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Developing a Patient-Centered ISHAPED Handoff With Patient/Family and Parent Advisory Councils

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Our hospital system used Lean strategies to develop a new process for the change-of-shift bedside handoff titled ISHAPED (**I** = Introduce, **S** = Story, **H** = History, **A** = Assessment, **P** = Plan, **E** = Error Prevention, and **D** = Dialogue). Several teams collaborated with a Parent Advisory Council and a Patient/Family Advisory Council to design a study to explore patient perceptions of the handoff. The findings from the study along with recommendations from the councils were used to develop education modules on implementing patient-centered handoffs. **Key words:** *bedside handoff*, *bedside shift report*, *communication*, *handoff*, *patient and family*, *patient-centered care*, *shift report*

HANDOFFS represent a challenging and complex communication process encountered by nurses in the provision of patient care. If not well executed, handoffs can place patients at risk as well as compromise the communication process between nurses.[1,2] A *handoff* is a process that supports the transmission of information and the transfer of responsibility during care transitions.[3] Findings from the Hospital Survey on Patient Safety Culture as reported by the Agency for Healthcare Research and Quality reveal that handoffs receive low safety scores across the nation: 44% (in 2009)[4] and 45% (in 2012).[5]

Handoffs are fraught with multiple problems, including data omission, lack of structure, and lack of access to data.[1,2] Inadequate, incorrect, or unclear handoffs place patients at risk for harm,[6-8] yet there is limited published research on best practices for handoffs within nursing[9] and the hospital environment.[10] A research study on simulated handoffs indicated that the use of a preprinted computer report combined with verbal report was associated with increased transmission of patient data.[11] Evidence-based recommendations for best practice include face-to-face communication, addressing the plans of care, and standardized documentation.[12]

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Handoffs need to be engineered in a manner that will optimize communication, maximize efficiency, and support the delivery of safe, patient-centered care. Handoffs have been examined in settings other than health care. Evidence-based strategies have been used in "high-risk" industries such as the nuclear industry.[13] The current inpatient environment presents unique challenges to the implementation of non–health care handoff strategies; handoffs in the health care setting pose several research opportunities.

BEDSIDE CHANGE-OF-SHIFT HANDOFF

One type of handoff within health care involves the nursing change-of-shift handoff or report. MEDLINE and CINAHL databases were searched using the terms "handover," "handoff," "shift report," and "changeover." References in retrieved articles were reviewed for other related publications. The literature reveals a variety of methods used in the change-of-shift report, including verbal, bedside, and recorded.[1,12] An increasingly important area is the inclusion of the patient in the handoff process by having the handoff take place at the patient's bedside.[14] The inclusion of the patient in the handoff process can support patient safety by allowing the patient and family to participate in the handoff to better understand their care[15] and communicate with the nurses during the transition in care.[16]

There have been a variety of reports supportive of bedside handoff. In one study in an adult acute care unit, authors reported "increased patient, staff, and physician satisfaction"[17(p117)] and financial savings after switching to a bedside handoff.[17] In a sample of 40 patients, more than 90% surveyed indicated satisfaction with the bedside handoff and all reported confidentiality handled with sensitivity at the bedside.[18] Perceptions by nurses of improved patient safety, improved staff accountability, and reassurance of patients were reported in a stroke rehabilitation unit after implementation of a bedside handoff.[19] Other reports have indicated patient satisfaction with implementation of a bedside handoff report.[20-22]

Patient perceptions of the handoff process have also been explored.[14] One such study found that patients do not always understand the terms used by nurses in handoffs.[23] Additional challenges to patients may include fatigue or inability to focus during the interaction.[24] The Joint Commission promotes patients speaking up and conveying concerns.[25] A bedside handoff that supports open communication between the patient and the health care provider presents a positive scenario for both the patient and the nurse[26] and can be a useful strategy to enhance patient engagement.[27]

CREATION OF ISHAPED

A multihospital system with 5 hospital campuses and more than 5000 nurses evaluated the handoff processes within the system. Internal findings indicated opportunities for improving the handoff process between shifts. One key finding was that the predominant handoff method was a telephone report, which did not support an optimum face-to-face communication; a second major finding was that no standardized approach existed across the system.

