



The Relationship Between the Implementation of the SBAR Communication Model and Patient Safety in the Inpatient Ward of Koja Hospital, Jakarta

Siswani Marianna^{a*} |
Herni Halifah^b | Erika
Lubis^c | Liwayway T
Vallesteros^d | Indra
Gilang Pamungkas^e

^{a,d} Nursing Program,
Philippine Women's
University, Manila, Philippines
^{b,c,e} Faculty of Nursing and
Midwifery, Universitas
Binawan, Jakarta, Indonesia

***Correspondence:**

2023t1350@pwu.edu.ph

Volume 8(2), 820-829
©The Author(s) 2026
<https://doi.org/10.54832/phj.v8i2.1570>

e-ISSN 2715-6249

Received : August 26, 2026
Revised : September 5, 2026
Accepted : September 23, 2026



This is an **Open Access** article
Distributed under the terms of the
[Creative Commons Attribution 4.0
International License](https://creativecommons.org/licenses/by/4.0/).

ABSTRACT

Background: Patient safety is a fundamental component of nursing care that is significantly influenced by the quality of communication among healthcare professionals. Communication failures during patient handovers are widely reported in the literature as one of the leading contributing factors to patient safety incidents. The SBAR (Situation, Background, Assessment, Recommendation) structured communication model was designed to standardize the exchange of clinical information and prevent medical errors.

Objective: This study aims to analyze the association between nurses' reported implementation of the SBAR communication model and their reported patient-safety practices in the inpatient wards of Koja Regional General Hospital, North Jakarta, using a confirmatory hypothesis-testing approach.

Methods: This was a quantitative study with a cross-sectional design. The study population consisted of all nursing staff in various roles (staff nurses, team leaders/shift supervisors, and ward managers) in the inpatient wards of Koja Regional General Hospital (N=750). Sampling was conducted using a probability sampling technique with a two-stage cluster sampling approach, resulting in the selection of 97 nurses from 15 inpatient wards. The research instruments comprised an SBAR implementation questionnaire (17 items) and a patient safety questionnaire based on the International Patient Safety Goals (IPSG) (20 items). Both instruments showed adequate item-level validity in the validation sample (corrected item-total correlation $r > 0.361$) and very high internal consistency reliability (Cronbach's alpha = 0.967 for SBAR and 0.971 for IPSG). Data analysis involved frequency distribution tests (univariate) and Chi-Square tests (bivariate).

Results: The majority of nurses reported good implementation of the SBAR communication model (74.2%, n=72), and most self-reported patient-safety practices fell into the "good" category (76.3%, n=74). Bivariate Chi-Square test results indicated a significant association between SBAR communication implementation and self-reported patient-safety practices (p-value = 0.001; $p < 0.05$). Among nurses who reported good SBAR implementation, 70.1% (n=68) also reported good patient-safety practices, whereas the majority of nurses with poor SBAR implementation reported patient-safety practices categorized as poor (19.6%, n=19).

Conclusion:

There is a significant positive association between the implementation of the SBAR communication model and self-reported patient-safety practices in the inpatient wards of Koja Regional General Hospital (RSUD Koja), Jakarta. Greater discipline and consistency among nurses in applying SBAR communication are associated with better self-reported patient-safety practices; however, causality cannot be established from this cross-sectional design.

Keywords: SBAR Communication; Patient Safety; Nursing Handover; International Patient Safety Goals; Inpatient Ward

Introduction

Patient safety is one of the main pillars in the delivery of high-quality, standardized healthcare services that focus on individual safety. According to the World Health Organization (WHO) definition, patient safety is a planned effort to prevent, minimize, and reduce risks, errors, and the impact of unintended harm during the delivery of healthcare services. The WHO emphasizes that patient safety is a fundamental human right for every patient receiving medical or nursing care in a healthcare facility. In Indonesia, the national commitment to patient safety is explicitly regulated in Law No. 17 of 2023 on Health (which revoked and replaced the earlier Law No. 44 of 2009 on Hospitals, effective August 2023) and Regulation of the Minister of Health of the Republic of Indonesia No. 11 of 2017 on Patient Safety, an implementing regulation that remains in force insofar as it does not conflict with Law No. 17 of 2023. These regulations require

all healthcare facilities to implement safe clinical governance through a systematic incident prevention system.

