LITERATURE REVIEW: EFFECTIVENESS OF HAND OVER SBAR METHOD IN SERVICE NURSING

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ABSTRACT

Background: Nursing handover is the process of transferring information, responsibility, and accountability of patient care between nurses that plays an important role in maintaining continuity of care and patient safety. Ineffective communication during the handover process can cause miscommunication, incompleteness of clinical information, and an increased risk of clinical error and medication error. The SBAR method (Situation, Background, Assessment, Recomendation) presents as a structured communication model designed to improve the quality of clinical communication in the patient handover process. Objective: This literature review aims to analyze the effectiveness of applying the SBAR method in nursing handover activities in hospitals, particularly in improving effective communication and reducing the occurrence of clinical errors. Methods: This study uses a literature review approach by analyzing 10 international research articles published between 2023–2025. Articles were obtained through scientific databases on Google Scholar such as BMC Nursing, MJN, Journal of Education and Health Promotion, JERN, and SAGE Open Nursing. Article selection was based on inclusion criteria consisti.ng of studies that discuss SBAR implementation in nursing handover in hospitals. Results: The synthesis results show that the application of the SBAR method consistently improves inter-nurse communication effectiveness through more structured, clear, concise, and comprehensive information delivery. In addition the use of SBAR has proven to reduce risk clinical error and medication error by minimizing the loss of important information during the handover process, improving the accuracy of clinical communication, and strengthening coordination among health workers. SBAR also contributes to increased nurse confidence in communication and supports a patient safety culture in hospitals. Conclusion: The SBAR method is a highly effective communication model in in activities handover nursing because it can improve the quality of communication clinical, clarify the transfer of information, and reduce the occurrence of clinical errors. The consistent implementation of SBAR is recommended as a standard of communication in nursing handover to improve service quality and patient safety in hospitals.

Keywords: *SBAR, Nursing Handover, Effective Communication, Clinical Error, Patient Safety, Hospitals.*

INTRODUCTION

Communication is the key in the transition process, or often referred to as handover, in the continuity of patient safety. Failure to communicate is stated as the main cause of sentinel events (unexpected events that result in fatal outcomes) (Wardhani, 2017). Effective communication is the delivery of information that aims to improve patient safety and reduce the number of patient deaths. Effective communication is very important for improving the quality of the services provided. Therefore, information must be communicated in a comprehensive manner, in a way that can be understood, and easily understood by the recipient.

Ensuring patient safety is a prerequisite so that effective communication can succeed and improve the standards of nursing care (Erianti, et.al, 2022).

Effective communication among healthcare professionals plays an important role in supporting patient safety. Joint Commission International (JCI) identifies effective communication as the second indicator of the International Patient Safety Goals (IPSG), highlighting its importance in preventing unwanted events. The importance of effective communication with SBAR to improve patient safety in hospitals is consistent with case reporting by JCI and WHO: 25.000-30.000 permanent disabilities in patients in Australia, 11% of which are caused by communication failure (International Joint Commissions, 2026). Patient safety incidents can be caused by a lack of effective communication, resulting in patient safety problems that continue to increase every year.

Patient handover is designed as one method to provide relevant information to the nursing team at every shift change, as a practice guide to provide information regarding the patient's current condition, treatment goals, nursing plan, and to determine service priorities. Well-executed handovers can help identify errors and facilitate continuity of patient care (Fitrian Maku et.al, 2023).

Handover or transfer of responsibility is the primary responsibility in providing clinical care to conduct an effective transfer of communication of the patient care plan between healthcare professionals, which is carried out when a patient is handed over by the outgoing nurse to the incoming nurse between shifts, regarding the patient's current condition and is very important for ensuring continuity of care. The first aspect carried out in SBAR communication during handover is situation/situasi, namely an explanation of the description of the event aimed at the patient (5. Albyn, et.al , 2022).

