I'm not a robot

ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information. It originates from SBAR, the most frequently used mnemonic in health and other high risk environments such as the military. The “I” in ISBAR is to ensure that accurate identification of those participating in handover and of the patient is established. SA Health is using ISBAR as a tool to aid the safe transfer of patient information in clinical handover. It is generic aid and should be adapted to fit the clinical context. Adapting ISBAR for the clinical context is an opportunity for the health care team and patients to decide what essential information should always be handed over (eg estimated blood loss in the handover of a surgical patient). Resources Fact sheet The patient’s concerns or input into the clinical handover process should be considered in the adaptation of how ISBAR is to be used. An example of how an obstetric unit has created a minimum dataset of information for clinical handover using ISBAR can be found on the ISBAR fact sheet (PDF 93KB). Lanyard card The ISBAR lanyard card (PDF 66KB) has been designed as a prompt for staff to remember what type of information should be communicated using ISBAR. Organisations within or external to health are invited to use this tool to assist in the practice of using ISBAR for clinical handover. Other resources telephone sticker (PDF 45KB) poster (PDF 457KB) telephone pad (PDF 452KB) How to order resources Details on how to purchase all of the ISBAR resources are available on the ordering of clinical handover resources form (PDF 377KB). Contact Clinical Governance Unit Email: Health.DHWClinicalGovernanceEnquiries@sa.gov.au ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information. 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Lanyard card The ISBAR lanyard card (PDF 66KB) has been designed as a prompt for staff to remember what type of information should be communicated using ISBAR. Organisations within or external to health are invited to use this tool to assist in the practice of using ISBAR for clinical handover. Other resources telephone sticker (PDF 45KB) poster (PDF 457KB) telephone pad (PDF 452KB) How to order resources Details on how to purchase all of the ISBAR resources are available on the ordering of clinical handover resources form (PDF 377KB). Contact Clinical Governance Unit Email: Health.DHWClinicalGovernanceEnquiries@sa.gov.au When transmitting information about a patient to a new person/team within the healthcare system, a handover is thus performed. A handover is best described as sharing specific details about a patient to someone else. When done right, it allows a lot of information to be passed down quickly and effectively, which can be challenging. They occur in numerous places around the hospital and are commonly performed, be it when: patients arrive at the hospital (from the ambulance in ED), being admitted or consulted by staff, during shift changeovers, handover to ward call, ward call reviewing on a night shift, handing over to nursing staff after ward rounds, escalating to a consultant, inter-hospital transfer, theatre time-outs, discharge summaries or referral letters, and so on.An ISBAR is a recognised and effective method to deliver handovers practically to another person/team. The ISBAR is simple, quick-to-use, memorable and portable. It is designed to have a logical, structured approach in providing concise and easy-to-understand information, making communication more effective and streamlined.About 70-80% of medical errors are related to communication errors or problems with interpersonal interaction, especially between teams. As well as being related to malpractice claims, poor communication harm patients and make work-life unnecessarily tricky. In addition, the more there are handovers, the more chance of having errors occurring. Hence, becoming skilful in creating a reliable handover using the ISBAR method is crucial.Before starting with an ISBAR, here are some tips to increase your success in making an effective handover:Make sure you have all the information in front of you (such as investigations, results, notes and so on). Sit in front of the computer if you have to.Stay relaxed and calm; it can be difficult and annoying when the person you are talking to is distracted. Always be polite as it can be helpful; politeness takes you to places further and more efficiently. Don't forget your thank you!Be clear about what you need at the start of the phone call.How detailed the handover differs from situations and staff. The depth and breadth need to be tweaked.It is always appreciated when you ask if there is anything you can do in the meantime.Practise all the time as it is a complex and daunting skill. Always ask for advice from friends and colleagues. Document your conversation whether you have been helped or not, and seek advice from a senior staff member if you have to.INTRODUCTIONIntroduce yourself.Name, position, where you are calling from.Check who you are calling.SITUATIONWhat is happening