Although the legal framework and service standards have been designed accordingly, global data indicate that patient safety incidents still occur at an alarming rate. Earlier WHO-cited estimates placed the burden at approximately 134 million adverse events each year in hospitals in low- and middle-income countries, contributing to more than 2.6 million deaths (Ningsih & Endang Marlina, 2020). The current WHO fact sheet on patient safety (updated 2023) reports more recent figures: around 1 in every 10 patients is harmed while receiving health care, more than 3 million deaths occur annually due to unsafe care, and in low- and middle-income countries as many as 4 in 100 people die from unsafe care (World Health Organization, 2023). The forms of patient safety incidents vary widely, ranging from medication errors, healthcare-associated infections (HAIs), errors in medical procedures, patient falls, and pressure ulcers to delays or inaccuracies in clinical diagnosis.

In Indonesia, the situation regarding patient safety incidents also warrants serious attention. A research report titled “Hubungan Komunikasi Efektif dengan Pelaksanaan Budaya Keselamatan Pasien di RSUD Raden Mattaher Provinsi Jambi” (in English: “The Relationship Between Effective Communication and the Implementation of a Patient Safety Culture at Raden Mattaher Regional Hospital, Jambi Province”) (Irwanti et al., 2022) notes that 145 patient safety incident reports were officially recorded from various provinces in Indonesia during the reporting period covered by that source, with the largest proportion occurring in the DKI Jakarta region (37.9%), followed by Central Java, the Special Region of Yogyakarta, and other regions. As a raw count without a defined denominator, this figure should be read as reported cases rather than an incidence rate. These reported figures are widely believed, based on prior literature rather than data from the present study, to represent only the tip of the iceberg. Many incidents are thought to go unreported (underreporting) due to healthcare staff's high levels of concern regarding a blame culture, administrative sanctions, and social stigma in the workplace (Paramita et al., 2020). Nurses' motivation to consistently apply structured communication tools such as SBAR has similarly been linked to workplace factors including workload, supervision, and organizational support (Chandrawati et al., 2025).

Analysis of various patient safety incident reports indicates that communication failures among healthcare professionals are the most dominant contributing factor (Fajriyah et al., 2023). Analyses of root causes reported by The Joint Commission (TJC) in the United States have historically found ineffective communication among the leading contributing factors in sentinel events, with older TJC data (1995–2005) attributing nearly two-thirds of reported sentinel events to communication failure; more recent TJC reporting continues to list communication among the top contributing factors, though not always quantified as a single “>70%” figure, and this should be distinguished from Joint Commission International (JCI), the organization's international accreditation arm (Joint Commission, 2006). Separately, the Institute of Medicine's (IOM) landmark 1999 report, “To Err is Human,” estimated that 44,000–98,000 deaths occur annually in U.S. hospitals due to preventable medical errors broadly; this estimate was not specific to miscommunication during handover, and is often imprecisely cited as such in secondary literature (Kohn et al., 2000). The Agency for Healthcare Research and Quality (AHRQ) emphasizes that communication failures during the handover process can triple the risk of medical errors (Hartawan & Fachrin, 2020).

In inpatient nursing practice, nurses interact intensively 24 hours a day with patients and other healthcare professionals (doctors, pharmacists, dietitians). The process of transferring patients between work shifts is a critical point for the exchange of clinical information. To ensure that information is conveyed accurately, systematically, and in a timely manner, the SBAR (Situation, Background, Assessment, Recommendation) structured communication model was developed. The SBAR model, adapted from the high-reliability organization communication standards of the Navy, has been proven effective in minimizing bias, clarifying patients' critical conditions, and accelerating clinical decision-making (Situmeang et al., 2023).

Although the SBAR model has been adopted nationally as a standard operating procedure (SOP) for communication in hospitals, its effectiveness depends heavily on the level of implementation, understanding, and discipline among nurses in carrying it out. A study by Christina and Susilo (2021) at a referral hospital in Jakarta indicated that only 45% of nurses consistently and compliantly applied SBAR. This variation appears consistent with other reports indicating that nurses' knowledge of SBAR components during handover differs considerably across hospital settings, which may partly explain inconsistent implementation rates (Krisnawati & Yanti, 2023). On the other hand, the inpatient ward at Koja Regional General Hospital in North Jakarta is a highly complex care unit with a heavy workload and a dynamic variety of medical cases. Based on a preliminary study and informal interviews at Koja Regional General Hospital, it was found that SBAR reports are sometimes omitted or not fully documented due to high workloads, an overwhelming number of patients, and time constraints. These preliminary observations motivated the present study and are not part of its formal empirical findings. Additionally, informal reports at that time indicated near-miss incidents and patient falls that were communicated verbally without being formally recorded in the hospital's reporting system; these observations likewise did not constitute measured outcomes of the current study.

