ISBAR communication tool for handing over or reviewing seriously ill children on a ward round

Introduction

- Introduce yourself, your role, your location
- Introduce the patient, or introduce yourself to the patient and family

Situation

- State the current / immediate clinical situation
- State particular risks or concerns

Background

- Provide relevant clinical history and background
- Presenting problems and clinical history

Assessment:

Work through the physical assessment on a ward round. For a seriously ill child this can be

A – airway, is there stridor, upper airway obstruction

B – breathing, RR, signs of respiratory distress, SpO_2, respiratory distress score

C – circulation, heart rate, blood pressure, pulse volume, capillary refill, cold hands / feet

D – disability / neurology / GCS response to pain

D – review all drugs, check doses, what drugs are no longer needed

E – exposure: temperature / IV cannula / pressure areas

E – electrolytes, creatinine and urea, if needed

F – fluids and feeding

G – glucose, is the BSL normal, is the child on sufficient glucose / feeding, etc

H – haematology / anaemia / thrombosis risk / signs of infection on FBE

I – clinical signs of infection

What is your **overall assessment** of the patient, the diagnosis, complications?

Recommendations

- What you have done so far
- What is your treatment plan
- What more information
- What supportive care and monitoring is needed
- What do you want the person to do
- Be clear about what you are requesting and the timeframe