at the moment? Involve a couple of sentences that should inform quickly about the current situation.Introduce the patient (name, DOB/UR, age, sex, location).Provide the timing of the current problem.What do you want? (review, consult, advise). Make it very clear in the area you wish to be informed on and the patient's management. Mention a possible diagnosis if you have one.BACKGROUNDThis section provides the patient's overview, including the most relevant details. The appropriate information changes from person to person, situations, specialities, teams, etc.Date of admission.Presenting complains.Ongoing diagnosis and other current issues/complications.Relevant pst medical and past surgical history.Relevant medication/allergies.Results of the necessary investigation (bloods, imaging).Intervention to date (any surgeries, fluids, Abx), ceiling of care. What is their current management, and how are they going?ASSESSMENTAssessment regards the objective clinical evaluation of the patient.Vital signs: oxygen saturation, pulse (rate, character and volume), blood pressure, respiration rate, temperature.Clinical examination findings: provide acute and relevant baseline findings. DRS ABCDE may be helpful in this context.Overall diagnosis and clinical impression (including trajectory).RECOMMENDATION/RESPONSE & REVIEWWhat should be done to correct this situation? Giving your recommendation about what should be done in managing the patient as well as hearing what advice the other person is recommending.State your plan/recommendation: the ongoing diagnosis, what needs to happen, and the plan and management time frame.Ask the advisor: if/when they will review the patient and their given time frame. Whether there is anything further you can do or reasons to escalate. Whether the patient needs to be transferred, such as ICU, theatre, etc.If you are unsure, it is okay to say, "I am unsure of the diagnosis and/or the next step in the management, I am concerned, and your input is greatly appreciated."Has the advisor understood the situation, and do they have any further questions?Clarify the expectation of the response.Document the discussion.Stay polite and thank them for their busy time.Published 15th January 2022. Last reviewed 25th March 2022. ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information. It originates from SBAR, the most frequently used mnemonic in health and other high risk environments such as the military. The “I” in ISBAR is to ensure that accurate identification of those participating in handover and of the patient is established. SA Health is using ISBAR as a tool to aid the safe transfer of patient information in clinical handover. It is generic aid and should be adapted to fit the clinical context. Adapting ISBAR for the clinical context is an opportunity for the health care team and patients to decide what essential information should always be handed over (eg estimated blood loss in the handover of a surgical patient). Resources Fact sheet The patient’s concerns or input into the clinical handover process should be considered in the adaptation of how ISBAR is to be used. 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Lanyard card The ISBAR lanyard card (PDF 66KB) has been designed as a prompt for staff to remember what type of information should be communicated using ISBAR. Organisations within or external to health are invited to use this tool to assist in the practice of using ISBAR for clinical handover. Other resources telephone sticker (PDF 45KB) poster (PDF 457KB) telephone pad (PDF 452KB) How to order resources Details on how to purchase all of the ISBAR resources are available on the ordering of clinical handover resources form (PDF 377KB). Contact Clinical Governance Unit Email: Health.DHWClinicalGovernanceEnquiries@sa.gov.au Clinical handover is defined as “The exchange between health professionals of information about a patient accompanying either a transfer of control over, or of responsibility for, the patient” [1]. It is one of the most critical steps in a patient’s journey [2] and is a core skill that needs to be taught to health professional students and junior clinicians. Performed well, clinical handover should ensure that lapses in continuity of patient care, errors and harm are reduced in the hospital or community setting [2]. The key function of clinical handover is to improve the effectiveness of the actions taken by the recipient/s [1]. Despite its importance, clinical handover is often poorly performed – with potentially serious consequences for the patient [1]. Australian research suggests that critical detail is often omitted during handover, and included information is sometimes irrelevant [3, 4]. Although essential to safe medical practice and provision of excellence in patient care [2, 5, 6], training in clinical handover is often inadequate and not always included in university healthcare curricula [3]. Using ISBAR as a framework, the purpose of this paper is to highlight key elements of effective clinical handover, and to