Given the urgency of this issue, this study aims to thoroughly evaluate the relationship between nurses' implementation of the SBAR communication model and patient safety levels in the inpatient wards of Koja Regional General Hospital in North Jakarta. The findings of this study are expected to provide empirical evidence supporting the benefits of SBAR and to serve as a catalyst for hospital management to evaluate and optimize the patient safety culture.

Methods

This study employed a quantitative approach with an analytical observational design using a cross-sectional study. In this design, measurements of the independent variable (implementation of the SBAR communication model) and the dependent variable (patient safety) were conducted simultaneously at a specific point in time without providing any specific treatment or intervention to the study subjects. Because both variables were measured at a single time point, this design allows for the estimation of an association but not the establishment of temporal precedence or causality; it cannot determine whether stronger SBAR implementation precedes better patient-safety practices, or whether nurses with a stronger existing safety orientation are simply more likely to also report better SBAR implementation. Causal language is therefore avoided throughout this manuscript. The unit of analysis is the individual nurse: both SBAR implementation and patient-safety practices were self-reported by the same respondent, so this study examines the association between two self-reported constructs rather than a relationship between SBAR and independently or objectively measured patient outcomes.

Population and Sampling Technique

The target population in this study was all nursing staff in various roles (staff nurses, team leaders/shift supervisors, and ward managers) in the inpatient units of Koja Regional General Hospital in North Jakarta, with a total population of 750 nurses spread across 25 inpatient rooms.

The sampling technique used the Probability Sampling method with a Two-Stage Cluster Sampling approach:

1. First Stage (Cluster Sampling): From the 25 existing inpatient wards, 15 wards were selected as clusters using the Simple Random Sampling technique (random selection of ward numbers). The total population of nurses in these 15 selected wards is 450 nurses.
2. Second Stage (Proportional Random Sampling): From the 15 selected wards, the sample size per ward was determined proportionally based on the number of nurses in each unit. Then, nurse respondents were selected using simple random sampling from the attendance list of nurses who met the inclusion criteria. Proportional allocation followed the formula $n_i = (N_i / \sum N_i) \times n$, where n_i is the sample size for ward i , N_i is the number of eligible nurses in ward i , $\sum N_i = 450$ (total eligible nurses across the 15 selected wards), and $n = 97$ (total sample size).

The resulting eligible-population and sample sizes for each of the 15 selected wards were: Gurame ($N_i=25$, $n_i=5$), Bindara ($N_i=35$, $n_i=8$), Dori ($N_i=25$, $n_i=5$), Nila ($N_i=35$, $n_i=8$), Lumbalumba ($N_i=35$, $n_i=8$), Barongan ($N_i=30$, $n_i=6$), Tenggiri ($N_i=25$, $n_i=5$), Mackarel ($N_i=35$, $n_i=8$), Bilis ($N_i=35$, $n_i=9$), Tuna ($N_i=25$, $n_i=5$), Balanak ($N_i=25$, $n_i=5$), Belida ($N_i=35$, $n_i=8$), Penyakit Dalam Paru ($N_i=30$, $n_i=6$), Isolasi ($N_i=25$, $n_i=5$), and HCU ($N_i=30$, $n_i=6$), summing to 450 eligible nurses and 97 sampled nurses.

The sample size was calculated using the Slovin formula with a margin of error (e) = 10% (0.10):

$$n = N / [1 + N(e)^2] = 750 / [1 + 750(0.10)^2] = 750 / 8.5 = 88.24 \approx 88 \text{ nurses}$$

To account for a potential *dropout* rate of 10%, the sample size was increased using the formula: $n_{\text{total}} = 88 + (10\% \times 88) = 88 + 8.8 = 96.8 \approx 97$ respondents. Thus, the total sample analyzed in full in this study consisted of 97 nurses.