In response to these findings, the health system leaders assembled a performance improvement (Kaizen) team in 2010. The team consisted of 13 nurses representing various clinical areas from the 5 hospitals in the system, 2 facilitators who had expertise in Lean techniques, a project manager, and a communications expert. Communication theory and the state of the science related to handoffs were reviewed, including best practices from the literature. The team developed a charter and was charged with analyzing various handoff methods that have been tried with success, selecting a guiding method for patient handoffs, and drafting a deployment plan for the new handoff method.

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The team undertook a deliberate process to assess various handoff methods. A Pugh Matrix,[28] also known as a criteria-based matrix, was used to rate 6 handoff methods. The team developed 13 criteria considered essential for assessing a change-of-shift handoff method. The most important criteria were more heavily weighted, and the highest scoring method of the 6 methods assessed was selected by the team. The criteria developed by the team are listed in Supplemental Digital Content Figure 1 (available at: http://links.lww.com/JNCQ/A7). The method selected by the team was designed to convey critical change-of-shift information, decrease risk of omissions, and engage the patient in the handoff communication during shift change. The method incorporated a standard template, customizable for different inpatient units, to support a universal handoff process. The new method, titled ISHAPED (**I** = Introduce, **S** = Story, **H** = History, **A** = Assessment, **P** = Plan, **E** = Error Prevention, and **D** = Dialogue), provides a structure for guiding the communication between staff. Elements of ISHAPED are described in Table 1.

The ISHAPED model was piloted in 2010, and modifications were made to the process. It was recommended that the IPED elements of the ISHAPED method should always occur at the bedside, whereas the SHA elements may occur away from the bedside, depending on the patient situation and professional discretion. A flow diagram of the ISHAPED method is depicted in Supplemental Digital Content Figure 2 (available at: http://links.lww.com/JNCQ/A8).

The implementation of ISHAPED represented a major change for the organization. In addition, diffusion of the ISHAPED innovation varied across the system and opportunities for more actively engaging the patient in the process were identified. Observing the difficulty in including the patient in a traditionally nurse-centered process highlighted a greater need for a paradigm shift toward a more holistic, patient-centered focus. An enhanced focus on patient engagement in the handoff was needed.

Table 1. The ISHAPED model

I	*Introduce*: The outgoing nurse introduces the incoming nurse to the patient. This includes verification of the patient's identity, AIDET®[a] (A—Acknowledge; I—Introduce; D—Duration; E—Explanation; T—Thank You);[34] and information introducing the patient.
S	*Story*: Review the event(s) or circumstance that prompted the patient's admission to the hospital, including diagnosis and/or reason for admission.
H	*History*: Review the patient's medical history, especially details relevant to the hospitalization.
A	*Assessment*: Review the patient's current condition and status, including a system review appropriate for the patient's clinical status.
P	*Plan*: Review the plan of care, including daily goals or shift goals (eg, pain management, patient education), discharge plan, and, if applicable, core measures.
E	*Error Prevention*: Review the potential safety issue(s) specific to the patient. Communicate high risk and critical information including, but not limited to, any precautions (eg, falls, aspiration).
D	*Dialogue*: Throughout the report there is a discussion involving the nurse and the patient. Nurses encourage the patient to ask questions and provide feedback.

[a]AIDET® is a registered trademark of Studer Group.

Patient-centered perspective

The Institute of Medicine defines *patient-centeredness* as:

Healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need

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to make decisions and participate in their own care.[29(p41)]

To this end, a nursing research team was convened to study patient and parent perspectives of the bedside ISHAPED process. The team applied for and received a Picker Institute Always Events Challenge Grant. An Always Event is defined as "those aspects of patient and family experience that should always occur when patients interact with health care professionals and the delivery system."[30] Bedside patient-centered handoffs should be an Always Event. Input from patients and families would be used in further development of the ISHAPED process. Their perspective was deemed critical in designing a process that would be patient- and family-centered.

