCD: For this pain I am having right now, morphine works best for me. Provider: That sounds reasonable. Let me examine you and we will go from there.

about the care that they receive in the emergency department, including time to treatment and staff attitudes and knowledge.[16] These concerns are often validated by compromised opioid administration, delayed pain control, and premature decisions on disposition with early return visits and possibly avoidable hospital admissions.[17] Credibility can be improved through communication skills, and therefore adults with SCD may be more likely to receive individualized, proactive pain strategies to improve the quality of their pain management experience in the emergency department.[18] To increase the potential for appropriate and timely treatment, adults with SCD must be able to give the health care provider substantive information that leads the provider to arrive at the conclusion that this is a well-informed, credible individual. The adult with SCD needs to know what information the health care provider needs and how to communicate that information.

By improving the communication skills of individuals with SCD to use the same language as providers, care seeking for pain management may be improved. If individuals with SCD use SBAR, it may "put them on the same page with providers" (S. Randolph, ED Clinical Supervisor, Duke University Hospital, oral communication, September 2010). Individuals with SCD should communicate using SBAR as soon as possible with ED staff. This potentially positive interaction may set the tone for the remainder of the visit. Regardless of the provider with whom the patient comes into contact, using SBAR may establish not only credibility but also trust. Haywood et al[19] note that poorer adult SCD patient ratings of provider communication are associated with lower trust toward the medical profession. Information provided in the form of SBAR by the individual with SCD will enhance dialogue between and among all providers including ED staff and perhaps the individual's primary care provider. The Table 1 provides an example of a patient using SBAR to communicate with a provider.

Discussion

The idea that improving provider communication improves the health care encounter—in particular, trust—in individuals with SCD has been supported.[19] However, there have been no published studies examining the impact of improving the communication skills of the individual with SCD. One way of improving communication is presenting for care before pain impacts communication. It is important to design interventions that improve communication skills and, thus, care seeking in individuals with SCD as a means

to eliminate or reduce health-related stigmas.[20] SBAR for patients may be an asset for individuals such as those with SCD who frequent emergency departments. SBAR can be introduced in nursing curricula as a part of educating individuals who live with chronic disease to enhance self-care management. It could also be incorporated as a part of the discharge teaching for individuals discharged from emergency departments or inpatient units. Another ideal time to teach SBAR would be in an outpatient SCD clinic, where most individuals are coming for maintenance and not an acute illness. In addition, SBAR could be incorporated into transition programs as individuals move into adult care.

REFERENCES

1. Christie P, Robinson H. Using a communication framework at handover to boost patient outcomes. *Nurs Times.* 2009;105(47):13-5.
2. Beckett CD, Kipnis G. Collaborative communication: integrating SBAR to improve quality/patient safety outcomes. *J Healthc Qual.* 2009;31 (5):19-28.
3. Baker SJ. Bedside shift report improves patient safety and nurse accountability. *J Emerg Nurs.* 2010;36(4):355-8.
4. Woodhall LJ, Vertacnik L, McLaughlin M. Implementation of the SBAR communication technique in a tertiary center. *J Emerg Nurs.* 2008;34 (4):314-7.
5. Hassell KL. Population estimates of sickle cell disease in the U.S. *Am J Prev Med.* 2010;38(4)(suppl):S512-21.
6. Strickland O, Jackson G, Gilead M, et al. Use of focus groups for pain and quality of life assessment in adults with sickle cell disease. *J Natl Black Nurses Assoc.* 2001;12(2):36-43.
7. Smith WR, Scherer M. Sickle-cell pain: Advances in epidemiology and etiology. *Hematology Am Soc Hematol Educ Program.* 2010;2010:409-15.
8. Yale SH, Nagib N, Guthrie T. Approach to the vaso-occlusive crisis in adults with sickle cell disease. *Am Fam Physician.* 2000;61(5):1349-56, 1363-64.
9. Yusuf HR, Atrash HK, Grosse SD, et al. Emergency department visits made by patients with sickle cell disease: A descriptive study, 1999-2007. *Am J Prev Med.* 2010;38(4)(suppl):S536-41.
10. Jacob E. Pain management in sickle cell disease. *Pain Manag Nurs.* 2001;2(4):121-31.
11. Jenerette CM, Lauderdale G. Successful aging with sickle cell disease: Using qualitative methods to inform theory. *J Theory Constr Test.* 2008;12(1):16-24.
12. Michelen W. Reducing frequent flyer emergency department visits. *J Health Care Poor Underserved.* 2006;17(1)(suppl):59-69.
13. Tanabe P, Myers R, Zosel A, et al. Emergency department management of acute pain episodes in sickle cell disease. *Acad Emerg Med.* 2007;14 (5):419-25.
14. Ely B, Dampier C, Gilday M, et al. Caregiver report of pain in infants and toddlers with sickle cell disease: Reliability and validity of a daily diary. *J Pain.* 2002;3(1):50-7.
15. Todd KH, Green C, Bonham VL Jr, et al. Sickle cell disease related pain: Crisis and conflict. *J Pain.* 2006;7(7):453-8.
16. Neumayr L, Pringle S, Giles S, et al. Chart card: Feasibility of a tool for improving emergency department care in sickle cell disease. *J Natl Med Assoc.* 2010;102(11):1017-23.
17. Solomon LR. Pain management in adults with sickle cell disease in a medical center emergency department. *J Natl Med Assoc.* 2010;102 (11):1025-32.
18. Malat JR, van Ryn M, Purcell D. Race, socioeconomic status, and the perceived importance of positive self-presentation in health care. *Soc Sci Med.* 2006;62(10):2479-88.
19. Haywood C Jr, Lanzkron S, Ratanawongsa N, et al. The association of provider communication with trust among adults with sickle cell disease. *J Gen Intern Med.* 2010;25(6):543-8.
20. Jenerette CM, Brewer C. Health-related stigma in young adults with sickle cell disease. *J Natl Med Assoc.* 2010;102(11):1050-5.

Submit descriptions of procedures in emergency care and/or quick-reference charts suitable for placing in a reference file or notebook to **Reneé S. Holleran, APRN, PhD, CEN, CCRN, CFRN, CTRN, FAEN, FNP-BC**
or
Andrew Harding, RN, MS, CEN, NEA-BC, FAHA
http://ees.elsevier.com/jen