

FREE FACULTY RESOURCE – US–FIRST EDITION

SBAR Audio Handoff Discussion Pack

Seven fixed fictional, synthetically voiced handoffs for listening, private judgment, discussion, and focused replay. No sign-up, score, AI feedback, or comparison with other users.



Open the audio pack

A simple facilitation loop

1. READ + LISTEN

Read the scenario card, then play the recording once without stopping.

2. JUDGE PRIVATELY

Each person marks five judgments before the group discusses them.

3. REVEAL + REPLAY

Use the discussion lens, name the evidence, then rehearse the narrow re-teaching target.

The five private judgments

1	Was the priority or reason for the call or handoff clear early?	Clear ☐ Needs discussion ☐ Not sure ☐
2	Was enough relevant background provided, without unnecessary detail?	Clear ☐ Needs discussion ☐ Not sure ☐
3	Did the speaker state an assessment or concern, rather than only reporting facts?	Clear ☐ Needs discussion ☐ Not sure ☐
4	Was the expected next step clear, including its urgency or by-when?	Clear ☐ Needs discussion ☐ Not sure ☐
5	Did the receiver confirm who would do what and by when?	Clear ☐ Needs discussion ☐ Not sure ☐

Clear: I heard enough evidence that this behavior was achieved. **Needs discussion:** I heard evidence that this behavior was incomplete or unclear. **Not sure:** I cannot decide from the recording or would need local context or policy.

Boundaries and timing

Allow about **10 minutes per recording**, or about 20 minutes for one of the suggested pairings overleaf, which also states how the recordings relate to each other. Recordings 1, 2, 3 and 6 keep the patient facts and participants constant. Recordings 4, 5 and 7 deliberately change the task. Fictional case. Synthetically voiced conversation. These cases use US-English voices and familiar US nursing roles. This activity asks you to judge communication behavior, not clinical correctness. The vital signs describe this patient and are not escalation thresholds. The stated arrival times are fictional communication commitments, not recommended waiting periods. A promised arrival does not suspend ongoing assessment or local escalation procedures, and deterioration can require action sooner. Adapt role names and expectations to your institution's policy. Use local rapid-response criteria and policy. This is a formative discussion specimen, not a validated assessment or clinical guide.

Context note: The recordings use US-English voices and familiar US nursing terminology. Roles are adaptable to your institution. Interest in India, UK, and Australia editions can be registered on the web page.

Pack URL: <https://medical.linguacopilot.in/guides/sbar-audio-handoff-discussion-pack>

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FOR ONE CLASS

Choosing material

These are alternative versions and related situations on one fictional patient, not seven consecutive events. Recordings 1, 2, 3 and 6 are four versions of the same 6:45 p.m. call. Recording 5 is a shift handoff at the bedside; in Recording 7 the handoff has not yet taken place and Jamie is still the responsible nurse. Choose a pairing rather than playing all seven in order.

Teaching purpose	Suggested selection	Time
Establishing a clear escalation	Recording 1 and Recording 2	About 20 minutes
Transferring responsibility at shift change	Recording 4 and Recording 5	About 20 minutes
Maintaining a concern under resistance	Recording 2 and Recording 6	About 20 minutes
Adapting structure when the receiver interrupts Optionally after Recording 2.	Recording 3	About 10 minutes
Communicating a critical result	Recording 7	About 10 minutes
Initial escalation and follow-up update An optional extension, not a controlled comparison: new information arrives between the two calls.	Recording 2 and Recording 7	About 20 minutes

This facilitator pack deliberately includes quality labels, case interpretations, and discussion lenses. For learners' first listen and private judgments, use the web page with the discussion lens closed.

COVERING-PHYSICIAN CALL – 1:19

Recording 1

Disclosure: Fictional case. Synthetic voices.

Roles: Jamie Carter, bedside nurse | Dr. Alex Morgan, covering physician

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



Open this recording

SCENARIO CARD – READ BEFORE LISTENING

Elena Martinez, 68, is post-operative day 1 after abdominal surgery on 4 North.

It is 6:45 p.m. Jamie Carter, the bedside nurse, is calling covering physician Dr. Alex Morgan about Ms. Martinez in room 412. Her medical record number ends in 4821.

Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by the covering physician.

Vital sign	2:00 p.m.	6:45 p.m.
Blood pressure	128/76 mmHg	96/58 mmHg
Heart rate	82/min	112/min
Respiratory rate	16/min	22/min
Oxygen saturation	97% on room air	95% on room air
Temperature	98.4 degrees Fahrenheit	98.8 degrees Fahrenheit

Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Controlled-design note: The physician's response is the same in all three phone recordings. It is part of the controlled exercise, not a treatment recommendation.