To engage patients and families as advisors for the project, a series of steps were implemented. First, a plan was developed to assess patient perceptions. Second, the research team convened a Patient/Family Advisory Council, a volunteer group consisting of adult patients and families of adult patients. Third, the researchers invited the newly created Patient/Family Advisory Council and a preexisting Parent Advisory Council to collaborate with researchers, educators, and clinical staff to develop a study with a survey and interview questions to obtain the patient perspective about handoffs. Finally, teams were formed to address implementation of educational programming and system process changes needed to support a patient-centered handoff.

Pilot study

The aim of this study was to explore patient perceptions of the ISHAPED bedside change-of-shift report process via survey and patient interviews and to identify opportunities for improvement. The perspective of the patient would be used to inform the nursing education process to support patient-centered handoffs at the change of shift.

METHODS

The study population was derived from 8 hospital units across a multihospital system that piloted the ISHAPED handoff process. The 8 units included 1 obstetric, 2 pediatric, and 5 medical units. A team of 8 nurse researchers surveyed and interviewed patients or parents of patients. Scripts were developed to guide these interviews. A convenience sample of 93 adult patients and 14 parents of pediatric patients who experienced a bedside report, were able to communicate in English, and were able to provide informed consent were surveyed. The participants completed demographic information and 11 survey questions using a 5-point Likert scale (ranging from 1 = strongly disagree to 5 = strongly agree). Item means and frequencies were used to analyze responses.

A subcohort of 16 patients and 6 parents from these same units were interviewed using a semistructured interview guide. The principal investigator and 2 nurse researchers who completed study-specific training conducted in-depth interviews with patients and parents. The Interview Guide Questions asked patients and parents the following: 1. could you please describe what the nurses did and talked about during the bedside change of shift report? 2. how does having a bedside change of shift report make you feel? 3. please tell me if you think the nursing bedside change of shift report gives you confidence that your (or your child's) care is well coordinated and is being administered safely? 4. do you like having the nurses provide a bedside change of shift report so you can hear the outgoing nurse's report? 5. what is most important to you about the bedside change of shift report process? 6. how can the bedside change of shift report process be improved? 7. did you have any concerns with your privacy during the bedside change of shift report? 8. did you have any concerns with the bedside change of shift report? The interviewers used additional prompts such as "Could you tell me more about that?" as needed to encourage the interviewees to expand on answers.

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All interviews were recorded, transcribed verbatim, and downloaded into Nvivo 9 software (version 9, 2010; QSR International Pty Ltd, Doncaster, Victoria, Australia) for analysis. To protect patient confidentiality, a pseudonym selected by the patient or parent was used in the interview. The transcripts were reviewed and coded by the principal investigator. A sample of interviews was coded by 2 other members of the research team, and an outside consultant performed a coding check with the principal investigator.

Qualitative analysis was conducted using a line-by-line technique and constant comparative method.[31] Each section of the text was coded with 1 or more codes; codes were derived from participants' words. Codes and assigned text were rechecked to assess their coding consistency. A communication expert reviewed all transcripts, and themes were agreed on by consensus of the research team.

RESULTS

Survey

Overall, mean scores by patients regarding the ISHAPED process ranged from 3.6 to 4.6, with 9 of the 11 survey questions answered at 4 or above (from 1 = strongly disagree to 5 = strongly agree). The parent group also rated the same 9 questions above 4 (Table 2).

Themes

Five themes emerged from the data analysis. *Theme 1 was introducing the new nurse*. A prevailing theme identified among the narratives was the importance of an introduction to the new nurse coming on shift, as illustrated in the following quote: "They really went out of their way to introduce me to the new nurses to explain that they were changing over. It was very reassuring."

Theme 2 was knowing through collaboration and communication. The concept and act of knowing was a thread seen through narratives, encompassing more than only the transmission of facts. The importance of synthesizing information received through collaboration and communication is a component of the handoff observed by patients.

