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Patient Safety Tip of the Week

September 29, 2020

ISHAPED for Nursing Handoffs

We've covered just about every type of handoff in healthcare in our previous columns (see the full list below) and touched upon almost every one of the mnemonics for those handoffs. But one we have never discussed is ISHAPED.

ISHAPED stands for Introduction, Story, History, Assessment, Plan, Error-Prevention, and Dialogue. It is a format that has been used in shift-to-shift nursing handoffs at the bedside. At Seattle Children's Hospital shift-to-shift handoffs were not considered to be problematic but anecdotal concerns had been raised regarding **handoffs between departments** (intensive care to acute care, emergency department to acute care, etc.). A prior systematic review (Ong 2011) had also found that exposure of handoffs at patient transfers presented challenges that are not experienced in inter-shift handoffs. So, clinicians and researchers at Seattle Children's Hospital (Stimpson 2020) implemented a modified ISHAPED (m-ISHAPED) tool to align the content shared and the expectations for interdepartmental handoffs. Their quality improvement team and relevant stakeholders studied multiple handoff tools and ultimately chose ISHAPED as the one to use for interdepartmental handoffs.

The original ISHAPED tool was developed by the Inova Health System (Friesen 2013). The original ISHAPED tool from Inova Health is available on the IHI (Institute for Healthcare Improvement) website. Because the original tool was intended for shift-to-shift bedside handoffs, the Seattle Children's team modified it for interdepartmental handoffs and pediatric patients. The resultant m-ISHAPE Form is available on the web: http://links.lww.com/JNCQ/A671.

Their implementation plan included 4 key elements:

1. Creation of a job aid, intended to be used as a reference at the time of handoff
2. Creation of an education plan that leveraged preexisting annual nurse education time. The education consisted of a short didactic section, a video demonstrating the process in action, and time for the nurses to practice using it with short scenarios;
3. Creation of a superuser support plan for the first week of go-live. Nurses who were involved in the project received additional training to support the new practice change;

4. K-card audit and coaching, which included realtime coaching, and collection of feedback from the nurses.

They then implemented the new interdepartmental handoff process and the m-ISHAPED tool across the ED, acute care units (medical, surgical, and oncology), ICUs (pediatric, cardiac, and neonatal), rehabilitation unit, postanesthesia care unit (PACU), inpatient psychiatric unit, and ambulatory infusion area.

Audits revealed the process was widely adhered to and the tool used correctly 82.6% of the time. Handoff failures were identified as having incorrect or missing information or resulting in a delay, omission, or delivery of inappropriate care. The rate of handoff failures fell from 6.84 per 100 patient days pre-implementation to 1.57 per 100 patient days post-implementation ($P < .001$). Nurse satisfaction with the handoff process improved from 81.1% pre-implementation to 90.6% post-implementation ($P < .001$).

The authors note that some nursing units and departments have begun using the tool for shift-to-shift handoffs as well.

We note that the tool conveys a tremendous amount of information. Hence, some of the important considerations for any handoff apply, such as allowing ample time, doing the handoff in a quiet environment devoid of interruptions and distractions, and allowing the receiver to ask questions and seek clarification. Importantly, the tool emphasizes the use of "**repeat-back**". When Inova originally developed ISHAPED they also identified multiple best practices for handoffs, including use of face-to-face communication, use of written documentation, and importance of read-back. They also emphasized that handoffs involve not only the transfer of information but also the unambiguous **transfer of responsibility**.

So go ahead and add ISHAPED as one more option to choose from when you are looking at improving your handoffs, particularly your interdepartmental handoffs.