The exercise begins after the fictional unit has identified the covering-physician call as one required communication step. It does not model whether a rapid-response or code process should also be used.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to the conversation, then make five private judgments about the reason for the call, background, stated concern, next step, and confirmed ownership. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

Clear ☐ Needs discussion ☐ Not sure ☐

3. Did the speaker state an assessment or concern, rather than only reporting facts?

Clear ☐ Needs discussion ☐ Not sure ☐

4. Was the expected next step clear, including its urgency or by-when?

Clear ☐ Needs discussion ☐ Not sure ☐

5. Did the receiver confirm who would do what and by when?

Clear ☐ Needs discussion ☐ Not sure ☐

Selections are private prompts, not a score. Name the words you heard before naming your judgment.

DISCUSSION LENS – CLEARLY IMPROVABLE – NOT AN ANSWER KEY

History Before Priority

What changes when complete background arrives before the reason for calling?

Jamie knows the patient, but the receiver hears history and an earlier vital-sign set before hearing what changed now.

0:00 – The opening block

Jamie demonstrates knowledge of the patient, but the current change has not yet been stated.

Discuss: At what exact phrase did you first understand why this call was happening now?

0:30 – The receiver extracts the message

Dr. Morgan has to ask first for the change and then for Jamie's concern and request. The current set that finally arrives has blood pressure and heart rate only.

Discuss: Which question could have been unnecessary if the opening had led with the change and concern?

RECORDING 1 – DISCUSSION LENS CONTINUED

DISCLOSED AFTER LISTENING – WHAT WAS AGREED

Across all three recordings, Dr. Morgan says they are on the way and will assess Ms. Martinez at the bedside by 7:00 p.m. Jamie is to get a complete vital-sign set at 6:50 p.m., remain with the patient until the oncoming nurse has taken over, and call Dr. Morgan sooner if Ms. Martinez becomes less responsive or her blood pressure falls further. This repeated outcome is part of the controlled exercise. It is not a treatment recommendation or universal escalation process.

RE-TEACHING TARGET

Lead with why the call is happening now, then select background that helps the receiver act on that priority.

COMMUNICATION TENSION

Completeness can feel safe to the sender while making the priority harder for the receiver to find. The facts are not false. Their order is the issue.

Reasonable alternatives:

Some institutions require a particular identity or chart-verification sequence at the start. Separate required identification from the additional history and earlier vital signs that delay the current problem.

The current respiratory rate and oxygen saturation also changed from the 2:00 p.m. set, but neither is spoken and Dr. Morgan does not ask. Ask whether the receiver could act on this call without them, and whether that omission belongs to the sender, the receiver, or both.

FIVE-MINUTE REPLAY

1. Give pairs 60 seconds to rewrite Jamie's opening in no more than two sentences.
2. Require the patient, new change, one meaningful trend, Jamie's concern, and the requested time.
3. Read the revised opening aloud, then continue with the unchanged response and read-back.
4. Ask which receiver question is no longer needed.

COVERING-PHYSICIAN CALL – 1:15

Recording 2

Disclosure: Fictional case. Synthetic voices.

Roles: Jamie Carter, bedside nurse | Dr. Alex Morgan, covering physician

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



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SCENARIO CARD – READ BEFORE LISTENING

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It is 6:45 p.m. Jamie Carter, the bedside nurse, is calling covering physician Dr. Alex Morgan about Ms. Martinez in room 412. Her medical record number ends in 4821.

Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by the covering physician.

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Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Controlled-design note: The physician's response is the same in all three phone recordings. It is part of the controlled exercise, not a treatment recommendation.

The exercise begins after the fictional unit has identified the covering-physician call as one required communication step. It does not model whether a rapid-response or code process should also be used.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to the conversation, then make five private judgments about the reason for the call, background, stated concern, next step, and confirmed ownership. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

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5. Did the receiver confirm who would do what and by when?

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DISCUSSION LENS – STRONG – NOT AN ANSWER KEY

Clear Escalation

The same clinical situation, communicated around priority, concern, action and closure.

The opening links the current change and the four vital-sign trends to concern and a time-bound request, then leaves background for the next turn.

0:00 – Priority before background

The listener receives the new problem, four vital-sign trends, concern, and requested time in the opening.

Discuss: Which words make this more than a list of changing vital signs?

0:51 – Action and read-back

The response identifies actions, owners, timing, and a call-sooner condition, followed by a read-back.

Discuss: What could be lost if Jamie replied only, 'Okay, thanks'?