> It just lets me know that everybody is staying on top of what's going on with my case . . . . Everybody that's involved in a patient's care should be paying attention and listening to what happened to that person the night before, and then they can know what to expect during the day.

Theme 3 was engaging the patient to participate and provide their perspective. The act of sharing information allows patients to be "in the loop with everybody else," which is essential to patient involvement and can provide the opportunity for the patient to be kept abreast of information. One patient commented, "It definitely makes me feel more comfortable knowing that I know what's being communicated to the next shift and can voice in if I agree or disagree or have something I want to add." A critical aspect of this patient-centered bedside change-of-shift report supports a converse paradigm from the "not knowing" of information or the transmission of information in a "secret" location. This is reflected in the following statement by a patient: "I've been in the hospital many times, and this is the first time that that has been done. In the past, [they would] go to a secret room and talk about you."

Theme 4 was educating health care providers. The narratives of patients can be used to inform and educate nurses about strategies that can be implemented to improve the bedside report from a patient's perspective. The aspect of explaining what is not understood was observed. For example, the use of the white board in the patient room to write information needed by the patient is a strategy that helps a patient "know." A patient stated: "For the things that I didn't understand, she broke it down for me and told me what it was as far as all the tests that they had done and so forth." Another patient noted, "You know, I love this board [white board]. This board is absolutely wonderful. It lets me know who I can contact for whatever."

Patients provided insights that could be beneficial to nurses seeking to provide

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Table 2. Patient and Parent Perceptions of Change-of-Shift Report Process (Mean Scores)[a]

Survey Item	Patient (n = 93)	Parent (n = 14)	Combined Descending Order (N = 107)
I liked being introduced to my new nurse at the end of the shift	4.60	4.81	4.64
I like having the nurses provide a bedside change-of-shift report	4.43	4.75	4.48
The nurses were knowledgeable about my care during the bedside change-of-shift report	4.44	4.63	4.47
I would rather the nurses NOT exchange information at my bedside[b]	4.36	4.81	4.43
I felt comfortable asking questions during the bedside change-of-shift report	4.28	4.75	4.36
The nurses exchanged information with me using words I could understand	4.32	4.50	4.35
The bedside shift-to-shift report process between nurses made me think that the nurses were really paying attention to me and my health needs	4.31	4.25	4.30
The nursing bedside change-of-shift report gives me confidence in the health care I received	4.13	4.44	4.18
I felt like the bedside shift-to-shift process allowed me to contribute to my health care	4.07	4.13	4.07
I learned more about my condition and plan of care during the bedside shift-to-shift report	3.97	3.69	3.93
The nurses reviewed today's goals and wrote the plan of care on the white board	3.71	3.19	3.64

[a]Scale from 1 = strongly disagree to 5 = strongly agree. Scores based on the number of answers provided.
[b]This item has been reversed to reflect positive response.

patient-centered care. Comments from patients indicate that the role of the patient should not be passive and can support improved communication. By partnering patients and nurses, the patient's unique issues and perspectives can be addressed. A patient explained, "I would feel a lot safer if it's presented in front of me. Talk to me about it. Educate me."

The final theme, *theme 5, was managing privacy*. An issue that is reported in the literature on the subject of bedside reports is the concern with maintaining patient privacy during the handoff.[14,18,23] One of the interview guide questions addressed whether patients were concerned about privacy during the bedside report. There was an acknowledgment of challenges with hard-of-hearing patients in semiprivate rooms and sensitive topics. The advantage of a report in a patient room versus the hallway was noted by one patient: "They don't speak loudly, and it's done in my room and not in the hallway. That makes me feel better." Another perspective by patients suggested that the need to know information about their care is more important

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than concerns they may have about privacy. "No, when you are sick, there is no privacy. Everyone needs to know what is going on".

