Please find attached ISBAR Implementation Kit for use on your wards and within your departments.

As you are all aware, good communication is central to the effective care of our patients. The majority of adverse events and complaints occur due to communication breakdown or poor communication.

ISBAR has been identified by the Department of Health and Sydney South West Area Health Service as a framework for optimising communication in clinical handover and inter-hospital transfers.

‘ISBAR’ is an acronym for Identification, Situation, Background, Assessment and Recommendation, and is a template to follow when trying to communicate complex information succinctly. It is particularly useful when trying to convey information about patient care, although it is applicable also to non-clinical and written communications.

ISBAR should be used when communicating information between multidisciplinary team members (for example for Clinical Review Calls, referrals) and for handover of patient information (such as during nursing handover, multidisciplinary board rounds, case conferences).

At this stage, the ISBAR acronym will not replace current documentation standards in medical files, however, all managers should ensure that relevant clinical documentation contains the information which ISBAR covers within their clinical area.

In the coming months, the Area Clinical Handover Policy will be available and will include Policy Directives for Nursing, Allied Health and Medical. These policies will further expand upon the key standard principles of clinical handover and the ISBAR framework.

Please find the attached ISBAR resources for dissemination within your clinical area. The kit contains the following –

- ISBAR posters
- ISBAR lanyard cards
- ISBAR stickers for phones
- ISBAR handouts for staff
- ISBAR practical tasks / role plays
- ISBAR introduction information

ISBAR should be introduced at staff meetings and regularly revised to ensure learning of the concept. All students and staff should be given practice and encouraged to use ISBAR when communicating about patient care and within the multidisciplinary team.

We will be providing short education sessions on the wards in the coming months on ISBAR. All attached resources will be placed on the shared drive in the ‘everyone’ folder, so they are available for further use.

Please don’t hesitate to contact us if you need any further assistance or information.

Clinical Handover Working Group
ISBAR Information

What is ISBAR?

ISBAR is an acronym. It stands for:
I – Introduction
S – Situation
B – Background
A – Assessment
R – Recommendation

Why should we use ISBAR?

ISBAR provides a framework for clinical conversations. It is a consistent and reliable tool for clinical discussions. Evidence shows that when a standardised approach is implemented, the effectiveness of that approach increases. The listener knows what to expect and the speaker knows what is expected to meet the needs of the listener.

Where can ISBAR be used?

The ISBAR framework may be used in any information handover situation. For example:
- Shift changes
- Discharge to community services
- Inter-hospital transfers
- Intra-hospital transfers
- Time-critical situations such as medical emergencies or evacuations
- Procedure documents
- Reports, memorandums and briefings

Who can use ISBAR?

All clinical staff are encouraged to use ISBAR. Because it focuses on the issue at hand, it means that those of different discipline and seniority will speak the same language. This allows more effective communication. ISBAR creates a shared mental model for the transfer of relevant, factual, concise information between clinicians. It flattens the hierarchy and so eliminates the power differences that may inhibit information flow.
- Doctor to Doctor,
- Nurse to Nurse,
- Nurse to Doctor,
- Doctor to Allied Health
- Nurse to Allied Health
- Allied Health to Allied Health
- To and between ward staff, housekeeping and clerical staff.

Why would I use ISBAR?

Key reasons for using ISBAR are
- It is portable, memorable and easy to use
- Can be used to present information clearly in any situation
- Helps you to organise what you’re going to say
- Standardises communication between everyone
ISBAR

Clinical conversations should be clear, focused and the information relevant.

Poor communication risks patient safety and contributes to adverse outcomes.

I - Introduction

“I am …… (name and role)"
“I am calling from……”
“I am calling because……..”

Confirm you are communicating to the intended person and ensure that the recipient is in a position to receive the communication.

Identification of the patient must include the patient’s name, date of birth and medical record number.

S – Situation

“I have a patient (age and gender) who is stable yet I have concerns unstable with rapid/slow deterioration”
“The presenting symptoms are……”

B – Background

“This is the background of ….”
(Give pertinent information which may include: Date of admission/ presenting symptoms on admission / medications/ test results/ status changes)
This step also includes a brief synopsis of treatment to date and assessments / tests that are pending.

A – Assessment

On the basis of all of the above I believe the:
The patient’s condition is ……
And they are at risk of ……
And in need of …..

R – Recommendation

Be clear about what you are requesting.
e.g. “This patient needs transfer to / review ….
Under the care of ….
In the following time frame ….

(Taken from SSWAHS Clinical Handover Policy (SSW_PL2010_001)) – Appendix A.
### ISBAR Handout

<table>
<thead>
<tr>
<th><strong>Introduction</strong></th>
<th>Identify yourself, your role and location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
<td>State the patient’s diagnosis or reason for admission and current problem</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>What is the clinical background or context?</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>What are your patient’s clinical observations? What do you think the problem is? Be ready to give the current observations.</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td>What do you recommend or what do you want the person you called to do? Be clear about your request and timeframe. Repeat to confirm what you have heard</td>
</tr>
</tbody>
</table>

### ISBAR Handout

<table>
<thead>
<tr>
<th><strong>Introduction</strong></th>
<th>Identify yourself, your role and location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
<td>State the patient’s diagnosis or reason for admission and current problem</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>What is the clinical background or context?</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>What are your patient’s clinical observations? What do you think the problem is? Be ready to give the current observations.</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td>What do you recommend or what do you want the person you called to do? Be clear about your request and timeframe. Repeat to confirm what you have heard</td>
</tr>
</tbody>
</table>
Role Play 1 - Discussion not using ISBAR

**Directions:** Three volunteers needed. Each given a role to read aloud.

Anne: Hey Emma, I have to run downstairs to get some medications. Am worried about bed 3, her obs are a bit off. Can you page the doctor and tell him to review her?