RECORDING 2 – DISCUSSION LENS CONTINUED

DISCLOSED AFTER LISTENING – WHAT WAS AGREED

Across all three recordings, Dr. Morgan says they are on the way and will assess Ms. Martinez at the bedside by 7:00 p.m. Jamie is to get a complete vital-sign set at 6:50 p.m., remain with the patient until the oncoming nurse has taken over, and call Dr. Morgan sooner if Ms. Martinez becomes less responsive or her blood pressure falls further. This repeated outcome is part of the controlled exercise. It is not a treatment recommendation or universal escalation process.

RE-TEACHING TARGET

Link the current change to an explicit concern and a time-bound request, then close the loop on the agreed plan.

COMMUNICATION TENSION

A strong escalation must be concise without becoming cryptic. The opening carries enough evidence for action while leaving less urgent context for the next turn.

Reasonable alternatives:

Some educators may find the opening information-dense or prefer the full post-operative context before the request. Ask what they would move without delaying the reason for calling.

Dizziness and temperature are on the card but not spoken. Dizziness may help the receiver interpret the current change; both temperature readings are normal. Ask which omissions represent reasonable selection and which might matter to the receiver.

FIVE-MINUTE REPLAY

1. Ask pairs to remove one detail from the opening without weakening priority, concern, or requested timing.
2. Have them explain what information the receiver still needs next.
3. Read the edited opening and Dr. Morgan's response aloud.
4. Finish with an exact read-back of owner, action, and time.

COVERING-PHYSICIAN CALL – 1:14

Recording 3

Disclosure: Fictional case. Synthetic voices.

Roles: Jamie Carter, bedside nurse | Dr. Alex Morgan, covering physician

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



Open this recording

SCENARIO CARD – READ BEFORE LISTENING

Elena Martinez, 68, is post-operative day 1 after abdominal surgery on 4 North.

It is 6:45 p.m. Jamie Carter, the bedside nurse, is calling covering physician Dr. Alex Morgan about Ms. Martinez in room 412. Her medical record number ends in 4821.

Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by the covering physician.

Vital sign	2:00 p.m.	6:45 p.m.
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Heart rate	82/min	112/min
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Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Controlled-design note: The physician's response is the same in all three phone recordings. It is part of the controlled exercise, not a treatment recommendation.

The exercise begins after the fictional unit has identified the covering-physician call as one required communication step. It does not model whether a rapid-response or code process should also be used.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to the conversation, then make five private judgments about the reason for the call, background, stated concern, next step, and confirmed ownership. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

Clear ☐ Needs discussion ☐ Not sure ☐

3. Did the speaker state an assessment or concern, rather than only reporting facts?

Clear ☐ Needs discussion ☐ Not sure ☐

4. Was the expected next step clear, including its urgency or by-when?

Clear ☐ Needs discussion ☐ Not sure ☐

5. Did the receiver confirm who would do what and by when?

Clear ☐ Needs discussion ☐ Not sure ☐

Selections are private prompts, not a score. Name the words you heard before naming your judgment.

DISCUSSION LENS – GENUINELY DEBATABLE – NOT AN ANSWER KEY

Structure Under Interruption

Does an interrupted call remain effective when the nurse adapts and resets?

Jamie answers the receiver's questions out of the planned order, then independently returns to the concern and request.

0:18 – The interruption and response

Dr. Morgan cuts off the background and asks for the current and earlier blood pressure and heart rate. Jamie gives those, then adds age, hypertension, the held medication, and dizziness. Neither speaker raises the respiratory rate or oxygen saturation, which also changed.

Discuss: Is answering the receiver's priority a loss of structure, or effective adaptation?

0:42 – The self-initiated reset

After a neutral acknowledgment, Jamie returns to the reason for calling without another prompt.

Discuss: Does the reset recover the structure, or did the concern still arrive too late?

RECORDING 3 – DISCUSSION LENS CONTINUED

DISCLOSED AFTER LISTENING – WHAT WAS AGREED

Across all three recordings, Dr. Morgan says they are on the way and will assess Ms. Martinez at the bedside by 7:00 p.m. Jamie is to get a complete vital-sign set at 6:50 p.m., remain with the patient until the oncoming nurse has taken over, and call Dr. Morgan sooner if Ms. Martinez becomes less responsive or her blood pressure falls further. This repeated outcome is part of the controlled exercise. It is not a treatment recommendation or universal escalation process.

RE-TEACHING TARGET

After an interruption, use a short verbal reset that returns the exchange to the concern and requested action.

