IMPROVING THE ACCURACY OF PATIENT HANDOVER USING SBAR IN AN ACUTE WARD

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Safety gaps from patient handover errors from the acute ward through the situation, background, assessment, recommendation (SBAR) model will be addressed by this quality improvement plan. Safety gaps are the direct result of various communication barriers. Many records exist on this topic, yet a clear understanding of the framework remains elusive (Howick *et al.,* 2024; Keshtkar *et al.,* 2025). The National Health Service (NHS) is handling patient overflow with imbalanced results. This makes the fundamentals of care, especially safer transfers, much more urgent (Department of Health and Social Care, 2025). I will address the leadership, teamwork and change management strategies I will use during the execution and during the assessment of the improvement plan. I will construct and examine the resources, supports and barriers, and the means of professional accountability, and figure with a very brief explanation of a single point of reflection which will be a guiding principle in my future work.

Leadership, Teamworking and Change Approaches

Heading up this work means blending big-picture changes with team-wide involvement, even as hands-on care stays central each day. Shared purpose pulls people together, especially noticeable when different jobs need to move in step. Drive builds not only from clear leads but also from listening, as input from every level counts most when pressure rises (Nazir, Gautam, and Zhu, 2025). Growth often comes bit by bit, supported by real tasks, coaching, and steady support rather than one-off training sessions (Phillipson et al., 2025). Since real work problems make lessons stick, short reflections after tasks or quick chats about them between shifts, turn out useful (Hofmann *et al.*, 2024; Russ *et al.*, 2023; Scheffer, 2025). Still, knowing exactly where to improve matters just as much. Beginning with tiny steps, adapting quickly through experience, while keeping organisational goals close at hand, and that keeps things grounded. Efforts feel

manageable because they grow from actual needs.

Despite its simplicity, teamworking theory holds weight since accurate handovers reflect how well a group thinks together. With fresh members entering the team frequently revisits phases marked by friction and doubt, just as Tuckman described (Jhas, 2025). Clarity within the unit hinges not only on data transfer but on mutual tracking, common grasp of context, and forward-looking coordination. That means passing information cannot be passive. It should shape a unified picture of the patient and next steps. Evidence shows interventions designed around these elements improve both safety and staff experience in high-pressure settings, reinforcing strategies of combining SBAR with brief collaborative exercises plus defined responsibilities per briefing (Weller *et al.*, 2024). Since hierarchy plays a role, the person leading the handover asks for team input then outlines choices along with assigned duties.

Change sticks better when tiny tweaks slip into daily patterns without force. From stillness to motion, Lewin's model pairs with Force Field Analysis to map the push and pull of shifts. Unfreezing first, yet examples reveal hiccups, as muddled guidance leads to delayed referrals during tense moments (Howick *et al.*, 2024; Keshtkar *et al.*, 2025). Not every fix fits, as instead, teams jot down what lifts or drags efforts, such as crowded hallways or lack of quiet corners near patient beds. Short SBAR phrases, along with one-sheet prompts, weave into rounds by cycling through PDSA steps.

Stakeholder Involvement and Coproduction

Those involved range from nurses and physicians to support workers, administrative staff, student trainees, plus family members and caregivers. Without manageable ways to join, involvement tends to favour only those already interested. Evidence shows people take part when they know about it, feel it matters, their daily routines allow time, leaders show consistent

backing, and messages stay straightforward (James, Lewis and Stroud, 2024). Brief updates during regular team check-ins, a visual summary placed where shifts overlap, along with fast responses showing impact, these help make engagement real. Watchfulness stays key, particularly if some groups similar to night crews or temporary hires remain less present.

Coproduction with service users should be purposeful, not tokenistic. Though teams aim to collaborate, certain perspectives often get overlooked. Studies of multidisciplinary discussions show authority linked to roles affects outcomes, limiting input from those receiving care (McShane *et al.*, 2024). While acute settings vary in structure, rank-based influence may still mute less experienced workers, trainees, or individuals under treatment. To counter this, one person will guide transitions between shifts, introducing a short stoppage allowing questions just prior to finalising suggestions. Studies of teamwork in emergency stroke treatment show that trust, being seen, shared growth, openness to others' views, kindness help bonds grow slowly (Park, Machin and Straughair, 2025). Because of this, attention will be paid carefully to how contributions are valued, especially those made by assistants whose daily contact may spot warning signs sooner.

