I-PASS with SAFETY: System Wide Implementation of RN Bedside Handoff
Nicole Lincoln MSN, RN, APRN-BC; Katherine Scanlon MSN, RN, APRN-BC; Kristen Kremer MPH, MA; Karen Villanova BSN, RN

BACKGROUND
Healthcare organizations are increasingly utilizing patient-centered approaches to nursing handoff by shifting to the bedside and engaging patients in their care. The purpose of this quality improvement (QI) project was to improve the accuracy of communication during nursing handoff with the goal of enhancing patient safety and satisfaction on a cardiac interventional floor at an inner city safety net academic medical center.

AIM
• Improve patient safety and decrease adverse events on the pilot unit by 25%
• Engage the patient during bedside handoff to improve nurse-patient communication
• Improve patient satisfaction (HCAHPS scores) by a minimum of 8 points in the communication with nursing domain
• Increase efficiency and accuracy of handoff with a goal of <7 minutes per patient handoff
• Decrease fall rate by 25% by reinforcement of increased risk to fall, individualized plan of action, and toileting
• Improve nurse accountability and satisfaction with communication during shift handoff

METHODS
• Conducted a 90-day rapid cycle improvement project on a cardiac interventional medical floor
• I-PASS mnemonic was paired with the SAFETY acronym, which resulted in a standardized verbal format and provided a structured, consistent approach to nursing bedside handoff
• Unit champions created a 12-minute training video for unit staff
• Nurse manager and clinical educator were present during handoff to provide leadership support
• The standardized verbal report and structured bedside safety check were validated by performing observation-based audits
• Nurses surveyed post implementation to assess accountability, satisfaction and communication

RESULTS PILOT UNIT

<table>
<thead>
<tr>
<th>Nursing Perception (N=15)</th>
<th>Significantly Increased</th>
<th>Increase</th>
<th>No Change</th>
<th>Decrease</th>
<th>Significantly Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Accountability</td>
<td>23%</td>
<td>33%</td>
<td>47%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing satisfaction</td>
<td>7%</td>
<td>40%</td>
<td>53%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Patients knowledge about care</td>
<td>20%</td>
<td>53%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing Perception (N=15)</td>
<td>Much Better</td>
<td>Somewhat better</td>
<td>No Change</td>
<td>Worse</td>
<td>Much worse</td>
</tr>
<tr>
<td>Quality and Accuracy of Nursing Handoff</td>
<td>33%</td>
<td>67%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing Communication</td>
<td>47%</td>
<td>33%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

CONCLUSIONS
Implementing bedside handoff using I-PASS with SAFETY provided a standardized verbal handoff and a consistent structured bedside safety check. Involving frontline staff nurses in the development and implementation of this handoff process proved to be invaluable. The success of this project has led to a hospital-wide initiative implementing I-PASS with SAFETY as the standard for nursing bedside handoff.

HOSPITAL-WIDE DATA

SOLUTIONS TO IDENTIFIED BARRIERS
• To protect patient confidentiality in a double room setting, I-PASS occurs in the hallway outside of the patient’s room while SAFETY checks are done at the bedside
• Encouraged use of interpreter phone for patients with preferred languages other than English
• Assignments were made so that an RN would not be giving report to more than 2 nurses at handoff, thereby decreasing the time it took to complete the handoff process

NEXT STEPS
The organization is developing a concrete sustainability strategy utilizing:
• Regular observation-based auditing and real-time coaching of specific elements of I-PASS with SAFETY to reinforce key concepts
• A customized electronic nursing handoff tool is being developed to hardwire the I-PASS with SAFETY handoff process

Contact Nicole.Lincoln@bmc.org or Katherine.scanolon@bmc.org 3/2/2016