COMMUNICATION TENSION

SBAR can support a shared mental model without requiring four uninterrupted blocks. The debate is whether the self-initiated reset makes the interrupted call functionally complete.

Reasonable alternatives:

Functional reading: Jamie identifies the current problem, answers the questions, resets, and closes the loop.

Stricter reading: the concern and request arrive only after two questions and extra background, so priority was not clear early enough, and the changed respiratory rate and saturation never reach the receiver.

FIVE-MINUTE REPLAY

1. Read the transcript as written.
2. Replay it without Jamie's reset, so the concern and request do not arrive unless Dr. Morgan asks.
3. Move the interruption until after Jamie's concern statement and ask whether the background judgment changes.
4. Have each pair state the evidence standard they applied to the first judgment.

NURSE-TO-NURSE SHIFT HANDOFF – 0:56

Recording 4

Disclosure: Fictional case. Synthetic voices.

Roles: Jamie Carter, off-going nurse | Taylor Brooks, oncoming nurse

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



Open this recording

SCENARIO CARD – READ BEFORE LISTENING

Elena Martinez, 68, is post-operative day 1 after abdominal surgery on 4 North.

It is just before 6:50 p.m., shortly before the 7:00 p.m. shift change. Jamie Carter, the off-going nurse, is handing Ms. Martinez in room 412 over to oncoming nurse Taylor Brooks. Her medical record number ends in 4821.

Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by covering physician Dr. Alex Morgan.

Vital sign	2:00 p.m.	6:45 p.m.
Blood pressure	128/76 mmHg	96/58 mmHg
Heart rate	82/min	112/min
Respiratory rate	16/min	22/min
Oxygen saturation	97% on room air	95% on room air
Temperature	98.4 degrees Fahrenheit	98.8 degrees Fahrenheit

Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Already pending:

- Dr. Morgan is on the way and has agreed to assess Ms. Martinez at the bedside by 7:00 p.m.
- A complete vital-sign set is due at 6:50 p.m.
- The responsible nurse is to remain with her and call Dr. Morgan sooner if she becomes less responsive or her blood pressure falls further.

These actions are conditions of the fictional exercise, not a treatment recommendation or universal shift-handoff process. The activity does not model whether a rapid-response or code process should also be used.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to the conversation, then make five private judgments about the reason for the handoff, background, stated concern, next step, and confirmed ownership. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

Clear ☐ Needs discussion ☐ Not sure ☐

3. Did the speaker state an assessment or concern, rather than only reporting facts?

Clear ☐ Needs discussion ☐ Not sure ☐

4. Was the expected next step clear, including its urgency or by-when?

Clear ☐ Needs discussion ☐ Not sure ☐

5. Did the receiver confirm who would do what and by when?

Clear ☐ Needs discussion ☐ Not sure ☐

Selections are private prompts, not a score. Name the words you heard before naming your judgment.

DISCUSSION LENS – CLEARLY IMPROVABLE – NOT AN ANSWER KEY

The Ownerless Shift Handoff

The tasks and times are audible, but has responsibility actually transferred?

The current priority and pending actions are understandable, but neither nurse explicitly transfers or accepts each time-sensitive responsibility.

0:24 – Pending work without a named owner

Jamie says the plan is for 'someone' to stay until the oncoming nurse takes over while speaking directly to Taylor, the oncoming nurse.

Discuss: Who is the oncoming nurse in this conversation, and which pending actions could both nurses still assume the other person will do?

0:41 – A friendly but vague acceptance

'I'll keep an eye on her' sounds cooperative, and the conversation closes. Neither nurse states the complete current vital-sign set, so the changed respiratory rate and oxygen saturation are not handed over.

Discuss: What responsibility has Taylor explicitly accepted, and what remains uncertain?

RECORDING 4 – DISCUSSION LENS CONTINUED

RE-TEACHING TARGET

Close a shift handoff with explicit transfer and acceptance of each time-sensitive action.

COMMUNICATION TENSION

A handoff can contain all the right tasks while still failing to transfer responsibility. Friendly acknowledgment is not always closed-loop acceptance.

A reasonable alternative:

In a familiar team, 'I'll keep an eye on her' may be understood locally as acceptance of care. Ask whether that interpretation remains unambiguous for a float nurse, new staff member, or distracted receiver.

FIVE-MINUTE REPLAY

1. Keep the opening and Taylor's question unchanged.
2. Rewrite only the pending-work turn and Taylor's response so each action has an owner and time.
3. Require Taylor to summarize what Taylor has accepted before Jamie closes.
4. Replay both endings and identify the words that make responsibility observable.