explore teaching techniques that aim to ensure the framework is embedded in practice effectively.ISBAREvidence suggests the use of structured, standardised frameworks for handover improves information transfer and patient outcomes [7]. In order to improve handover, a number of structured formats have been developed. One example is the I-PASS handover system, developed for use in paediatrics (Illness severity, Patient summary, Action list, Situation awareness and contingency planning, Synthesis by the receiver) [8]. However, one of the most widespread and well-studied frameworks is ‘ISBAR’ (Fig. 1) [9,10,11,12]. ISBAR is based on ‘SBAR’ – a system developed by the US Navy to ensure clear, precise communications between nuclear submarines. The ISBAR framework, endorsed by the World Health Organisation provides a standardised approach to communication which can be used in a wide range of clinical contexts, such as shift changeover, patient transfer for a test or an appointment, inter-hospital transfers and escalation of a deteriorating patient [9, 10]. In the hospital setting, ISBAR has been shown to increase transparency and accuracy when practicing interprofessional handovers [10, 12]. ISBAR has also proven to be a successful tool for handover in rural and remote Australian settings [11]. Fig. 1ISBAR framework [9,10,11,12]Clinical handover works best when all parties are using the same framework [13] and ISBAR provides a shared model for the transfer of relevant, succinct information between clinicians [13]. By providing a clear and standardised framework, it can assist in reducing the power differences that may hinder the transfer of information [13]. Information transfer may include: doctor to doctor; nurse to nurse; doctor to nurse; allied health to doctor; nurse to allied health. ISBAR can be used in a number of interactions, such as shift change, inter-hospital transfers, reports and briefings, medical emergencies, and patient discharge to community services. This approach doesn’t only apply to verbal communication, but can also be used in written forms, including reports, memos, radiology request forms, and referral documents. The structured framework of ISBAR is used extensively within the Australian healthcare system [12,13,14].Tips for preparing for ISBARThere are important elements to consider in the clinical handover process. Handover must include transfer of accountability for patient care, and the confidentiality of patient information must be maintained. Key tips for preparing for ISBAR are listed in Fig. 2 [12, 13]. Fig. 2Key tips for preparing for ISBAR [12, 13]The benefits and challenges of using ISBAR are listed in Fig. 3 [13]. Challenges can include the complexity of patient cases, and ensuring the person receiving the handover has understood correctly. To help overcome challenges, face to face handover is recommended wherever possible, allowing for interaction and clarification of information [13]. Fig. 3Benefits and challenges of using ISBARFlow of patient information is vital to patient safety, and a balance between efficiency and comprehensiveness is required [6]. In planning and organising clinical handovers, it is essential to consider: 1. Who should be involved? 2. When should it take place? 3. Where should it take place? 4. How should it occur? 5. What information should be handed over? Staff rosters should ensure shifts cross over, with dedicated handover time, and clear leadership practices. Sufficient and relevant patient information is required during handover. Junior members of staff must be adequately briefed, and clinically unstable patients must be highlighted to senior clinicians [6, 15]. Any incomplete tasks must be clearly understood by the incoming healthcare team. Similarly, once handover is complete, information must be acted upon. Tasks need to be prioritised; patient care plans need to be acted upon; and unstable patients need to be monitored and reviewed in a timely manner [6]. Key elements in helping to ensure continuity of patient information and care during and following clinical handover are summarised in Fig. 4. Fig. 4Key elements in helping to ensure continuity of patient information and care during and following clinical handover [6]The use of electronic systems may assist with the efficiency of handover. Within the hospital setting, some functions of the electronic handover tools include provision of the name and contact details of covering doctors for each consultant; and identification of patients in need of review, and outstanding tasks [6]. Benefits of using electronic systems include the ability to have multiple users, linkage of information; immediate update of information; and assistance with further planning and prioritisation.Education, training and practice in clinical handoverAlthough ISBAR is proving to be a valuable handover tool, for it to be successful, it must be effectively taught, and health professionals must be adequately trained in its use [10]. A recent systematic review of education interventions [16] revealed