Inclusion and Exclusion Criteria

Inclusion Criteria:

1. Practicing nurses, team leaders (Katim), or ward managers who are actively assigned to the selected inpatient units.
2. Minimum educational qualification of a Diploma III (D3) in Nursing or a Bachelor's Degree in Nursing (S1 Ners). This reflects the hospital's minimum staffing qualification for nurses assigned to inpatient units and matches the composition of the wider study population, though it may limit generalizability to settings with different minimum qualification policies.
3. Willing to participate voluntarily and sign the informed consent form.

Exclusion Criteria:

1. Intern nurses, new contract nurses on probation, or clinical practicum students.
2. Nurses currently on maternity leave, sick leave, or study leave at the time of data collection.

Research Instruments, Validity, and Reliability

Data collection used three structured questionnaires:

1. Questionnaire A (Demographics): Measures age, gender, educational level, length of employment, and SBAR training history.
2. Questionnaire B (Application of SBAR Communication): Adapted from Idealistiana & Salsabila (2022), it consists of 17 positive statements regarding the components of Situation (4 items), Background (4 items), Assessment (4 items), and Recommendation (5 items) on a 4-point Likert scale (1=Never, 2=Sometimes, 3=Often, 4=Always). The theoretical score range is 17–68. Scores were categorized using the observed sample mean, not the theoretical midpoint of the score range: descriptive statistics showed $M = 51.03$ ($SD = 14.217$, median = 59.00, minimum = 21, maximum = 66, $N = 97$, no missing data). Using this mean-split approach, scores were categorized as Good (>51) and Poor (≤ 51); this is a descriptive mean-split categorization commonly used in this type of survey research, rather than a clinically validated diagnostic threshold.
3. Questionnaire C (Patient Safety): Adapted from Anggreini et al. (2023) based on IPSG indicators 1–6, consisting of 20 positive statements using a 4-point Likert scale (1=Never to 4=Always). The theoretical score range is 20 to 80. Scores were categorized using the observed sample mean, not the theoretical midpoint: descriptive statistics showed $M = 60.63$ ($SD = 16.765$, median = 70.00, minimum = 26, maximum = 75, $N = 97$, no missing data). Using this mean-split approach, categories were: Good (> 60) and Poor (≤ 60).

The SBAR implementation questionnaire (17 items) was adopted from Idealistiana and Salsabila (2022), whose original validation reported item-total correlations ranging from 0.412 to 0.721 and a Cronbach's alpha of 0.786. The patient-safety questionnaire (20 items, based on the IPSG indicators) was adopted from Anggreini et al. (2023), whose original validation reported item-total correlations ranging from 0.369 to 0.735 and a Cronbach's alpha of 0.864. Because both instruments were being applied to a new population, validity and reliability were re-tested for

this study on 30 nurses with characteristics similar to the study population (same hospital system, comparable roles and units) who were not included in the main study sample. The validity test results showed that all items were valid, with corrected item-total correlation values ranging from $r_{\text{(calculated)}} = 0.731$ to 0.844 (SBAR) and $r_{\text{(calculated)}} = 0.719$ to 0.812 (IPSG), exceeding the critical value (0.361). Reliability tests showed very high internal consistency, with Cronbach's Alpha values of 0.967 for the SBAR instrument and 0.971 for the Patient Safety instrument. The substantially higher alpha values obtained in this re-test, compared with the original validation studies, may reflect some item redundancy in the present sample; this is noted as a limitation in the Discussion. No missing responses were recorded on either instrument ($N=97$ valid, 0 missing on both the SBAR and patient-safety scales).

Research Ethics and Data Collection Procedures

This study obtained Ethical Clearance from the Health Research Ethics Committee (KEPK) of Binawan University, Letter No.: 515/KEPK-UBN/VIII/2025, issued in August 2025 prior to the start of participant recruitment and data collection. Following ethical clearance, the research team obtained sequential administrative permits: an introductory letter and data-collection permit from the Faculty of Nursing and Midwifery of Binawan University (Nos. 505/S-Ext/UBN.FKK/VIII/2025 and 504/S-Ext/UBN.FKK/VIII/2025), official administrative permits issued by the PPID of the DKI Jakarta Health Office (No. 568/HM.10.02) and the Training Division of the Koja General Hospital in Jakarta. The principles of research ethics—Autonomy, Anonymity, Confidentiality, Beneficence, Non-Maleficence, and Justice—were strictly adhered to throughout the data collection process.