BEDSIDE SHIFT REPORT, PATIENT PRESENT – 1:56

Recording 5

Disclosure: Fictional case. Synthetic voices.

Roles: Jamie Carter, off-going nurse | Elena Martinez, patient | Taylor Brooks, oncoming nurse

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



Open this recording

SCENARIO CARD – READ BEFORE LISTENING

Elena Martinez, 68, is post-operative day 1 after abdominal surgery on 4 North.

It is just before 6:50 p.m. on 4 North, shortly before the 7:00 p.m. shift change. Jamie Carter, the off-going nurse, is handing Elena Martinez over to oncoming nurse Taylor Brooks at the bedside. Ms. Martinez is in room 412, and her medical record number ends in 4821. Room 412 is a single room with the door closed. She is awake and can hear the handoff.

Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by covering physician Dr. Alex Morgan.

She may ask whether her nurse is leaving or say that she still does not feel right, and she may acknowledge the oncoming nurse at the close. Nothing she says adds a fact that is not already on this card.

Vital sign	2:00 p.m.	6:45 p.m.
Blood pressure	128/76 mmHg	96/58 mmHg
Heart rate	82/min	112/min
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Oxygen saturation	97% on room air	95% on room air
Temperature	98.4 degrees Fahrenheit	98.8 degrees Fahrenheit

Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Already pending:

- Dr. Morgan is on the way and has agreed to assess Ms. Martinez at the bedside by 7:00 p.m.
- A complete vital-sign set is due at 6:50 p.m.
- The responsible nurse is to remain with her and call Dr. Morgan sooner if she becomes less responsive or her blood pressure falls further.

These actions are conditions of the fictional exercise. They are not a treatment recommendation or a universal shift-handoff process. The exercise does not model whether a rapid-response or code process should also be used.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to the conversation, then make five private judgments about the reason for the handoff, background, stated concern, next step, and confirmed ownership. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

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3. Did the speaker state an assessment or concern, rather than only reporting facts?

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4. Was the expected next step clear, including its urgency or by-when?

Clear ☐ Needs discussion ☐ Not sure ☐

5. Did the receiver confirm who would do what and by when?

Clear ☐ Needs discussion ☐ Not sure ☐

Selections are private prompts, not a score. Name the words you heard before naming your judgment.

DISCUSSION LENS – STRONG – NOT AN ANSWER KEY

Report at the Bedside

Does the handoff still transfer priority, actions, and ownership when the patient can hear every word?

The same shift handoff as Recording 4, moved to the bedside with the patient awake and able to speak. The facts and pending actions are identical; the setting, the patient's participation, and the explicit acceptance are not. This is a focused communication excerpt. It does not show, and does not need to show, a complete bedside assessment, a safety check, or an exploration of the patient's own concern. The Strong reading applies to the communication behaviours the recording does demonstrate.

0:00 – The patient is invited in, and answered

Jamie says what is about to happen and invites the patient to correct the report. The patient's reply changes the room: she is listening, and she says she still does not feel right. Jamie answers her before turning to Taylor.

Discuss: What did Jamie's first sentence buy for the rest of the handoff, and what would have been lost by going straight on to Taylor after 'I still don't feel right'?

1:25 – Responsibility accepted out loud, in front of the patient

Taylor says she is taking over the patient's care, lists each pending action with its time, and then tells Ms. Martinez directly who her nurse is and that she is staying. Compare with 'I'll keep an eye on her' in Recording 4.

Discuss: Which words here would still be unambiguous to a float nurse, a new graduate, or a family member who walked in a minute later?

RECORDING 5 – DISCUSSION LENS CONTINUED

RE-TEACHING TARGET

A bedside report transfers the same priority, actions, and ownership as a report at the desk, includes the patient as a participant, and the receiver says out loud, to the sender and to the patient, that they have taken over.

COMMUNICATION TENSION

Everything Jamie says about the patient is said in front of the patient, including 'newly confused'. The report is honest and respectful, and it is not softened. Faculty will differ on whether 'newly confused' should be reframed for a patient who can hear it. That is a question about sensitivity and patient understanding, not about clarity. A statement can be clear and still be worth rewording.

A reasonable alternative:

An educator may hold that Jamie's answer to the patient is too brief, and that a bedside report should pause to ask the patient what feels wrong before the nurse-to-nurse content begins. Another may hold that the patient's own concern is already the subject of the report and that a longer exchange would delay the transfer. Either view can be defended from the recording, and neither changes the five judgments.

ALSO WORTH DISCUSSING

– How did the nurses involve and respond to the patient? Point to the lines where Ms. Martinez was invited in, answered, and told who is responsible for her now.

