ISBAR
A standard mnemonic to improve clinical communication

- **Identify** — Who you are and what is your role?
  Patient identifiers (at least 3)
- **Situation** — What is going on with the patient?
- **Background** — What is the clinical background/context?
- **Assessment** — What do I think the problem is?
- **Recommendation** — What would you recommend?
  Risks- patient/occupational health and safety?
  Assign and accept responsibility/accountability

Customise ISBAR for your clinical context

Clinical areas may want to agree to a minimum set of information they want under each letter of ISBAR for their clinical context so essential information does not get missed. An example of an obstetric unit is shown below.

Identify

> Patient's MRN, Name and DOB

> Name and title/role of staff handing over

Situation

> Reason for admission
(eg Hyperemesis @12 weeks)

> Diagnosis if known
(eg Active stage of labour)

> Mode of delivery and date
(eg LSCS for CTG changes)

> Operation and date
(eg Vag hyste + A/P repair)

Background

> Relevant previous history
eg Elective LSCS for breech, allergic to penicillin, any social issues of note

Assessment

> Latest clinical assessment, clinical & investigations
eg VE: 4 cm ROT -1 @ 7.30
Urine output, Labs, Hb
B/P, pulse, temperature and respirations, pain score, patient anxiety

Recommendation

> Actions required after handover
(eg Call surgeon for urgent consult –specify level of urgency with timeframe; "Dr Jones to discuss situation with patient and partner at 10:00am")

> Risks - eg eclampsia

> Assign individual responsibility for conducting any task

For more information

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