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| ISBAR  Communication Tool | |
| **I**  **Identify** |  |
| **S**  **Situation** |  |
| **B**  **Background** |  |
| **A**  **Assessment** |  |
| **R**  **Recommendation** |  |

Print out 2 ISBAR forms.

Watch the Youtube video and take report as if you are the nurse coming on duty, Patty. Fill out the ISBAR.

https://www.youtube.com/watch?v=RHpbuljThoc

Submit this form under the ISBAR assignment.

The second ISBAR is for you to give me report after your shift as the patient’s nurse. This can be done after the math exam on Wednesday 2/17/21 or you can send me a recording of you giving me report on the patient.

Your Shift

It is 4:00pm, you go to assess your patient. Your patient has no neurological changes and is responding to questions. She states her pain is still at a level “3”, but it is tolerable.

Lungs are clear with fine crackles in the lower lobes. O2 saturation is 94% on 3 liters of oxygen. You lower the oxygen to 2 liters and continue your assessment. Her skin is warm and dry no cyanosis. Distal pulses are palpable. Abdomen is soft and bowel sounds are present. Her IV is running and no leaking or swelling.

Before you leave the room, you ask her if she needs anything and remind her to use her call bell for assistance to get out of bed. Call bell is within reach of the patient. Bed is locked and in the lowest position.

Later the patient care assistance (PCA) yells for help. You get to the room and your patient is laying in the floor, face down. “I was just trying to get to the toilet and tripped on my IV.” She lifts her arm and you see blood coming from the IV site. It has come out of her arm.

Patient is alert and oriented to person, place, time and situation. She is able to move all of his extremities. “I’m ok. My back is hurting some now. I’m so embarrassed. I forgot about the compression stockings and tripped over the tubing. I thought I could go to the bathroom by myself.” The healthcare provider (HCP) assesses the patient and the patient is assisted to bed. An x-ray of the back is ordered.

You do a complete assessment and but a dressing on the bleeding IV site. You call the IV team and they place a new IV # 20 in the left hand. You restart the IV fluid Lactated Ringers at 125 mL/hr. You completed the incident report as per hospital policy and notify the nursing supervisor of the fall. The x-ray was completed and awaiting results.

It is 10pm and you are finishing up your work, when your patient’s call light goes off. She requests pain medication and rates her pain a “7” on the 0-10 numerical scale. You give the patient the pain medication as ordered. Her vital signs are T 98.8 orally, HR76 and regular, R 22 and unlabored, SPO2 93% on 2 Liters BP 132/76.

The HCP calls to check on your patient and says the x-ray was negative for fractures or dislocations. HCP gives an order for out of bed as tolerated with assistance and also discontinues the compression stockings since the patient is ambulating.

It is now the change of shift and you need to give a verbal report to the oncoming nurse/your instructor.