FIVE-MINUTE REPLAY

1. Keep the opening through the pending-work turn unchanged.
2. Replace Taylor's acceptance with the Recording 4 line, 'Okay. I'll keep an eye on her,' and stop there, with a third person playing Ms. Martinez. Leave out Jamie's closing line: it tells the patient who is staying, and would answer the next question for her.
3. Ask the person playing the patient what they now believe about who is looking after them.
4. Restore the original acceptance and ask what specific words changed that belief.

COVERING-PHYSICIAN CALL – 1:36

Recording 6

Disclosure: Fictional case. Synthetic voices.

Roles: Jamie Carter, bedside nurse | Dr. Alex Morgan, covering physician

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



Open this recording

SCENARIO CARD – READ BEFORE LISTENING

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Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by the covering physician.

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Oxygen saturation	97% on room air	95% on room air
Temperature	98.4 degrees Fahrenheit	98.8 degrees Fahrenheit

Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Controlled-design note: This is a fourth version of the same 6:45 p.m. call. What changes is how the receiver replies. It is part of the controlled exercise, not a treatment recommendation.

The exercise begins after the fictional unit has identified the covering-physician call as one required communication step. It does not model whether a rapid-response or code process should also be used.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to the conversation, then make five private judgments about the reason for the call, background, stated concern, next step, and confirmed ownership. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

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5. Did the receiver confirm who would do what and by when?

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Selections are private prompts, not a score. Name the words you heard before naming your judgment.

DISCUSSION LENS – GENUINELY DEBATABLE – NOT AN ANSWER KEY

Holding the Concern

The same opening as Recording 2. This time the physician pushes back before committing.

Jamie's opening is word for word the opening of Recording 2. This time the receiver is genuinely busy elsewhere and proposes a deferral. The closing commitment and read-back are identical to Recordings 1 to 3. The case isolates the receiver's behaviour as the only manipulated variable. Because this receiver never asks for background, Recording 6 does not speak the post-operative context, age, history, or held medication that Recording 2 does. That omission follows from the receiver's behaviour rather than a separate change to the script, and it is worth naming when the two are played together.

0:35 – A real reason, and a deferral

The physician gives a real reason for not coming and a plan that defers the decision by an hour. Jamie acknowledges the reason, then puts the observed change and the two trends back in front of the receiver and says she is not comfortable waiting.

Discuss: What did acknowledging the workload buy Jamie, and what would have happened to the call if she had said only, 'Okay, I'll recheck in an hour'?

0:59 – The request repeated, and the next step named

Jamie restates the concern and the request in the same words as the opening, then names what will happen if the request is not met.

Discuss: Is the last sentence an escalation or a threat? What is the difference between naming the next step and going over someone's head?

RECORDING 6 – DISCUSSION LENS CONTINUED

DISCLOSED AFTER LISTENING – WHAT WAS AGREED

In this recording, as in Recordings 1 to 3, Dr. Morgan ends by saying they are on the way and will assess Ms. Martinez at the bedside by 7:00 p.m. Jamie is to get a complete vital-sign set at 6:50 p.m., remain with the patient until the oncoming nurse has taken over, and call Dr. Morgan sooner if Ms. Martinez becomes less responsive or her blood pressure falls further. This repeated outcome is part of the controlled exercise. It is not a treatment recommendation or universal escalation process. For this fictional unit, when the covering physician cannot attend within the requested time, the next step is for the 4 North charge nurse to contact the attending surgeon, Dr. Nia Okafor. This is a condition of the exercise, not a chain-of-command policy.

RE-TEACHING TARGET

Acknowledge the receiver's situation, hold the concern with the observed evidence, repeat the request and its time unchanged, and state the next step as a plan rather than a threat.

COMMUNICATION TENSION

A nurse can hold a concern without arguing with the receiver and without giving way. This recording reaches the commitment in three moves. Three moves is the structure of this recording, not a required number of attempts before escalating. Whether a shorter exchange would have worked is the discussion, and the pack does not answer it.

Reasonable alternatives:

Some educators will hold that the second turn should have restated the request and the time, not only the discomfort, so the receiver had a specific ask to accept or refuse a move earlier. Others will hold that answering the deferral with evidence first, then repeating the ask, is the correct order. A third group will say the next escalation step should have been named a turn earlier and saved a full exchange. All three can point to evidence.

The next escalation step in this recording is a condition of the fictional unit, disclosed after listening. Substitute your own institution's route and ask whether the words Jamie used would still work.