Results

Respondent Characteristics

Demographic and professional characteristics were also collected as potential covariates. Of the 97 respondents, most were aged 25–35 years (73.2% , $n=71$), female (79.4% , $n=77$), held a Diploma (D3) in Nursing (72.2% , $n=70$) rather than a Bachelor's degree (S1 Ners, 27.8% , $n=27$), had more than 5 years of tenure (78.4% , $n=76$), and had previously received SBAR communication training (82.5% , $n=80$; 17.5% , $n=17$ had not). These variables (age, gender, education level, tenure, and prior SBAR training) were collected but were not entered into an adjusted statistical model in the present bivariate analysis; this is noted as a limitation in the Discussion, and these variables are available for future stratified or multivariable analysis.

Overview of the Implementation of the SBAR Communication Model

The application of the SBAR communication model was measured using 17 indicators and categorized based on the observed sample mean of 51.03 (rounded to 51 ; $SD = 14.217$, median = 59.00), rather than the theoretical midpoint of the 17–68 score range.

Table 1. Frequency Distribution of SBAR Communication Model Implementation ($N = 97$)

SBAR Implementation Categories	Frequency (n)	Percentage (%)
Good (Score > 51)	72	74.2
Poor (Score ≤ 51)	25	25.8
Total	97	100.0

The results in Table 1 show that the majority of nurses in the inpatient ward at Koja Regional General Hospital reported applying the SBAR communication model at a “good” level, namely 72 nurses (74.2%), while 25 nurses (25.8%) reported a “poor” level of application.

Patient Safety Overview

Patient-safety practices were measured based on 6 IPSPG indicators and categorized using a cutoff of mean = 60.

Table 2. Frequency Distribution of Patient Safety Categories (N = 97)

Patient Safety Category	Frequency (n)	Percentage (%)
Good (Score > 60)	74	76.3
Poor (Score ≤ 60)	23	23.7
Total	97	100.0

The results in Table 2 show that self-reported patient-safety practices in the inpatient ward at Koja Regional General Hospital were rated as “good” by 74 respondents (76.3%), while 23 respondents (23.7%) rated their own patient-safety practices as “poor.”

Bivariate Analysis: Relationship Between SBAR Implementation and Patient Safety

Cross-tabulation and a Chi-Square statistical test were conducted to examine the relationship between the implementation of the SBAR model and patient safety.

Table 3. Bivariate Analysis of the Relationship Between the Implementation of the SBAR Communication Model and Patient Safety in the Inpatient Ward of Koja Regional General Hospital (N = 97)

SBAR Communication Implementation	Patient Safety				Total		p-value
	Good n	%	Poor n	%	n	%	
Good	68	70.1%	4	4.1%	72	74.2%	0.001
Poor	6	6.2%	19	19.6%	25	25.8%	
Total	74	76.3%	23	23.7%	97	100.0%	

Based on Table 3, among the 72 nurses who reported implementing SBAR communication at the “good” level, 68 nurses (94.4% within this group; 70.1% of the total sample, N=97) also reported “good” patient-safety practices, while 4 nurses (5.6% within this group; 4.1% of the total sample) reported “poor” patient-safety practices. Among the 25 nurses with “poor” SBAR implementation, 19 nurses (76.0% within this group; 19.6% of the total sample) reported “poor” patient-safety practices, while 6 nurses (24.0% within this group; 6.2% of the total sample) reported “good” patient-safety practices.

The results of the Chi-Square statistical test yielded a p-value of 0.001. Since the p-value is less than 0.05 ($\alpha = 0.05$), the Null Hypothesis (H_0) is rejected and the Alternative Hypothesis (H_a) is accepted. This provides statistical evidence of a significant association between nurses’ implementation of the SBAR communication model and patient safety in the inpatient wards of Koja Regional General Hospital in North Jakarta, though it does not establish causality.

Discussion

Discussion on the Implementation of the SBAR Communication Model

The research findings show that 74.2% of nurses reported implementing SBAR at a “good” level. This finding may suggest that the SBAR structure is becoming established as a communication standard during shift handoffs and when reporting critical conditions via telephone (TBAK/SBAR), although this interpretation is not directly confirmed by documentary or observational evidence. However, 25.8% of nurses reported a “poor” level of implementation.

Based on informal field observations by the research team, which were not part of the study’s formal data collection, barriers to SBAR implementation appeared to primarily occur in the Assessment and Recommendation components. Some practicing nurses sometimes struggled to formulate precise clinical analyses or hesitated to provide intervention recommendations to the

attending physician (DPJP) due to hierarchical concerns. Additionally, high workloads when patient-to-nurse ratios exceed ideal capacity lead to rushed verbal handoffs and delayed completion of SBAR forms (Rahman et al., 2024; Sulistyawati et al., 2020).

