SOP: Communication and Reporting to Supervising Nurse/Physician

This SOP details the **communication and reporting to supervising nurse/physician** process, emphasizing clear, timely, and accurate information exchange regarding patient status, treatment updates, and any changes in condition. It includes guidelines for verbal and written reporting, documentation standards, escalation protocols, and the use of standardized communication tools to ensure continuity of care and prompt clinical decision-making.

1. Purpose

To establish standardized procedures for effective communication and reporting between staff and supervising nurses/physicians, enhancing patient safety and ensuring continuity of care.

2. Scope

This procedure applies to all clinical staff involved in patient care and their interactions with the supervising nurse or physician.

3. Responsibilities

- **Clinical Staff:** Accurately and promptly report relevant patient information.
- **Supervising Nurse/Physician:** Receive, clarify, and act upon information provided; offer guidance and oversight.

4. Procedures

4.1 Verbal Reporting

- Use a standardized format (e.g., SBAR: Situation, Background, Assessment, Recommendation).
- Clearly state the reason for the report and relevant patient details.
- Ensure two-way communication, allowing for questions and clarification.
- Report immediately in case of changes in patient condition or urgent matters.

4.2 Written Reporting & Documentation

- Document all significant communications and patient status changes in the patient's medical record immediately after reporting.
- Ensure entries are clear, concise, accurate, and include date, time, and signature/initials.
- Follow facility documentation policies for electronic or paper records.

4.3 Escalation Protocols

- Escalate concerns or unresolved issues to higher authority (e.g., attending physician or nurse manager) as per organizational hierarchy.
- Follow the chain of command in urgent or emergent situations.

4.4 Standardized Communication Tools

Tool	Description	When to Use
SBAR	Structured method for concise communication: Situation, Background, Assessment, Recommendation.	During handover, critical lab reporting, or condition changes.

Read-back/Repeat-back	Repeating orders/information to confirm accuracy.	When receiving verbal or telephone orders.

5. Documentation Standards

- All reports (verbal/written) must be recorded in the patient's medical record.
- Include: time, content of communication, recipient, and outcome/action taken.

6. Compliance & Audit

Regular audits will be conducted to ensure adherence to this SOP. Non-compliance may result in retraining or disciplinary action as per facility policy.

7. References

- Facility Communication Policy
- Joint Commission: National Patient Safety Goals