Three-way Repeat-Back and Read-Back

Error types prevented in the Generic Error Modeling System (GEMS)

Skill-based	Rule-based	Knowledge-based
Slip	**Wrong rule**	Decision-making
Lapse	**Misapplication**	Problem solving
Fumble	Non-compliance	

Note: Primary shown in bold red: secondary shown in red.

The least you should know

- Complete and accurate communication is a practice habit that ensures that we understand the patient we are asked to care for and/or the task we are asked to do. This understanding is called *situational awareness*.
- Clear communication is the best way to maintain situational awareness. And since patient safety is our first priority, we will be repeating important information, especially orders, to ensure that we heard what was said.
- Repeat-back is all oral communication and can be used over a wide range of communications. Read-back is a related practice. Read-back includes documenting the information and reading what was documented back to the sender. Read-back is required by hospital policy for telephone orders and critical lab values.

A Three-way Repeat-back

Sender initiates using receiver's name

Receiver acknowledges with "I understand…"

(… and repeats the message verbatim)

Sender acknowledges with "that's correct"

"Let me repeat that back"

How should we use this tool?

- Use repeat-back for oral communications where precise detail must be communicated as well as meaning. The correct response for sender acknowledgement is "that's correct." Do not say "right" because this can be interpreted as a laterality instead of an acknowledgement.

Did you know?

1. The word communication comes from the word commune – to be as one, as in "one in thought."
2. Repeat-backs ensure authenticity of communication – you heard it the way I said it.
3. Use repeat-backs and clarifying questions together. Clarifying questions ensure understanding.

A Case in Point

A 50 y.o. M in ICU had a blood glucose of 27. The CNA immediately reported this value to the nurse, who thought the CNA said 527. The nurse asked the CNA to repeat the blood glucose. The second blood glucose was 29, which was reported to the nurse as "the same." The nurse then obtained a telephone order for insulin; she should have obtained an order for D50.