Discussion of Patient Safety Levels

The level of patient safety at Koja Regional General Hospital was rated as good by 76.3% of respondents. This overall result may be related to nurses' adherence to the two-factor identification procedure (IPSG 1), the implementation of double-check verification for high-alert medications (IPSG 3), hand hygiene at five key moments (IPSG 5), and the application of fall-risk wristbands (IPSG 6).

However, 23.7% of respondents reported less favorable patient-safety practices. This may be related to challenges in implementing IPSG 2 (effective communication) and, as suggested by external literature rather than measured directly in this study, the phenomenon of underreporting of near-miss incidents. When minor errors or near-misses in medication administration occur that do not directly impact patients, staff tend not to report them to the Hospital Patient Safety Committee (KKPRS) due to fear of sanctions (Arsani & Fevriasanty, 2023).

Discussion of the Relationship Between SBAR Implementation and Patient Safety

The results of the bivariate test indicate a statistically significant association between the implementation of SBAR and patient safety ($p = 0.001$). From the cross-tabulation analysis, nurses who reported effective SBAR implementation were more likely to also report optimal patient-safety practices (70.1%), whereas inconsistent application of SBAR was associated with a lower proportion of good patient-safety practices (19.6%). As this is a cross-sectional association, no causal or predictive claim is made. This finding is consistent with a comparative study conducted at a hospital in Tangerang, which similarly found that nurses' compliance with SBAR communication was significantly associated with the implementation of a stronger patient-safety culture (Dewi et al., 2021), suggesting that this association is not unique to the present study setting.

The following theoretical explanation for this association is offered as interpretation and was not directly measured in this study, which did not assess information completeness, communication errors, adverse events, or decision-making time. SBAR communication provides a standardized and unambiguous format. When nurses convey patient information in a systematic manner—starting with the acute problem (Situation), critical medical history (Background), vital signs data (Assessment), and proposed actions (Recommendation)—the recipient of the message (whether a physician or the next nursing shift) receives a complete and precise clinical picture. This is consistent with comparative work on structured handover models such as SBAR and I-PASS (Hastuti et al., 2021). This proposed mechanism is broadly consistent with descriptions of the SBAR technique in the wider nursing literature (Nurhuda et al., 2023), although, as noted above, it was not directly tested in the present study.

This standardization eliminates the potential for one-sided assumptions, misinterpretation of verbal instructions, or the loss of vital patient data (such as a history of drug allergies or critical laboratory values). In line with the findings of the "(Christina & Susilo, 2021; Rahmawati & Kristyaningsih, 2023), the consistent implementation of SBAR is able to minimize adverse events to the lowest possible level and significantly improve interprofessional team coordination.

It should be noted that both SBAR implementation and patient safety were measured through self-report questionnaires completed by the same respondents at the same time, which may introduce common-method and social-desirability bias and could inflate the observed association. In addition, because the patient-safety instrument includes items related to communication (IPSG 2) that conceptually overlap with SBAR itself, part of the observed relationship may reflect measurement overlap rather than a fully independent association. Demographic and professional characteristics that could plausibly confound this relationship—age, gender, education level, tenure, and prior SBAR training—were collected (see Respondent

Characteristics) but were not entered into an adjusted analysis in the present bivariate design; the reported association should therefore be interpreted as unadjusted. Future adaptation of these instruments would also benefit from more extensive content-validation procedures, such as formal expert review, following approaches used in other SBAR-based instrument development work (Dedi et al., 2025). These limitations should be considered when interpreting the strength of the reported relationship.

Conclusion

Among the nurses sampled from the participating inpatient wards of Koja Regional General Hospital in North Jakarta, the results indicate a significant association between the implementation of the SBAR (Situation, Background, Assessment, and Recommendation) communication model and self-reported patient-safety practices. These findings are limited to this sample and setting and should not be generalized to all inpatient wards, other hospitals, or to objectively measured patient outcomes without further supporting evidence. The majority of nurses—74.2%—reported implementing SBAR communication at a “good” level, while patient-safety practices were self-rated as “good” in 76.3% of cases. The results of the Chi-Square test showed a p-value of 0.001 ($p < 0.05$), indicating a significant association between the implementation of SBAR communication and patient safety. Nurses who reported effective SBAR implementation mostly also reported good patient-safety practices (70.1%), whereas inadequate SBAR implementation was more frequently found among those reporting poorer patient-safety practices (19.6%). These findings suggest that structured, systematic, and consistent communication through SBAR may play an important role in supporting the accurate transmission of clinical information and in patient safety, though this cross-sectional association does not establish a causal or predictive effect.