Emma: Sure thing! *Pages Doctor.*

Emma: Hi Doctor, Anne wants you to review bed 3.

Doctor: Who is this? Who is bed 3? Why does she need a review?

Emma: Oh, this is Emma. On Level 7. Bed 3, her obs are bad.

Doctor: Who is bed 3? What is wrong with her obs?

Emma: Don’t really know much about her, can’t find the file. Anne said her obs are off. Needs a review.

Doctor: I need more information, can you find the bed chart please? What was she admitted with?

Emma: Well, she probably fell at home I would guess. Can’t reach the chart right now. If you could review her, that would be great.

Doctor: Is it urgent?

Emma: Well, probably?

**Reflection questions:**
- What was wrong with the conversation? (Prompt: Lack of knowledge about patient, not having chart nearby, not having clear conversation process, not being specific with time frame, obs etc)
- How could it have been improved? (Prompt: Collected information prior to placing call, nurse looking after patient making the phone call, having chart nearby, outlining what you want the doctor to do, identifying yourself).
Role Play 2 – Discussion using ISBAR

**Directions:** Two volunteers needed. Each given a role to read aloud.

Anne: *Pages doctor.*

Anne: Hi Doctor, this is Anne, the RN from Level 5. I am calling about Mrs Smith in Bed 3 on Level 5. She is an 88 year old lady admitted with community acquired pneumonia. I am concerned about her. She was previously saturating at 98% on 1L O2 and is now at 78% on 5L O2. Also, her respiratory rate is gradually climbing and is now at 33. She became disconnected from her oxygen this morning and coughed for over 5 minutes until it settled. Other observations are within normal limits however her BP is climbing. I would like you to come and review her please. When can you come and see her?

Doctor: It appears she has deteriorated significantly since this morning in regards to her respiratory status. I will be there within 10 minutes. In the meantime, please increase the O2 to high flow and aim for SaO2 over 90%, sit her up and do an ECG.

Anne: Ok Doctor, I will increase the O2 to high flow, sit her up and do an ECG. I will see you within 10 minutes.

Doctor: Thanks. See you soon.

**Reflection questions:**

- How was that improved to the previous role play? (Prompt: clear, concise information given, clear roles of each communication partner, ISBAR was used)
- Could you see the ISBAR framework in use?
Practical exercises

Directions: Divide staff into pairs. Give them each a different task and direct them to use ISBAR to discuss the following scenarios.

Task: Use the ISBAR framework to discuss the following with a medical officer.

- 87 year old female admitted with incontinence.
- Fell in bathroom while showering.
- Did not hit head.
- No obvious fractures.
- All observations within normal limits.
- Needs to be reviewed prior to ward round.

Task: Use the ISBAR framework to discuss the following with a speech pathologist.

- 94 year old male admitted following multiple falls at home.
- Background of dementia and reflux.
- Observed at lunch to be pooling food in mouth during eating and dribbling a lot.
- Currently on full diet and thin fluids.
- All observations within normal limits.
- Needs to be referred to speech pathology for swallowing assessment.

Task: Use the ISBAR framework to provide nursing handover to an AIN coming on to special a patient.

- New admission – 88 year old female found wandering in her dressing gown.
- Only speaks Italian and appears confused.
- Climbs out of bed and the water chair.
- Has not been assessed for manual handling. Falls risk.
- Full diet, thin fluids but needs assistance with meals.
- Refuses to take medication and becomes combative with observations.
Task: Use the ISBAR framework to provide medical handover to a consultant after hours over the phone.

- 47 year old female admitted post knee reconstruction.
- Background of hypertension, diabetic.
- New onset facial droop, ptosis and weakness with reported slurred speech.
- Has not taken medication for blood pressure for 3 days.
- Suspected new stroke, needs transfer to RPAH.

Task: Use the ISBAR framework to provide handover of a deteriorating patient to a senior medical officer.

- 70 year old male transferred from RPAH to Rehabilitation for mobility practice.
- Has been stable for 1 week – obs within normal limits.
- Mobilising with physiotherapist, complained of SOB, sharp stabbing pain on left side of chest.
- Lips and extremities blue in colour.
- Resp rate = 38, clammy to touch.
- Needs urgent review, ECG.

Task: Use the ISBAR framework to provide handover to ambulance officers.

- 7 year old male presented through GPC.
- Probable asthma attack.
- Has multiple allergies
- Clearly wheezy and short of breath despite use of inhalers and corticosteroids.
- Increasing facial colour and distress.
- Saturations fluctuating between 79-88%.
- Rapid respiratory rate.
- Needs urgent transfer to RPAH.

Task: Use the ISBAR framework to provide handover to the dietitian.

- 88 year old male admitted with decreased oral intake.
- On admission, the Malnutrition Screening Tool was used while completing the Adult Admission and Discharge Assessment form. Patient had a score above 2 on the Malnutrition Screening Tool.
- Poor oral intake, eating less then 20% of meals.
- Poor skin integrity.
- Needs referral to dietitian.