This situation contains patient data including the patient's name, date of birth, date of admission, day of care, the responsible doctor and nurse, room name, bed number, reason for admission to the hospital, medical diagnosis, nursing problems, and the patient's main complaint (6. Sulastien & Sudariani, 2020). The next SBAR communication, namely background or the background, provides important information about what is related to the patient's current condition, including the list of medicines given to the patient, allergy history, the latest results of the patient's vital signs and laboratory tests, and other information from the family. This aspect is carried out so that the history of therapy or procedures given in each shift can be monitored as an evaluation of the next procedures.

The third SBAR communication is assessment, where the nurse must report the results of the assessment of the patient’s condition latest, for example physical examination. The patient’s condition is described from head to toe. The examination results should be described completely so that, at every nurse shift change, each nurse knows the patient’s physical condition—what problems have been identified, whether they can already be addressed during the care that has been provided, or whether there are other issues. The last communication sequence of SBAR during handover is the recommendation: in this aspect, what needs to be done to address the patient’s current problem (Noprianty, 2018)).

The nurse’s task in this aspect of SBAR communication is to recommend nursing interventions that have already been carried out and need to be continued, including discharge planning as well as educating the patient and family. This recommendation aspect is not only done to propose medical actions to the attending/responsible physician regarding the patient’s condition, but the nurse must also recommend the nursing actions that have already been done and need to be continued so that nursing care continues throughout the patient’s hospitalization.

To ensure patient safety after handover, the information that is conveyed must be accurate and received by the right people at the right time (Unairnews, 2022). Some types of patient handovers related to nurses include:

1) Patient handover between shifts: The method of patient handover between shifts can be carried out using various methods, including: verbally, handwritten notes, at the patient’s bedside, via telephone, recordings, nonverbal methods, using electronic reports, computer printouts, and memory. The strength of the bedside reporting method is an effort to focus on the report and the patient’s condition. However, there are concerns that patient confidentiality may be compromised if it is not handled carefully. A qualitative study focused on the description of patients’ perceptions who were involved in handover activities found that some patients supported bedside handover, while others did not. Patients also expressed their concerns regarding the jargon used by nurses during the handover activities.
2) Patient handover between nursing units: Patients may often be transferred between nursing units during their stay in the hospital. However, a number of factors have been identified as contributing to inefficiency during the transfer of patients from one nursing unit to another, including: incomplete medical records, delays or wasted time caused by communication congestion, waiting for responses from nurses or doctors, or responses

from the management of the nursing unit where the patient will be placed, or problems with the availability of beds.

3) Patient handover between care units and diagnostic examination units: Patients are often sent from nursing units for diagnostic examinations during hospitalization. Sending patients from nursing units to diagnostic examination locations (for example; radiology, cardiac catheterization, laboratories, and others) has been considered a contributor to the occurrence of errors. This is important, because when there is a change in the care unit for the patient—especially for a level of service that differs from the previous care unit—and for patient safety, the staff in the diagnostic examination unit must have complete information that they need and carry out consistent communication. The complexity of the patient’s condition may require nurses to accompany the patient to the diagnostic examination location,
4) Patient handover between health facilities: Patient transfers from one health facility to another often occur between different service settings. Transfers take place between hospitals when patients require a different level of care. Transfers of patients between facilities include; between hospitals, rehabilitation centers, home health care institutions, and other health service organizations. The factors that tend to make patient transfer ineffective are gaps and barriers in communication between facilities the health system itself and is also influenced by differences in organizational culture (Manurung, et,al 2023).

RESEARCH METHODS

The study design used in this research is a literature review or bibliographic study that is a synthesis of information that has been published on the topic research topic. The aim is to map what is known about a subject, describe methods that have been used previously, prevent duplication of research, and, in line with that, reveal gaps in the existing literature to justify the research project (Sports Management, 2025).

Identification, related analysis on the implementation of handover using the SBAR method in hospital care rooms obtained from several accredited journals from 2023 to 2025, with search methods through open access channels such as BMC Nursing, MJN, Journal of Education and Health Promotion, JERN, and SAGE Open Nursing. In the journal search, researchers use keywords handover in nursing and SBAR method from various full-text articles, then selected according to the inclusion criteria totaling 10 studies.