that although many handover studies mention interprofessional practice, educational interventions occur predominantly within the uni-professional context. This systematic review also highlighted inadequate reporting of educational interventions and outcomes, thus impeding replication studies [16]. Teaching approaches were mostly based on simulation and role-play, often sequenced with didactic teaching, video examples of handover, discussion and reflection. The systematic review concluded that a greater emphasis on multidisciplinary training of handover would add value to educational interventions [16].Organisations, including universities and hospitals, need to invest in the education and training of health professional students and health professionals to ensure good quality handover practice. However, due to time constraints in university curricula, and in hospital training, teaching and practice in clinical handover may not be prioritised. By embedding the teaching of handover within the university healthcare curricula, students are able to develop and practice required communication skills to better prepare for their future roles [17, 18]. Along with further training in the workforce, with dedicated teaching time, a well-led handover session itself, provides a useful setting for clinical education [6]. There are a number of online tools and videos available to assist with the teaching of ISBAR. For example: Support in education, training, practice, assessment and feedback are essential. Based on our own extensive experience of facilitating clinical handover tutorials, with large interprofessional classes (allied health, nursing, medicine, pharmacy, dentistry), we recommend the following teaching method, which combines large class and small group activities [17, 18]. Students watch suitable ISBAR videos online prior to class, and then attend a face-to-face class, facilitated by a clinical teacher, with interactive discussion. Then in small, interprofessional groups, students use relevant scenarios to participate in simulation/roleplay activities (approximately four students per group), providing an active method of practicing clinical handover. Two examples of scenarios are provided in Fig. 5. Learners can work in pairs to practice giving and receiving a clinical handover. Direct observation, assessment, and feedback, from both peers and an experienced clinician assist in the development of skills [22, 23]. When ISBAR is practiced in larger groups, it is possible for class participants to duplicate the handover, until it is eventually performed to ‘perfection’. Fig. 5Examples of ISBAR scenariosExamples of using ISBAR in a roleplay situation are found in Fig. 6. It is important to remember that direct observation of clinical practice, with feedback by an experienced clinician helps to close the gap between current and desired performance by the learner [21, 22]. Additionally, verbal qualitative feedback, with group participation, provides a useful method in teaching clinical handover [17, 18]. For example; “You gave excess information”; “The information was unfocussed”. It is important that the person giving the handover realises that the ‘receiver’ is likely to ask questions, and it is essential to have all available information at hand during ISBAR. Specific assessment tools can also be used. The “Clinical Handover Assessment Tool” (CHAT) was developed by Moore et al. (2017), and is based on the ISBAR handover framework [11]. We have used this model in the assessment of ISBAR performance during small group sessions. The items in this assessment tool are aligned with ISBAR, including, “Identifies self and position”, “Identifies main problem”, “Gives appropriate history”, “Give appropriate examination/observation”, “Makes logical assessment”, “Makes a clear recommendation” [11]. A four point scale, ranging from “Not performed competently” to “Able to perform under minimal direction” is used to rate the learners’ performance. A global rating is also provided, “How confident am I that I received an accurate picture of the patient?”. Importantly, written qualitative feedback is also provided to the learner [11]. Fig. 6Examples of the use of ISBAR in a role playPeer feedback within the interprofessional context is particularly valuable during interprofessional clinical handover practice activities [17, 18]. Interprofessional activities, within small groups, where participants share experiences within their own field of healthcare offers valuable learning and teaching opportunities, leading to knowledge and skills being socially constructed [17, 18]. Feedback from outside of one’s own health profession can be even more beneficial and meaningful than feedback from within the same discipline. Multidisciplinary feedback on the handover can help to provide an increased understanding of the knowledge, roles and skills of other health professionals; and provide an increased understanding of how this relates to their own health discipline [17, 18]. It also helps participants to reflect on