The communication tool SBAR and Perioperative Checklist were strategically placed on one piece of documentation for continuity of patient care in an ambulatory surgery center (ASC). Previous documentation was repetitive, on multiple forms, and time consuming.

SBAR represents Situation, Background, Assessment, and Recommendation. This is a concise reporting tool for need to know, and patient specific information. Our goal was to facilitate caregivers to assess, implement, and share a care plan at every hand off: Pre Surgery Clinic, Pre-Op, OR, and PACU. The concept suggests a face to face report based on this structure.

When the perioperative checklist was combined with the SBAR form, standards from ASPAN, AORN, WHO, and NPSG were utilized. This tool was customized to promote patient safety through informed consent, prevention of wrong site surgery, and SCIP measures. Merging the two was the key in linking the chain of every person involved in the patient experience. This process originates with the first pre-op phone call to the PACU RN wheeling the patient safely to his/her car.

The SBAR-Checklist implementation enhanced teambuilding, decreased medication errors, and increased compliance of antibiotic administration within one hour of surgery. Streamlining the documentation process allowed the nurse more time to focus on the patient. The outcome proves that patient safety tools can be streamlined and utilized efficiently in the ASC. It also demonstrates the effectiveness of communication on patient outcomes and staff cohesiveness.