RESULTS AND DISCUSSION

No.	Authors / Title	Year	Country	Objective	Participants	Design and Data Collection Method	Findings	Implications
1	**Marzie Yari, Fatemeh Sadat Izadi-Avanji, Mahdieh Sabery** / *Assessment of Clinical Handover among ICU Nurses Based on the Structured ISBAR Model*	2025	Iran	To assess the implementation of the ISBAR handover method in the ICU.	370 nurses working in six ICUs at Shahid Beheshti Hospital, Kashan.	Descriptive cross-sectional study using observation and evaluation.	Low compliance was found in the Identification and Background phases, while high compliance was observed in the Situation and Recommendation phases.	Structured handover tools, continuous training, and enhancement of patient safety culture are needed to improve care for ICU patients.
2	**Samer Al Haliq and Talal Al Shammari** / *Communication Handover Barriers among Nurses and Paramedics in Emergency Care Settings*	2025	Saudi Arabia	To identify barriers experienced by nurses and paramedics during handover in emergency departments.	Of 250 distributed questionnaires, 219 were completed (87.6% response rate), including 47.5% nurses and 52.5% paramedics.	Cross-sectional study using randomly distributed questionnaires among nurses and paramedics.	Vital signs reporting was often neglected during handover.	Strong communication and interaction between nurses and paramedics are required to improve patient safety during handover.
3	**Atefeh Alizadeh-Risani, Fatemeh Mohammadkhah, Ali Pourhabib, Zahra Fotokian, and Marziyeh Khatooni** / *Comparison of the SBAR Method and Modified Handover Model on Handover Quality and Nurse Perception in the Emergency Department: A Quasi-Experimental Study*	2024	Iran	To compare the SBAR method and a modified handover model regarding handover quality and nurses' perceptions in the ED.	31 emergency department nurses.	Quasi-experimental study using census sampling.	Significant differences were found between the modified handover model and SBAR in information transfer ($P < 0.001$), shared understanding ($P < 0.001$), working atmosphere ($P = 0.004$), handover quality ($P < 0.001$), and nurses' perceptions ($P < 0.001$).	Modification of handover guidelines is needed to improve the quality of nursing handover practices.

No.	Authors / Title	Year	Country	Objective	Participants	Design and Data Collection Method	Findings	Implications
4	**Ms. Sonali Ramkrishna Gawas, Mr. Amos Talsandekar, Mrs. Sunanda Kale** / *Effectiveness of an ISBAR-Based Training Program on Knowledge of Clinical Handover among Staff Nurses*	2025	India	To evaluate the effectiveness of an ISBAR training program on clinical nursing handover.	80 nurses working in a hospital in Kolhapur.	Quantitative approach using a one-group pretest-posttest pre-experimental design with purposive sampling.	Seventy percent of nurses had average knowledge and 23.8% had good knowledge. Mean scores significantly increased from 15.03 to 20.43 after the ISBAR intervention.	ISBAR training effectively improves communication and handover practices, thereby enhancing patient safety and reducing adverse events.
5	**Jack Pun** / *Nurses' Perceptions of the ISBAR Handover Protocol and Its Relationship to the Quality of Handover: A Case Study of Bilingual Nurses*	2023	Hong Kong	To analyze factors related to bilingual nurses' communication during handover.	206 nurses in Hong Kong hospitals using English and Cantonese.	Administration of validated questionnaires.	Nurses' knowledge did not directly influence the quality of handovers performed.	Nurses' compliance with the ISBAR protocol can enhance their ability to communicate effectively.
6	**Saurabh RamBihariLal Shrivastava, Sook Vui Chong, Prateek Sudhakar Bobhate** / *Facilitating Effective Communication through the Adoption of the SBAR Tool in Medical Training*	2025	India	To train clinical medical students in communication skills.	Medical students preparing for clinical practice.	SBAR training using lectures, role play, simulation-based teaching, peer teaching, case-based scenarios, and video demonstrations.	SBAR should be integrated consistently across all courses and departments to ensure its adoption by faculty and medical students.	The SBAR tool is highly beneficial in improving communication skills among clinical practice students.
7	**Alessia Galli, Elisa Andreoli, Fabienne Yvonne Pallual, Irene Silvestri, Agnese Manenti, Lucia Dignani, Susanna Contucci, Vincenzo G. Menditto** / *Improvement of Nursing Handover in Emergency Department: A Prospective Observational Cohort Study*	2025	Italy	To evaluate whether implementing a standardized tool based on the ISBAR model improves the completeness and accuracy of information exchanged during nursing handovers at shift changes.	150 nurses involved in handovers.	Prospective observational cohort study conducted in the emergency department.	Significant improvements in handover quality were observed after the introduction of the ISBAR-based standardized tool.	Standardized tools can significantly improve nursing handover quality in intensive and complex care settings, facilitating effective communication and reducing the risk of information loss and adverse patient outcomes.