their own technique, terminology and communication methods.Importance of ongoing training in clinical handoverThe healthcare workforce has seen many changes in recent years, including reduced working hours, and increasing demands for flexibility [24,25,26]. This is a consequence of better recognition of the impact of doctor fatigue on patient safety, the importance of work/life balance, an ageing healthcare workforce, and the increasing complexity of patient care. In turn, this increases the number of individuals involved in the care of each patient. Therefore the need for concise, accurate clinical handover is imperative [6]. High quality transfer of patient information from team to team is an essential component of good patient care, alongside the expertise of clinicians, teamwork and effective management [27]. However, good practices in clinical handover do not happen by chance. Institutions and organisations (for example, hospitals, universities, training and accreditation bodies) and their leaders, have responsibilities to ensure practice in good clinical handover is achievable [6, 27]. In the medical field, ISBAR is an acronym for identify, situation, background, assessment, and recommendation that refers to the steps that should be taken when a patient is handed over from one medical practitioner to another, such as during a shift change. During patient handover, also called transfer of care, a patient's care is reassigned either temporarily or permanently to another healthcare professional, department, or facility. The purpose of ISBAR is to set up communication standards for medical personnel to ensure that patients receive continued quality care. The first step, identify, has not always been a part of ISBAR—or SBAR as it was known—and was added to introduce all individuals involved in the communication. ISBAR also is used outside of medical settings, such as in the information technology (IT) field. The US Navy developed SBAR as a way to communicate while on submarines, but the healthcare sector adopted it as a tool to standardize communication.BackgroundClear communication is key because it can mean the difference between life and death in certain situations—especially in the healthcare environment concerning patients. A misunderstanding can have dire consequences and can compromise the safety of patients. Numerous healthcare providers communicate with one another on a daily basis through verbal, nonverbal, and written (or electronic) methods. They also interact with patients, their family members, and caregivers to deliver care and relay information. Effective communication skills are imperative to building and maintaining trusting relationships with patients and fellow healthcare providers.Communication is especially important during transfer of care to prevent negative health effects and consequences to a patient. Poor communication can result in errors and interruptions in treatment or medications, delays in diagnosis, and missed or double tests. Any of these can have dire results, leading to serious injury, illness, or even death, which can result in malpractice lawsuits and other legal troubles for medical personnel and facilities.Information on all aspects of care during a patient transfer should be accurate, clear, relevant, and timely. To prevent mistakes that could be detrimental to a person's health, the tool ISBAR has been developed. ISBAR is a standardized and structured communication tool that improves communication not only among health practitioners but also between medical providers and patients themselves. By using ISBAR, medical personnel can build relationships, facilitate continuity of care, promote safety, improve outcomes, and increase patient satisfaction.While the US Navy developed the method, the Joint Commission in the early twenty-first century created a set of National Patient Safety Goals to improve communication among health practitioners. It developed these goals to improve communication, since disorganized and unclear communication was identified as the main cause of unexpected death in medical settings.While nurses and physicians typically use ISBAR when communicating with one another, the process can also be used to communicate with other medical staff. When a nurse needs to schedule several tests for a hospitalized individual, they must communicate with several people. For example, the nurse must notify the department heads of the times of each test and the dietary staff to hold meals until after the tests are completed. If the nurse does not tell the dietary staff that the patient needs to fast until after the tests, then the patient might be given a meal before the test and then delay pertinent assessments. This is why communication needs to be thorough and clear.OverviewIn ISBAR, identify refers to the people involved in the communication; situation is the issue being conveyed; background is the history of the patient; assessment refers to the observation of symptoms; and recommendation is the care suggestion.Before a nurse begins the