Although SBAR implementation has generally been self-rated as good, some nurses reported not implementing it optimally, particularly regarding the Assessment and Recommendation components. Based on these findings, hospitals may consider strengthening SBAR implementation through regular training and refresher courses, supervision, compliance evaluations, and improved documentation during the patient handoff process. Fostering an open and non-blaming patient safety culture may also help encourage more effective reporting of incidents and near misses. These are presented as practice implications and hypotheses for future intervention research rather than as effects demonstrated by this study; such efforts would be expected, though not confirmed here, to improve communication quality among healthcare workers, strengthen coordination in nursing care, and support patient safety in inpatient units.

ACKNOWLEDGMENT

The authors would like to express their gratitude to Binawan University, Koja Regional General Hospital in North Jakarta, and all respondents who contributed to the implementation of this study.

DECLARATION OF INTEREST

The authors declare that there is no conflict of interest

FUNDING

This study received no external funding.

REFERENCES

- Anggreini, Y. D., Kirana, W., Yousriatin, F., & Safitri, D. (2023). Implementasi SBAR (Situation, Background, Assesment, Rekomendation) pada Perawat dengan Keselamatan Pasien di Rumah Sakit Kota Pontianak. *Malahayati Nursing Journal*, 5(11), 3715–3723. <https://doi.org/10.33024/mnj.v5i11.9731>
- Arsani, S. H., & Fevriasanty, F. I. (2023). Analysis Dimension of Healthy Work Environment for Successful Patient Safety Incident Reporting: A Cross Sectional Study. *JMMR (Jurnal*