No.	Authors / Title	Year	Country	Objective	Participants	Design and Data Collection Method	Findings	Implications
8	**Narges Toghian Chaharsoughi, Mohammad Nasr-Esfahani, Shahnaz Alikhah, Maryam Moghimian** / *Investigating the Impact of Implementing Structured Patient Handover through the SBAR Model on Clinical Errors of Nurses in the Emergency Department*	2024	Iran	To implement a standardized handover protocol to improve treatment outcomes, minimize errors, and enhance communication among nurses.	61 emergency department nurses.	One-group quasi-experimental pretest-posttest study conducted over three months using checklists before and after SBAR training.	Clinical errors decreased after SBAR training. The intervention significantly reduced laboratory, treatment, and handover errors ($P < 0.0001$; 95% CI).	The SBAR handover model significantly reduces clinical errors in emergency departments and should be implemented to improve patient safety.
9	**Nadia M. El-Sayed Ghonem, PhD and Wafaa A. El-Husany, PhD** / *SBAR Shift Report Training Program and Its Effect on Nurses' Knowledge and Practice and Their Perception of Shift Handoff Communication*	2023	Egypt	To evaluate the effects of an SBAR shift-report training program on nurses' knowledge, practice, and perceptions regarding handoff communication in non-critical departments.	All nurses (n = 105) working in medical-surgical, obstetric, pediatric, orthopedic, and urology units.	Quasi-experimental study using knowledge questionnaires, observational checklists, and perception scales.	Nurses were aged 22–45 years, with 85.5% female participants. After the intervention, knowledge increased from 4.8% to 92.8% ($p < 0.001$), practice reached 100%, and perceptions improved significantly ($p < 0.001$).	SBAR had a significant positive effect on participants' knowledge, practice, and perceptions regarding shift handoff communication.
10	**George Kipourgos, Angeliki Gkotsi, Evangelia Andreopoulou, Androniki Karathanasi, Eleftheria Nefeli Koulouri, Anastasios Tzenalis** / *The Effect of Structured Communication on Enhancing Nursing Students' Patient Handover Skills: A Pilot Study*	2025	Greece	To assess the impact of SBAR educational interventions on nursing students' ability to deliver structured patient handovers and explore attitudes toward nursing care.	32 seventh-semester nursing students from a university.	Experimental study.	The experimental group achieved significantly higher scores in the "Situation" and "Background" components of SBAR. Students reported that SBAR was easy to understand, resulted in fewer errors during simulated handovers, and strongly supported its inclusion in undergraduate nursing education.	SBAR is perceived as a practical and effective tool for improving nursing students' handover skills and should be incorporated into undergraduate nursing curricula.

2. Discussion

The SBAR method is one way to convey information during handover. Clear, complete, and adequate communication is the key to achieving success in the scope of healthcare services; therefore, healthcare staff in hospitals can choose communication strategies that have been developed to ensure the accuracy of information such as SBAR (Tatiwakeng, et.al, 2021). The use of SBAR helps nurses convey information systematically starting from the patient's current condition (situation), relevant clinical history (background), assessment results (assessment), up to recommendations for follow-up actions (recommendation). This structure has been proven to improve communication efficiency and reduce ambiguity of messages. In handover practice, unstructured communication often leads to loss of important information, miscommunication among staff, and delays in making clinical decisions. The presence of SBAR helps nurses convey information in a coherent sequence starting from the patient's actual condition, clinical background, results of assessing the current condition, and recommendations for follow-up actions, so that the message conveyed becomes easier for the information receiver to understand (Soed, et.al, 2025).

