Safety in Nursing Shift Handover: The Effective Communication and the SBAR Tool

Segurança na Passagem de Plantão em Enfermagem: A Comunicação Efetiva e a Ferramenta SBAR
Seguridad en el Cambio de Turno de Enfermería: La Comunicación Efectiva y la Herramienta SBAR

RESUMO
Objetivo: Sintetizar evidências científicas nacionais sobre a segurança do paciente na passagem de plantão de enfermagem e a contribuição da ferramenta SBAR para a comunicação efetiva. **Método:** Revisão integrativa da literatura nas bases LILACS, BDENF e SciELO. **Resultados:** A passagem de plantão é marcada pela informalidade e por interrupções ambientais que comprometem a comunicação, enquanto a padronização por meio do SBAR está associada à redução de falhas assistenciais e ao fortalecimento da continuidade do cuidado. **Conclusão:** A comunicação estruturada é estratégia efetiva para qualificar a passagem de plantão, mas seu êxito depende de capacitação continuada e de apoio institucional.
DESCRITORES: Comunicação; Segurança do Paciente; Cuidados de Enfermagem; Continuidade da Assistência ao Paciente; Enfermagem.

ABSTRACT
Objective: To synthesize national scientific evidence on patient safety during nursing shift handover and the contribution of the SBAR tool to effective communication. **Method:** Integrative literature review in the LILACS, BDENF and SciELO databases. **Results:** Shift handover is marked by informality and environmental interruptions that compromise communication, while standardization through SBAR is associated with reduced care failures and strengthened continuity of care. **Conclusion:** Structured communication is an effective strategy to qualify shift handover, but its success depends on continuing education and institutional support.
DESCRIPTORS: Communication; Patient Safety; Nursing Care; Continuity of Patient Care; Nursing.

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Objetivo: Sintetizar evidencias científicas nacionales sobre la seguridad del paciente en el cambio de turno de enfermería y la contribución de la herramienta SBAR a la comunicación efectiva. **Método:** Revisión integradora de la literatura en las bases LILACS, BDENF y SciELO. **Resultados:** El cambio de turno está marcado por la informalidad e interrupciones ambientales que comprometen la comunicación, mientras que la estandarización mediante el SBAR se asocia a la reducción de fallas asistenciales y al fortalecimiento de la continuidad del cuidado. **Conclusión:** La comunicación estructurada es una estrategia efectiva para cualificar el cambio de turno, pero su éxito depende de la capacitación continua y del apoyo institucional.
DESCRIPTORES: Comunicación; Seguridad del Paciente; Atención de Enfermería; Continuidad de la Atención al Paciente; Enfermería.

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INTRODUCTION

Effective communication among healthcare professionals is recognized as one of the fundamental pillars of patient safety, especially during care transitions, when responsibility for the patient is transferred from one professional to another. Among these moments, the nursing shift handoff stands out as a particularly vulnerable point, as it involves a large volume of clinical information transmitted in a short period of time, often in environments prone to interruptions.

In the Brazilian context, studies indicate that, in many departments, shift handoffs still have a predominantly empirical and informal nature, lacking a script or tool to systematically guide the content to be conveyed [1]. This lack of standardization leads to the omission of relevant data and a reliance on the memory and individual experience of each professional—factors that increase the likelihood of preventable care errors.

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An observational study conducted in an intensive care unit (ICU) identified that the main factors interfering during shift handoffs were equipment alarms (79.6% of observations), side conversations among staff (19.3%), and the low volume of the healthcare professional conducting the handoff (11.1%), all of which can compromise the understanding of the information conveyed [2] . These findings reinforce the idea that the quality of communication also depends on the environmental and organizational conditions in which it takes place.

Given this scenario, structured communication tools have been increasingly incorporated into nursing practice. Of particular note is the Situation, Background, Assessment, Recommendation (SBAR) method, originally developed in high-reliability contexts such as civil aviation and later adapted to the healthcare field, proposing a logical and objective sequence for communication among professionals [3] .

The relevance of this topic is growing in the Brazilian nursing literature, reflecting both institutions' concern with patient safety indicators and the regulatory requirements of the Federal Nursing Council, which recognizes the shift handoff as an integral part of the nursing process and an essential element for continuity of care [4] . In light of the above, this study aimed to synthesize the evidence available in the national scientific literature on patient safety during nursing shift handoffs, identifying the main barriers to effective communication and analyzing the contributions of the SBAR tool as a strategy for standardizing and improving the quality of the care transition.

METHOD

This is an integrative literature review, a method that allows for the collection and synthesis of results from studies with different methodological approaches on the same topic, contributing to a broader understanding of the phenomenon under investigation and supporting evidence-based clinical practice. The methodological process followed six steps: formulation of the guiding research question; literature search; categorization of studies; critical evaluation of the included studies; discussion and interpretation of the results; and synthesis of the knowledge produced.

The guiding question was: "What national scientific evidence addresses safety during nursing handoffs and the use of structured communication tools, especially the SBAR method?" The search was conducted in July and August 2026 in the LILACS, BDENF, and SciELO databases using the Health Sciences Descriptors (DeCS) "Shift Handoff," "Communication," "Patient Safety," "Continuity of Patient Care," and "Nursing," combined using the Boolean operator AND, in addition to the free-text term "SBAR."