ISBAR process, they should assess the patient and read their chart and any lab or test results. The nurse should also review any physician or nurse progress notes to ensure that they know the background of the patient before contacting the physician.In identify, a nurse identifies themself, the physician, and the patient. For example, "Hello, Dr. Kim, I am nurse Emanuel and calling about your patient, Mr. Williamson, who is under the care of our hospital in Room 17A."In situation, the nurse explains what is going on, and expresses observations and concerns. "Mr. Williamson is complaining of severe pain in his lower left abdomen and says he has blood in his urine. He has been sent for blood and urine analyses, and we are awaiting the results. His blood pressure is 110/70 mm HG, pulse rate is 112, and temperature is 102.3 degrees F. He describes the pain as 9 out of 10 on the pain scale."In background, the nurse provides a brief history on the patient. "Mr. Williamson is a 42-year-old male who was admitted for severe abdominal pain six hours ago. He has previously been treated in the last three months for nephrolithiasis, or kidney stones. His clinical presentation on admission included an elevated heart rate and body temperature."In assessment, the nurse tells the physician what they believe is wrong. "I think Mr. Williamson has kidney stones."In recommendation, the nurse suggests a treatment plan. "Dr. Kim, will you be coming to see Mr. Williamson? Would you like me to contact radiology for an X-ray or ultrasound of the patient's abdomen, or should we wait on the lab results? Should I give the patient pain medication and start an IV?"By using the ISBAR tool, medical personnel can effectively communicate with other people in the profession. Clear and concise communication in a healthcare setting is important to patient treatment and safety.BibliographyBurgess, Annette, et al. “Teaching Clinical Handover with ISBAR.” BMC Medical Education, vol. 20, no. 2, 2020, p. 459, doi.org/10.1186/s12909-020-02285-0. Accessed 2 Nov. 2024.Cudjoe, Kim Giselle. "Add Identity to SBAR." Nursing Made Incredibly Easy!, vol. 14, no. 1, Jan./Feb. 2016, pp. 6–7, journals.lww.com/nursingmadeincrediblyeasy/Fulltext/2016/01000/Add_identity_to_SBAR.2.aspx. 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Agency for Healthcare Research and Quality, Nov. 2019, www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html. Accessed 2 Nov. 2024. Sharing incorrect or omitting information can have harmful or life-threatening consequences for patients and residents in our care. Therefore, clinical handover and communication of critical information can be a high-risk process in healthcare. Clinical handover falls under Standard 6: Communicating for Safety Standard in the National Safety and Quality Health Care standards (NSQHS). The way we communicate can be affected by a range of factors, such as: The situation: what and why are we needing to communicate? Is it a shift handover? Is it urgent or non-urgent? Are there any distractions or potential disruptions? Do you have time to plan what you want to say? It’s ok to write what you want to communicate first, provided it is not a time critical conversation. The method: is it face to face? is it verbally over the phone? Is it written in a page or email? The location: is it at the bedside? Is it at a meeting? Is it in the staff/handover room? The participants: is it nurse/midwife to nurse/midwife? Is it to other members of the multidisciplinary team? Is the patient and their family involved? To ensure all healthcare professionals are communicating effectively, the ISBAR communication tool was developed. ISBAR stands for: Identify Situation Background Assessment Response/Recommendations ISBAR was originally used by several industries outside of healthcare, such as maritime and airline sectors. Healthcare adapted the SBAR tool to be more patient centred by adding the Identify component. ISBAR is a versatile and effective tool which can be used in a variety of situations, such as bedside handover, internal or external transfers (e.g. from nursing home to hospital, from ward to theatre) communicating with other members of the multidisciplinary team, and upon discharge/transfer to another health facility. Using ISBAR for verbal/written communication (e.g. phone call, email or referral) Identify: yourself and your role, and the patient/resident using the three patient identifiers (name, date of birth (DOB) and UR number). Refrain from referring to the patient by their location “the patient in bed 5”. Situation: what is going on, what is your reason for calling this person? Has there been a change in their condition? Do you need a medication order for pain or vomiting? Has there been an incident e.g. fall, refusal of care? Background: what has been happening with the patient/resident during your shift? What is their current diagnosis and plan of care? Assessment: provide details of observations, procedures, treatment thus far, what do you feel needs to be done or