On background, a Clear reading is available and reasonable: what the call turns on is the observed change and the stated concern, and the request is specific and timed. The reading recorded here is Needs discussion because the operation is the context a covering physician would use to interpret a falling pressure and a rising heart rate, and it is never spoken. Play Recording 2 alongside and compare what each receiver was told.

ALSO WORTH DISCUSSING

- How did Jamie maintain the concern after resistance? Point to what changed and what stayed the same across her three turns.
- What did the receiver owe the caller? Each of Dr. Morgan's first two replies gives a reason and an alternative. Ask what a constructive response to an asserted concern sounds like, and whether 'I hear you' was one. Both asserting a concern and responding to one are team skills.
- What if the physician still could not attend? Continue the call as if Dr. Morgan genuinely cannot leave, using your own institution's escalation route, and say who is responsible for Ms. Martinez while that route runs.

FIVE-MINUTE REPLAY

1. Keep the opening and the physician's first reply unchanged.
2. Rewrite Jamie's second turn so it both acknowledges the workload and repeats the request and time in the same turn.
3. Read it aloud and ask the person playing Dr. Morgan whether they would still have deferred a second time, and what a constructive alternative reply would be.
4. Finish with the controlled response and read-back unchanged, and ask whether the additional exchange improved shared understanding, and whether the commitment could have been reached sooner.

CRITICAL RESULT, LAB TO NURSE TO PHYSICIAN – 0:56

Recording 7

Disclosure: Fictional case. Synthetic voices.

Roles: Riley Nguyen, laboratory technologist | Jamie Carter, bedside nurse | Dr. Alex Morgan, covering physician

Before playing: Listen once without stopping. Make your five private judgments before revealing the discussion lens.



Open this recording

SCENARIO CARD – READ BEFORE LISTENING

Elena Martinez, 68, is post-operative day 1 after abdominal surgery on 4 North.

It is 6:52 p.m. on 4 North. Jamie Carter is still the nurse responsible for Elena Martinez in room 412, and her medical record number ends in 4821. The shift handoff has not yet taken place. At 6:45 Jamie called covering physician Dr. Alex Morgan about Ms. Martinez's new confusion and changed vital signs.

Ms. Martinez has a history of hypertension, and her usual blood pressure medication was held this morning. She was alert, oriented, and conversing normally earlier in the shift.

Jamie is concerned that the current change may represent deterioration. For this fictional exercise, the unit team has already identified the change as needing review by the covering physician.

For this fictional exercise, an evening complete blood count was drawn at 6:10 p.m. Riley Nguyen, laboratory technologist, telephones the result, reported 6:52 p.m., to the unit. Hemoglobin was 12.4 g/dL on the morning before surgery and is 6.8 g/dL on this draw. The laboratory reports it as a critical value under its own policy and requires a read-back. That designation is a condition of this exercise, not a statement about what hemoglobin value is critical in general.

The 6:45 commitment stands: Dr. Morgan will assess Ms. Martinez at the bedside by 7:00 p.m., a complete vital-sign set is due at 6:50 p.m., the responsible nurse is to remain with the patient until the oncoming nurse has taken over at the 7:00 p.m. shift change, and to call Dr. Morgan sooner if she becomes less responsive or her blood pressure falls further. Dr. Morgan is about two minutes from the unit. That vital-sign set is not part of this recording.

Vital sign	2:00 p.m.	6:45 p.m.
Blood pressure	128/76 mmHg	96/58 mmHg
Heart rate	82/min	112/min
Respiratory rate	16/min	22/min
Oxygen saturation	97% on room air	95% on room air
Temperature	98.4 degrees Fahrenheit	98.8 degrees Fahrenheit

Current status: Ms. Martinez is now confused, feels clammy, and reports dizziness when she sits up.

Controlled-design note: The recording contains two calls: the laboratory to Jamie, then Jamie to Dr. Morgan. Dr. Morgan's commitment from the 6:45 call is already in force. It is part of the controlled exercise, not a treatment recommendation.

The exercise begins after the fictional unit has identified the covering-physician call as one required communication step. The critical designation belongs to the fictional laboratory's policy. The exercise does not model whether a rapid-response or code process should also be used, and no part of it asks what the hemoglobin value means clinically.

PRIVATE CHECK – MARK BEFORE DISCUSSION

Listen to both calls, then make five private judgments about the second call in particular, and note where the first call helps you judge the second. There is no score or expert answer.