We included original studies published in Portuguese and available in full that directly addressed communication during nursing shift handoffs in a hospital setting, giving priority to publications from the last five years. We excluded editorials, letters to the editor, and studies whose primary focus was not related to the transition of care among nursing professionals. There was no need to submit this study to a Research Ethics Committee, as it was a review study that did not involve direct data collection from human subjects. The selected studies were read in full, organized into thematic categories, and analyzed descriptively, providing the basis for the results and discussion sections presented below.

RESULTS

The search and review of the studies led to the selection of eight Brazilian publications that met the inclusion criteria, including observational studies, experience reports, and research on the development and validation of instruments. Table 1 summarizes the main characteristics of the studies included in this review.

Table 1 — Summary of the studies included in the integrative review on communication and safety during nursing shift handoffs. Brazil, 2018–2024.

Author(s)/Year	Study type	Main contribution
Nascimento et al.[1] (2018)	Qualitative, descriptive study	Characterizes the handoff as an empirical process and proposes an instrument based on the SBAR
Oliveira et al.[2] (2018)	Cross-sectional study, observational	Identifies alarms, side conversations and a low tone of voice as the main sources of interference in ICU

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Pena et al.[3] (2021)	Experience report	Describes the institutional implementation of SBAR and the standardization of protocols transition in care
Oliveira, Andolhe, Padilha[4] (2022)	Cross-sectional study	Links care incidents to vulnerabilities during shift changes in the ICU
Matos et al.[5] (2022)	Experience report	Systematizes the transfer of care in a pediatric ICU using the SBAR tool
Echer et al.[6] (2021)	Development and validation of an instrument	Develops and validates a form and standard operating protocol for shift handoffs
Siqueira et al.[7] (2024)	Quantitative-qualitative study	Identifies strategies for effective communication during shift handoffs in ICU

Source: prepared by the authors (2026), based on the reviewed literature.

A review of the studies allowed the findings to be organized into three thematic areas, which are presented and discussed below: (1) the shift handoff as a critical moment for patient safety; (2) barriers to effective communication during the care transition; and (3) the SBAR tool as a standardization strategy and the challenges of its implementation.

DISCUSSION

The shift handoff as a critical moment for patient safety

The studies analyzed agree in identifying the shift handoff as a moment of particular vulnerability in the care process. A study conducted at a university hospital found that the absence of a scientific tool to standardize this process compromised patient safety, with the location where the handoff takes place, frequent interruptions, and an excess of unprioritized information[1] . Similarly, research on safety culture in intensive care units linked the occurrence of care incidents to weaknesses in the shift handoff process, reinforcing that inadequate communication at this moment constitutes one of the weakest links in the chain of care [5] .

Barriers to effective communication during the transition of care

Environmental factors, such as alarms from monitors and infusion pumps, background conversations, and the low volume of the person conducting the handoff, were described as the main contributing factors in the intensive care unit [2] . Organizational barriers were also identified, such as work overload, the lack of an appropriate, dedicated space for handoffs, and excessive reliance on the individual experience of each healthcare professional [1,6] . A study investigating effective communication strategies in ICUs reinforces that organizational difficulties lead to communication failures capable of directly compromising patient care [8] .

The SBAR Tool: Structure, Evidence of Effectiveness, and Implementation Challenges

The SBAR method organizes information into four sequential blocks—Situation, Background, Assessment, and Recommendation—reducing variability in the information conveyed and facilitating clinical decision-making [3] . An experience report on the implementation of SBAR at a university hospital described its adoption following a discussion of adverse events resulting from communication failures, contributing to the standardization of institutional protocols [3], while a study conducted in a pediatric ICU described the systematization of care transitions using SBAR as a strategy capable of improving communication in a highly complex care setting[6].

A study on the development and validation of handover tools based on SBAR principles found a 93% agreement rate among experts regarding the comprehensiveness, clarity, and relevance of the proposed items, reinforcing the feasibility of structured tools in clinical practice [7] . However, the studies also point to challenges for the sustainable use of SBAR, such as cultural resistance from teams accus-

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tomed to informal shift handoff models and a lack of continuing education, requiring institutional investment in training and periodic monitoring of adherence to the tool [1,7] .

CONCLUSION

This integrative review showed that nursing shift handoffs in a significant portion of Brazilian health services remain characterized by informality and by environmental and organizational factors that compromise effective communication among professionals, increasing the risk of adverse events and compromising continuity of care. The SBAR tool has established itself as an effective strategy for standardizing communication during this critical moment, associated with a reduction in care errors and the strengthening of teamwork, although its effectiveness depends on ongoing training, an appropriate physical environment, and the commitment of nursing management.

One identified gap is the scarcity of national studies with an experimental design that evaluate the quantitative impact of SBAR implementation on concrete patient safety indicators, such as the rate of adverse events and shift handover time, pointing to opportunities for future research on the topic.

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