changed? Remember, you can use subjective or objective data to communicate your assessment findings. The patient/resident’s vital signs and other observations may be normal, but their behaviour or appearance seems different compared to your previous assessment. Response/recommendations: how urgent do you require a response from this person? Set a deadline for when you would like your request acknowledged (e.g. “could you please reinsert her IV cannula prior to her next dose of IV antibiotics at 1800hrs?”). If any of the patient’s vital signs fall into MET criteria, or their condition is critical/life threatening, follow local procedures for escalation and initiating a MET call or Code Blue or calling 000 for an ambulance. Semi urgent example Hi Dr Roberts, it’s Anna calling from Ward 4 looking after Jane Citizen in bed 8. She is admitted with pneumonia on a background of Type 2 diabetes. Her BGL before lunch is 20.5mmol/L. She reports feeling a little dizzy and nauseated, and she looks quite pale. All her other observations are within normal parameters. She has had her morning NovoRapid dose of 6u and is not due any more insulin until 2000hrs. Would you be able to review her before lunch? Please contact me as soon as possible on 1234. Non-urgent example Hi Social Work department its Brooke calling from Ward A, I’m the nurse looking after Fred Harris. He has reported to me today stating he is experiencing financial difficulties at present, and would like to speak to someone from SW to see what assistance is available to him. He lives alone and is currently unemployed. We anticipate he will be discharged early next week once he is medically stable. Please call me on 1234. Using ISBAR for clinical handover (e.g. change of shift, prior to ward/external transfer) Identify: introduce and identify the patient using the three patient identifiers (name, DOB and UR number) – these identifiers can be checked with the patient/resident if they are cognitively intact, or using their wristband if the patient is cognitively impaired or has limited verbal communication. Situation: what is the patient or resident’s current diagnosis and medical history? What are the latest pathology and radiology results? Are there any alerts for this person identified as a result of your assessments e.g. falls risk, wandering behaviours, advanced care directives, allergies or adverse drug reactions, infectious risks? Provide any relevant documentation to the receiving nurse for them to visualise, such as a documented Advance Care Directive. Background: what has been happening with the patient/resident during your shift? Are there any abnormal findings or observations to report, and what have been your actions as a result of these findings (e.g. MET call initiated, doctor review, altered MET criteria)? What procedures or activities have occurred? Assessment: provide details of the plan of care – any procedures, treatment thus far, outstanding tasks or interventions, discharge planning. Response: has the person you are handing over to understood? Is there anything that requires clarification or follow up (e.g. what time was their procedure scheduled for? Could you follow up on the order from pharmacy?). Allow the staff member who is receiving handover to review the charts before moving on to the next patient. Example of good bedside hand over “Nurse A, this is (checks wristband) Mary Day, UR number 123456 DOB 1/1/1935. She has been admitted to us with a L fractured NOF post mechanical fall at home. She has a history of AF on Warfarin, OA and dementia. She is a high falls risk and has a documented allergy to Morphine which causes hallucinations. She has a documented advanced care directive – NFR. Her pain has been well controlled with the femoral nerve block from this morning, and regular analgesia as per the medication chart. Her vital signs have been within normal limits throughout the shift. Mary is currently fasting for theatre this evening, consent has not been done yet – the treating team are awaiting her MPOA to come in and meet with the team. She has a 12/24 bag of N/Saline running. She will need an IDC inserted and a theatre pack completed prior to going to OT. Did you have any questions in regards to Mary’s care?” Example of bad bedside handover “Hey how was your weekend? Check out this thing I saw on Facebook earlier. Oh, this is bed 5, you looked after her yesterday didn’t you? No change, she’s stable. Think she’s fasting for theatre, but I could be wrong, maybe I’m getting confused with bed 6” If the patient is cognitively intact and it is appropriate to do so, allow them the opportunity to have an input into their handover, such as clarifying their medical history, or allowing them to ask questions about things they may not understand or know about. This allows the patient to feel included and informed, and to understand the rationale for aspects of their care. If family members or other visitors are present at the time of the bedside handover, ensure the patient consents to them being present during the handover.