The results of the literature analysis show that the SBAR method functions as a structured communication framework capable of improving clarity, completeness, and the systematization of information delivery among nurses. In handover practice, unstructured communication often causes important information to be missed, data duplication, or misunderstandings among healthcare professionals. When communication takes place without a standard format, patient reports tend to be unsystematic, repetitive, too long, or, in contrast, lose important information about the patient's condition (Chaica, et.al, 2024). Handover using the SBAR method can convey information accurately and clearly. In addition, it can improve patient safety and reduce the rate of unexpected events in hospitals and in wards. To increase the rate of patient safety, nurses should be able to use the SBAR method during handover so as to produce effective communication, clear and accurate delivery.

Performance in providing nursing care improves patient recovery as well as the level of patient satisfaction with services in the hospital (Idealistiana, 2024). Improved effective communication through SBAR has a close relationship with the reduction of clinical error. Clinical mistakes in healthcare services largely stem from communication failures, especially when there is a transition of responsibility for patient care between shifts. Incomplete information regarding changes in vital signs, drug allergies, results of supporting examinations,

the patient’s response to therapy, or actions that have not yet been carried out can lead to interpretation errors and result in clinical error. By using the SBAR format, the opportunity for important information to be missed becomes much smaller because nurses follow a systematic and comprehensive order of information delivery. This improves continuity of nursing care and reinforces patient safety during the handover process (Müller, et.al, 2018).

Even so, the effectiveness of SBAR is strongly influenced by adherence to implementation, training, supervision, and organizational support. In some studies it was found that the use of SBAR has not been optimal because nurses are not yet accustomed organize communication systematically, high workload, limited handover time, and lack of monitoring by the head of the department. Therefore, hospitals need to integrate SBAR into the standard operating procedures for handover, provide periodic training, conduct clinical communication audits, and build an organizational culture that supports open communication. With this approach, the benefits of SBAR in improving effective communication and reducing clinical error can be achieved to the maximum (Suryani, 2023).

The effectiveness of SBAR implementation is not only influenced by nurses' understanding of the concept of structured communication, but also by organizational culture, managerial support, availability of standard operating procedures, ongoing training, compliance audits of implementation, and SBAR integration into the hospital's clinical documentation system.

Hospitals that successfully integrate SBAR into the handover process generally demonstrate better information transfer quality, lower miscommunication rates, and more effective service coordination among healthcare workers. Conversely, inconsistent implementation can cause SBAR to become merely a documentation formality without significant impact on the quality of clinical communication. Therefore, SBAR implementation should be understood as a transformation of professional communication culture, not just a change in patient report format.

SBAR communication implementation is regarded as having a positive relationship with conducting handover as an effort to maximize patient safety, and SBAR communication during handover has a significant relationship with patient safety (Shafira & Dhamanti, 2023). Therefore, using the SBAR method during nurse handover in the room can be considered very effective because it can improve the quality of clinical communication, streamline reporting time, standardize the content of communication, clarify transferred information, improve the readiness of receiving nurses for the shift, and reduce the potential for clinical errors.

In the context of a complex and dynamic hospital service, SBAR is not only a communication tool but has evolved into a patient safety strategy that supports the overall quality of nursing care. Therefore, consistent SBAR implementation through training, supervision, and integration into standard operating procedures for handover is highly recommended as part of professional evidence-based safety-oriented nursing practice in hospitals.

CONCLUSION

The SBAR method is a highly effective communication model in in activities handover nursing because it can improve the quality of communication clinical, clarify the transfer of information, and reduce the occurrence of clinical errors. The consistent implementation of SBAR is recommended as a standard of communication in nursing handover to improve service quality and patient safety in hospitals.

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