Read about many other handoff issues (in both healthcare and other industries) in some of our previous columns:

May 15, 2007	"Communication, Hearback and Other Lessons from Aviation"
May 22, 2007	"More on TeamSTEPPS™"
August 28, 2007	"Lessons Learned from Transportation Accidents"
December 11, 2007	"Communication…Communication…Communication"
February 26, 2008	"Nightmares….The Hospital at Night"
September 30, 2008	"Hot Topic: Handoffs"
November 18, 2008	"Ticket to Ride: Checklist, Form, or Decision Scorecard?"
December 2008	"Another Good Paper on Handoffs".
June 30, 2009	"iSoBAR: Australian Clinical Handoffs/Handovers"
April 25, 2009	"Interruptions, Distractions, Inattention…Oops!"
April 13, 2010	"Update on Handoffs"
July 12, 2011	"Psst! Pass it on…How a kid's game can mold good handoffs"

July 19, 2011 "Communication Across Professions"
November 2011 "Restricted Housestaff Work Hours and Patient Handoffs"
December 2011 "AORN Perioperative Handoff Toolkit"
February 14, 2012 "Handoffs – More Than Battle of the Mnemonics"
March 2012 "More on Perioperative Handoffs"
June 2012 "I-PASS Results and Resources Now Available"
August 2012 "New Joint Commission Tools for Improving Handoffs"
August 2012 "Review of Postoperative Handoffs"
January 29, 2013 "A Flurry of Activity on Handoffs"
December 10, 2013 "Better Handoffs, Better Results"
February 11, 2014 "Another Perioperative Handoff Tool: SWITCH"
March 2014 "The "Reverse" Perioperative Handoff: ICU to OR"
September 9, 2014 "The Handback"
December 2014 "I-PASS Passes the Test"
January 6, 2015 "Yet Another Handoff: The Intraoperative Handoff"
March 2017 "Adding Structure to Multidisciplinary Rounds"
August 22, 2017 "OR to ICU Handoff Success"
October 2017 "Joint Commission Sentinel Event Alert on Handoffs"
October 30, 2018 "Interhospital Transfers"
April 9, 2019 "Handoffs for Every Occasion"
November 2019 "I-PASS Delivers Again"
August 2020 "New Twist on Resident Work Hours and Patient Safety"

Some of our prior columns on intrahospital transports and the "Ticket to Ride" concept:

- April 8, 2008 "Oxygen as a Medication"
- November 18, 2008 "Ticket to Ride: Checklist, Form, or Decision Scorecard?"
- August 11, 2009 "The Radiology Suite…Again!"
- March 13, 2012 "Medical Emergency Team Calls to Radiology"
- August 25, 2015 "Checklist for Intrahospital Transport"
- September 1, 2015 "Smarter Checklists"
- November 2016 "Oxygen Tank Monitoring"
- February 2018 "Oxygen Cylinders Back in the News"
- May 22, 2018 "Hazardous Intrahospital Transport"
- October 30, 2018 "Interhospital Transfers"
- March 31, 2020 "Intrahospital Transport Issues in Children"
- June 23, 2020 "Telemetry Incidents"
- July 14, 2020 "A Thesis on Intrahospital Transports"
- August 4, 2020 "Intravenous Issues"

References:

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Stimpson M, Carlin K, Ridling D, Implementation of the m-ISHAPED Tool for Nursing Interdepartmental Handoffs, Journal of Nursing Care Quality 2020; 35(4): 329-335 https://journals.lww.com/jncqjournal/Abstract/2020/10000/Implementation_of_the_m_ISHAPED_Tool_for_Nursing.8.aspx

Friesen MA, Herbst A, Turner JW, Speroni KG, Robinson J. Developing a patient-centered ISHAPED handoff with patient/family and parent advisory councils. J Nurs Care Qual 2013; 28(3): 208-216 https://journals.lww.com/jncqjournal/Abstract/2013/07000/Developing_a_Patient_Centered_ISHAPED_Handoff_With.3.aspx

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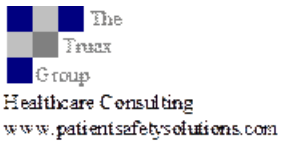
m-ISHAPE Form. Seattle Childrens' Hospital. http://links.lww.com/JNCQ/A671



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