- Medicoeticolegal Dan Manajemen Rumah Sakit*, 12(1), 32–45.
<https://doi.org/10.18196/jmmr.v12i1.29>
- Chandrawati, R., Widiyanto, P., & Nugroho, S. H. P. (2025). The Influence of Nurse Motivation on the Implementation of SBAR Communication during Handover. *Media Keperawatan Indonesia*, 8(1), 32–38. <https://doi.org/10.26714/mki.8.1.2025.32-38>
- Christina, L. V., & Susilo, A. P. (2021). Penggunaan Metode SBAR untuk Komunikasi Efektif antara Tenaga Kesehatan dalam Konteks Klinis. *KELUWIH: Jurnal Kesehatan Dan Kedokteran*, 3(1), 57–63. <https://doi.org/10.24123/kesdok.V3i1.4584>
- Dedi, B., Sunarno, R. D., & Aris Payung. (2025). Construction of Validity and Reliability of The SBAR-Based Assessment Scale among Nurses. *JURNAL INFO KESEHATAN*, 23(1), 61–70. <https://doi.org/10.31965/infokes.Vol23.Iss1.1900>
- Dewi, V. C., Sriningsih, N., & Winarni, L. M. (2021). Hubungan Kepatuhan Penerapan Komunikasi Sbar dengan Keselamatan Pasien pada Perawat di RSUD Kabupaten Tangerang. *BIMIKI (Berkala Ilmiah Mahasiswa Ilmu Keperawatan Indonesia)*, 9(1), 39–45. <https://doi.org/10.53345/bimiki.v9i1.137>
- Fajriyah, N., Wijaya, H., Mamesah, M. M., & Marga, I. (2023). Strategies for Improving Effective Communication and Patient Safety with SBAR among Healthcare Teams in Hospitals: A Systematic Review. *Journal of Health Management Research*, 2(1), 7. <https://doi.org/10.37036/jhmr.v2i1.366>
- Hartawan, A., & Fachrin, S. A. (2020). Kerjasama Dalam Unit dan Keterbukaan Komunikasi terhadap Persepsi Pelaporan Kesalahan Medis oleh Tenaga Kesehatan di RSUD Bantaeng. *Window of Nursing Journal*, 73–86. <https://doi.org/10.33096/won.v1i2.251>
- Hastuti, E. P., Faridah, I., & Afiyanti, Y. (2021). Perbandingan Handover Model Sbar Dan I-Pass Terhadap Insiden Keselamatan Pasien. *Jurnal Health Sains*, 2(3), 301–309. <https://doi.org/10.46799/jhs.v2i3.124>
- Idealistiana, L., & Salsabila, A. R. (2022). Hubungan Penerapan Metode SBAR (Situation, Background, Assessment, Recommendation) terhadap Komunikasi Efektif Antar Perawat di RS Taman Harapan Baru Tahun 2022. *Malahayati Nursing Journal*, 4(9), 2295–2304. <https://doi.org/10.33024/mnj.v4i9.6962>
- Irwanti, F., Guspianto, G., Wardiah, R., & Solida, A. (2022). Hubungan Komunikasi Efektif dengan Pelaksanaan Budaya Keselamatan Pasien di RSUD Raden Mattaher Provinsi Jambi. *Jurnal Kesmas Jambi*, 6(1), 32–41. <https://doi.org/10.22437/jkmj.v6i1.15551>
- Joint Commission. (2006). *Root causes of sentinel events, all categories*.
- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To Err Is Human: Building a Safer Health System*. National Academies Press. <https://doi.org/10.17226/9728>
- Krisnawati, K. M. S., & Yanti, N. P. E. D. (2023). Gambaran pengetahuan mengenai teknik komunikasi SBAR pada perawat dalam handover. *Jurnal Keperawatan*, 15(1), 221–226. <https://journal2.stikeskendal.ac.id/index.php/keperawatan/article/view/590/551>
- Ningsih, N. S., & Endang Marlina. (2020). Pengetahuan Penerapan Keselamatan Pasien (Patient Safety) Pada Petugas Kesehatan. *Jurnal Kesehatan*, 9(1), 59–71. <https://doi.org/10.37048/kesehatan.v9i1.120>
- Nurhuda, P. M., Ulfah, L. W., Julliyana, R., Damayanti, D. P., Damaiati, W. D., Ridwan, H., & Hudaya, A. P. (2023). Penerapan Teknik Komunikasi Efektif SBAR Pada Pelaksanaan Timbang Terima Perawat: Literatur Review. *JINTAN: Jurnal Ilmu Keperawatan*, 4(1), 9–20. <https://doi.org/10.51771/jintan.v4i1.721>
- Paramita, D. A., Arso, S. P., & Kusumawati, A. (2020). Faktor-Faktor Yang Berhubungan Dengan Motivasi Perawat Dalam Pelaporan Insiden Keselamatan Pasien Di Rumah Sakit X Kota Semarang. *Jurnal Kesehatan Masyarakat*, 8(6), 724–730. <https://ejournal3.undip.ac.id/index.php/jkm/article/view/28217/>
- Rahman, I. A., Gunawan, A., & Apriliyani, D. (2024). Peningkatan kepuasan kerja perawat di ruang rawat inap dengan teknik komunikasi SBAR saat timbang terima pasien. *Jurnal Kepemimpinan Dan Manajemen Keperawatan*, 7(1), 8–16.

- <https://doi.org/10.32584/jkkm.v7i1.2388>
- Rahmawati, I., & Kristyaningsih, P. (2023). Penerapan Komunikasi SBAR Perawat Ruang Rawat Inap RSUD LIRBOYO Kediri. *Jurnal Wiyata: Penelitian Sains Dan Kesehatan*, 10(2), 115–119. <https://doi.org/10.56710/wiyata.v10i2.667>
- Situmeang, W. Y., Handiyani, H., Pujasari, H., Afriani, T., & Nasri, K. (2023). Optimalisasi Komunikasi Metode Situation, Background, Assessment, and Recommendation (SBAR) dalam Serah Terima Perawat. *Journal of Telenursing*, 5(2), 3017–3025. <https://doi.org/10.31539/joting.v5i2.7878>
- Sulistyawati, W., Rahayu, K. I. N., & Dhanti, A. Y. P. R. (2020). Hubungan komunikasi SBAR pada saat handover dengan kinerja perawat dalam melaksanakan asuhan keperawatan di ruang rawat inap. *Jurnal Ilmu Kesehatan*, 9(1), 74–79. <https://doi.org/10.32831/jik.v9i1.308>
- World Health Organization. (2023). *Patient safety*. World Health Organization. <https://www.who.int/news-room/fact-sheets/detail/patient-safety>