Outcome Measures and Possible Unintended Consequences

How well things go will show through how tasks unfold, plus what results appear. What happens during shifts gets tracked by checking if SBIR steps stick, who holds which role, whether risky cases get flagged clearly, referrals move across properly, also how cleanly jobs are assigned. These pieces line up with formats seen in earlier studies aiming to sharpen shift changes (Banerjee *et al.*, 2024; Vallabhaneni *et al.*, 2022). Results take shape through time spent handing over, lags before urgent alerts rise, dropped referral notes.

Since weak communication can lead to safety issues the reasoning behind these steps

rests on observed links between dialogue breakdowns and adverse events, though differing contexts and inconsistent data weaken confidence in exact impact sizes (Keshtkar *et al.*, 2025). Rather than rely on one metric, drawing from a communication-safety framework reveals various connections, which justifies combining tools (Howick *et al.*, 2024). On this unit, assessment will track changes over time while spotlighting lessons that fit daily realities.

A different issue arises when measuring actions shifts how people behave. When workers sense constant oversight, following SBAR might become mechanical. Attention turns instead to what made the incoming team move forward without hesitation. Hidden downsides need tracking too, not just efficiency but extra time spent past shift end, or mounting irritation during transitions, patterns noted in actual clinical settings. Alongside scores, short written reflections will be examined because figures by themselves often fail to reveal the roots of safety (Vallabhaneni *et al.*, 2022). One way to test consistency is by reviewing several patient pathways, looking at whether essential actions outlined during shift changes happen on schedule (Banerjee *et al.*, 2024). Though broader team data varies, this approach holds assessment close to real practice.

How progress is checked stays open for everyone to see. During ward meetings, graphs showing results go up on the wall while key numbers also appear in official summaries. Following what the NHS pushes for, this step could help staff keep improvements going when they notice changes over time (Department of Health and Social Care, 2025). Improvement seen consistently might lead to testing these methods elsewhere. When results slip, adjustment takes priority over strict accuracy (Russ *et al.*, 2023). This approach fits within broader advice favouring growth through insight instead of rigid adherence.

Resources, Enablers, Barriers and Professional Accountability

Early on, shift transitions might slow slightly to allow space for SBAR updates along with wrap-up summaries. Time, staff availability, information access, and basic equipment form the foundation of needed resources. Oversight roles filled by extra handover leaders create openings for real-time feedback plus guided practice. Leading this effort is associated with a compact group of a senior nurse, a registrar, sometimes joined by someone speaking from patient experience. Near the transfer zone, progress becomes visible through those posted charts updated every seven days. Information helps teams grow instead of pointing fingers when things go wrong.

Starting with shared goals, clear reasoning makes change easier. Notably, the NHS strategy pushes changes meant to give workers more control, showing both employees and citizens expect better than what exists now (Department of Health and Social Care, 2025). Although proof must be tested locally, studies suggest safer care follows when talking across teams gets stronger (Howick *et al.*, 2024; Keshtkar *et al.*, 2025). Since ongoing growth matters, leadership evaluations stress mentoring paired with repeated follow-up (Park, Machin and Straughair, 2025; Phillipson *et al.*, 2025). When roles mix, feeling included and seen keeps teamwork alive, especially useful where staffing fluctuates.

Time pressures, shifting team sizes, authority gaps, and privacy needs create obstacles. Because junior staff might hold back when senior colleagues are present, leaders must model openness (Nazir, Gautam, and Zhu, 2025). Since real worries exist about patient details at bedsides, handovers adapt moment to moment but keep using SBAR format. Influence imbalances often tilt choices, pushing patient perspectives aside. One hurdle lies in how people grow their skills. After training ends, interest often fades, especially where chances to apply new

methods feel thin, as seen among nurses learning quality improvement (Armstrong, Shepherd and Harris, 2024). When hospital teams report weak research habits, it hints at deeper gap of confidence falters, teamwork lags (Dickens *et al.*, 2024). Simpler tools might help, if they cut effort while opening doors to clearer insights.