1. Was the priority or reason for the call or handoff clear early?

Clear ☐ Needs discussion ☐ Not sure ☐

2. Was enough relevant background provided, without unnecessary detail?

Clear ☐ Needs discussion ☐ Not sure ☐

3. Did the speaker state an assessment or concern, rather than only reporting facts?

Clear ☐ Needs discussion ☐ Not sure ☐

4. Was the expected next step clear, including its urgency or by-when?

Clear ☐ Needs discussion ☐ Not sure ☐

5. Did the receiver confirm who would do what and by when?

Clear ☐ Needs discussion ☐ Not sure ☐

Selections are private prompts, not a score. Name the words you heard before naming your judgment.

DISCUSSION LENS – GENUINELY DEBATABLE – NOT AN ANSWER KEY

A Critical Result While the Physician Is En Route

What was confirmed, and what remains uncertain?

Two calls in one recording. The laboratory phones a critical result and Jamie receives it with a complete read-back. Jamie then relays it to a physician who is two minutes away. The five judgments apply to the second call; the first call is evidence you can use.

0:20 – A read-back, not an acknowledgement

Jamie reads back the patient identifiers, hemoglobin value with units, and draw time, then states the receipt time. Riley confirms the read-back and receipt time.

Discuss: What makes this a read-back rather than an acknowledgement? Which of these elements, if any, would you expect to hear again when the result is passed to the physician thirty seconds later?

0:40 – The result travels, and an arrival is confirmed

The result reaches the physician accurately, with the previous value, and the physician confirms arrival.

Discuss: What has been confirmed at the end of this call? What remains uncertain? What happens if Dr. Morgan does not arrive within the stated two minutes, and who would say so?

RECORDING 7 – DISCUSSION LENS CONTINUED

RE-TEACHING TARGET

Relay a critical result as clearly as it was received, confirm that the receiver has it, and know what you will do if the confirmed next step does not happen on time.

COMMUNICATION TENSION

Closed-loop communication of a critical result is about receipt, acknowledgement, and follow-through. The first call shows receipt and acknowledgement done fully. The second shows a result stated clearly and an owner confirming arrival, with the acknowledgement of the value itself left implicit and the contingency unspoken. Whether that is enough when the physician is two minutes away, and whether it would still be enough if the two minutes became twenty, is the discussion. The two minutes is a stated commitment, not a safe waiting period.

Reasonable alternatives:

The primary reading on the ownership judgment is Clear: Dr. Morgan names the owner, the action, and the time, and the bedside assessment agreed at 6:45 is still in force. An educator may select Needs discussion instead, on the grounds that confirming arrival does not explicitly reconfirm the assessment. Educators will differ on whether an arrival that was already promised carries the assessment with it, or whether a reply should say so again once new information has been reported.

Whether the value itself was confirmed as heard, and what happens if the expected arrival does not occur, are separate questions. They belong to the case-specific prompt, not to the ownership judgment.

The critical designation in this recording is the fictional laboratory's policy. No part of this lens asks whether the value is critical or what it means clinically.

ALSO WORTH DISCUSSING

– What understanding and follow-through were actually confirmed? Separate three things: whether the physician received the value, whether the physician understood it as the caller meant it, and what the physician will do about it and when. Then ask what happens if Dr. Morgan does not arrive within the stated two minutes, and who would say so? A promised arrival does not suspend assessment: deterioration can require action before either time.

FIVE-MINUTE REPLAY

1. Keep the first call unchanged.
2. Add at most one sentence to the end of the second call, from either speaker, that confirms the value was heard or names what happens if the physician does not arrive within the stated two minutes. No clinical instruction may be added.
3. Ask a third person to play the other speaker and reply.
4. Replay both endings and ask which one leaves a clearer record of what was confirmed and what was still open.

REUSABLE FACILITATOR SHEET

Listen. Judge. Discuss. Replay.



Use this sheet with any of the seven recordings or with an institution-reviewed handoff of your own. Keep judgments private until everyone has marked a response.

Pack URL: <https://medical.linguacopilot.in/guides/sbar-audio-handoff-discussion-pack>

Case or recording: _____ Date: _____

Participants or group: _____

Private judgment	Clear	Needs discussion	Not sure	Words or moment that support your view
Was the priority or reason for the call or handoff clear early?	☐	☐	☐	
Was enough relevant background provided, without unnecessary detail?	☐	☐	☐	
Did the speaker state an assessment or concern, rather than only reporting facts?	☐	☐	☐	
Was the expected next step clear, including its urgency or by-when?	☐	☐	☐	
Did the receiver confirm who would do what and by when?	☐	☐	☐	

Where did judgments differ, and which exact words produced the difference?

What is the narrowest communication behavior to re-teach?

What will participants change in the replay?

Reminder: This sheet supports formative communication discussion. It is not a validated assessment or a substitute for local clinical and escalation policy.