APPLICATION IN THE CLINICAL SETTING

The results from the surveys and interviews were reviewed with the Patient/Family Advisory Council and the Parent Advisory Council. Both of these councils provided insight and recommendations for developing educational modules on patient-centered handoffs for nurses. Subsequently, an ISHAPED tool kit was developed, which included education resources and video vignettes demonstrating patient-centered handoffs for various clinical areas. Leadership was strongly supportive of the education initiative at each hospital and throughout the system. The senior vice president/chief nurse executive appeared in the educational videos, and the professional practice divisions and nursing education department collaborated in the education rollout. The education program has been deployed across the inpatient units in the system, and a new electronic record is being implemented that includes the ISHAPED template to support patient-centered bedside handoffs.

Implications for practice

The councils not only helped develop survey and interview guides but also collaborated in the development of nursing education modules on patient-centered handoffs. Working with the Patient/Family Advisory Council and the Parent Advisory Council was transformative and paradigm shifting, as this collaboration between consumers and health care providers created and supported the open exchange of ideas while providing opportunities to clarify needs and set new expectations.

A patient-centered handoff is not a 1-way communication or even a 2-way communication. Optimal handoffs involve conversation among a dynamic triad consisting of the outgoing nurse, the incoming nurse, and the patient/family. The interaction supports a more robust communication process by creating an opportunity to discuss, clarify, and confirm information, reiterate error prevention, and agree on the plan of care for the shift. It is essential for health care providers to have an "opportunity for discussion between the giver and the receiver of patient information."[32] Interaction provides the opportunity to seek clarification and ask questions, which is important in the communication process.

With the introduction of the patient-centered philosophy, a need to more actively and intentionally engage the patient and the parent was observed. Nurses needed education on how to conduct a patient-centered handoff. Behaviors that nurses may not value or think are important may have a different meaning for patients. The comments by patients provided an understanding of their perspective. Patients explained how valuable it was to know what was happening and to be included in the discussion. Using the patients' actual words in the nursing education modules was a powerful adjunct in underscoring the value of a patient-centered bedside handoff. Nurses may not always be aware that patients value knowing the nurses are communicating with each other and ensuring the continuity of care. While hearing what is going on is important, even more important is engaging the patient so that they can provide information to the nurses.

Implications for quality improvement

The survey was used to assess perceptions of the "new" bedside handoff from the patient perspective, and the patient interviews provided a richer understanding of the handoff experience. The data were used internally by several teams including the education team and performance improvement team. Together, the teams addressed opportunities for improvements, focusing efforts on further developing and implementing a patient-centered handoff. An effort of this nature requires leadership support and experts from an array of disciplines with varying skill sets. To deliver safe and effective patient-focused handoffs, processes and systems need to be

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in place to support the nurses. It is recommended that ongoing monitoring of the handoff process occurs to identify barriers or challenges that can be addressed to support patient-centered care.

Implications for research

Further research is needed to determine the most effective techniques for supporting patient-centered handoffs in different patient populations and settings. Research questions to consider in future studies include the following: "What types of systems optimally support a handoff and encourage a true interaction between patients and nurses?" "How does a bedside handoff impact the patient perception of the overall quality of care provided?" "Are there certain techniques that should be used in handoffs that are more patient-centered than other techniques?" "How does a bedside handoff influence nurse-to-nurse interaction?"

Limitation

This was a pilot study conducted in 1 multihospital system, using a convenience sample. The findings may not be applicable to other settings.

CONCLUSIONS

Failing to provide the patient an opportunity to hear and participate in the change-of-shift report is not patient-centered, as the patient is intentionally or unintentionally deprived of an opportunity to "know." Nurses need to advocate for patients by removing barriers that restrict the patient voice from being heard. Processes in health care facilities should be designed to encourage and not stifle patient-centered communication. ISHAPED is a model that can be used to support a patient-centered communication process.

More research is needed to gain a better understanding of patient needs regarding information, the system(s) to support optimal patient-centered handoff, and performance improvement activities to enhance and sustain the patient-centered handoff. A resource in gaining an understanding of the patient and family perspective is to collaborate with the Patient/Family Advisory Council and the Parent Advisory Council in the design of a patient-centered process. Engaging the patient in the discussion or planning is critical to this communication process; a motto of "nothing about me without me" should be heeded.[33]

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