One clinician directs the process, another documents completion, while unmet tasks find an owner without delay. Information serves improvement rather than fault finding, but, repeated lapses following guidance prompt oversight since protecting patients is fundamental. How leaders act influences team behaviour. Shaping a mindset focused on people, combined with inspiring shared purpose, helps maintain progress even when key individuals move on (Nazir, Gautam, and Zhu, 2025). When change unfolds, its shape often reflects where power comes from, sometimes rules set by leaders, sometimes habits within professions, sometimes what patients themselves say (Mikelyte *et al.*, 2024). Support from higher-level staff, along with straightforward guidance and responses from those receiving care, tends to strengthen that influence over time.

Learning faces limits when staff numbers fall short or organisational habits resist growth. Evidence from one mental health trust showed individuals and teams struggling to keep up, capability lagged behind need (Dickens *et al.*, 2024). Without consistent support, newly qualified professionals begin forgetting quality improvement methods within months, as early practice must involve hands-on projects to sustain skill (Armstrong, Shepherd and Harris, 2024). Authority for change rarely stays fixed, it draws on leadership backing, ethical standards in professions, and insights from service users, blending these depending on setting (Mikelyte *et al.*, 2024). Despite tight budgets, the NHS frequently delivers strong results when measured internationally. Its strategy stresses openness, digital systems, along with building team

capabilities, shifting how support reaches individuals (Department of Health and Social Care, 2025). Staff numbers remain low relative to population size while health performance varies widely. Under these conditions consistency during transitions gains importance. Since resources are constrained but demand grows, aligning transfer processes becomes more urgent.

Testing practical solutions begins with Plan-Do-Study-Act loops. One-third faster coordination came from a liaison group using SBAR, assigned leads during transitions, and clear task splits (Vallabhaneni *et al.*, 2022). A gynaecology effort saw strong improvements after adding a structured daily form plus routine consultant attendance, suggesting value in basic checklists and leadership visibility where possible (Banerjee *et al.*, 2024). To sharpen SBAR use, guidance drawn from clarity-focused research will shape training. Working together improves when teams meet routinely (Allan *et al.*, 2025). With managers and flow coordinators and also clinical allies, it takes time to recognise what already works well.

Reflection on One Learning Point with Implications for Future Practice

Thinking through this project made clear that systems fail without cultural backing. Though SBAR cuts confusion, mutual clarity still is not automatic. Fast-moving settings demand common grasp of unfolding events, people catch varied signals at different moments (Weller *et al.*, 2024). These days I watch for ownership and precision behind advice, not just if labels got mentioned. Training on team situation awareness and shared mental models, this is the first time that I understood that to achieve an accurate handover is not only about documenting the information.

Since leadership growth works best when woven into everyday routines, small moments of guidance matter more than occasional training events. Rather than relying only on workshops, people gain deeper insight when learning connects to actual challenges they face, a pattern seen

across recent analyses of meaningful skill uptake (Philipson *et al.*, 2025). Reflection after routine transitions, such as shift changes, gains strength from findings about purpose-driven education (Hofmann *et al.*, 2024). When leaders listen closely, the process becomes fairer and more responsive. Many health professionals report feeling unready for leading roles, a gap noted often enough to push some toward seeking advice early (Nazir, Gautam, and Zhu, 2025). Personal effort grows stronger alongside structured help, especially when guiding others through their first steps at handovers (Scheffer, 2025). Staying open to error while adjusting near front-line tasks influences long-term influence in subtle ways.

Change advice often points to staying humble. When quality efforts stick to actual tasks and expect adjustments, they tend to do better, this shows up in recent studies (Russ *et al.*, 2023). Persuasive findings around talking well and avoiding harm exist, though results differ enough that personal observation guides my choices now (Howick *et al.*, 2024; Keshtkar *et al.*, 2025). If signs shift, so will the approach, as learning matters more than sticking rigidly. Some early tries using SBAR, checklists, or open leadership did get results worth noting (Vallabhaneni *et al.*, 2022; Banerjee *et al.*, 2024). Still, those wins came only after constant effort and everyday focus showed through.

Conclusion

Midway through each shift, gaps in communication often slip under the radar. Using SBAR sharpens how info travels during these moments. Team dynamics follow stages people grow through naturally, not forced steps. Clarity comes when everyone senses the same surroundings at once. Change sticks better when tested fast, adjusted quickly. People affected help steer it day after day. Power lines matter and so does silence around private details. Patients show up as part of the loop at this time.

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