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| **INTRODUCTION**  *Blue Banner in CIS & Key Information Box (Patient Summary page)* |
| **STORY**  *Reference CIS as needed*   * Reason for Admission or Transfer 🡪 Stable or unstable? * Completed Care |
| **HISTORY**  *Documents/Notes*  Review last clinic/inpatient note, or ED Record |
| **ASSESSMENT**  *Nurse Overview tab*  Focused Assessment with Vital Signs (current, baseline & trend)   |  |  |  | | --- | --- | --- | | * Neuro | * Cardiac | * Psych/Social | | * Pain | * GI/Diet | * Mobility/Skin | | * Respiratory | * GU/ I&O |  |   □ Lines/Drains/Tubes  □ *eMAR (or Peri-Op Summary page) 🡪* Overdue or Non-routine Medications  □ *Lab tab 🡪* Abnormal Lab Values |
| **PLAN**   * Next Steps or Immediate Plan-of-Care * Checklists * D/C Plan or Long-term Goals * Education Needs |
| **ERROR-PREVENTION**  *Key information box, eMAR (as needed)*  Review High Risk Items and Key Points   |  |  |  |  | | --- | --- | --- | --- | | * At risk for pressure ulcer | * Restraints | * High risk meds | * Other precautions |   Use Safety Tool, Repeat-back |
| **DIALOGUE**   |  |  | | --- | --- | | * Timeline for transfer | * Transport needs |   **Sending RN:** “Do you have any questions or concerns about this patient’s transfer?”  **Receiving RN:** stop-the-line if any safety concerns are present |

**Overview**

* ISHAPED will be used to guide every patient transfer between departments (not shift-to-shift hand-off)
  + *Participating units*: Acute Care, ICUs, Rehab, ANI, ED, PACU (pre/post op)
* Both nurses need to reference CIS together (see *italicized* orange text for where to reference CIS)
* Follow the order of the tool from top to bottom

**How to Use ISHAPED**

**Introduction:**

Introduce yourself and verify the patient’s identity.

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| * Patient Name * Age * Dose Calc Weight (DCW) * Allergies | * Code Status (only if other than Full Code) * Isolation Status (only if not standard precautions) * Interpreter needs, if applicable |

Are any caregivers present? NOTE: This is a yes/no question; do not ask for names/specifics

**Story:**

* Reason for Admission/Transfer (the current diagnosis)
  + Do you think this patient is stable or unstable?
* Review the completed care (Did the patient have any recent diagnostic tests, therapies, or procedures?)
* Is the patient on a CSW Pathway (ex: Asthma Pathway)?

**History:**

Discuss any history that may affect your patient’s care. You do not need to go in-depth.

**Assessment:**

Review your patient’s focused assessment stating “within normal limits” or reporting any abnormalities for each system. Be sure to incorporate vital signs (Temp, HR, Resp Rate, BP, SpO2%) when reviewing the corresponding system. Vital Signs should be reported as the current reading compared to the patient’s baseline and trend. Include any MPEWS triggers, if applicable.

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| * Mobility/Skin   + Any transfer/mobility needs   + Fracture risk? * Neuro * Pain   + Using a PCA or drip? * Respiratory   + Any Oxygen needs? | * Cardiac * GI/Diet   + NPO time, if needed * GU/ I&O * Psych/Social   + Family needs   + Mental health status, if applicable   + CASPER details & plan, if applicable |

* Does the patient have any lines, drains, or other tubes?
* Do they have any overdue meds, non-routine meds, or ones given in the OR? Explain.
* Any abnormal lab values?

**Plan:**

* Review next steps or immediate plan-of-care (ex: still needs an x-ray; needs a blood transfusion)
* Review any checklists that are applicable (ex: Pre-Op Checklist or ICU 🡪 Floor Checklist)
* State the plan for D/C or other long-term goals (ex: D/C when pain controlled for >24 hours on oral meds; needs a Central Line placed to begin chemotherapy)
* Any educational needs? What has been completed or what still needs to be done?

**Error-Prevention:**

Review any applicable high-risk items and/or key points including, but not limited to: pressure ulcer risk, precautions (ex: falls, CLC risk, Hazardous Drug, etc.), restraints, high risk medications, etc. Use **Repeat Back.**

**Dialogue:**

* Review the timeline for transfer and any transport needs
* *Sending RN*: ask, “Do you have any questions or concerns about this patient’s transfer?”
* *Receiving RN*: answer “no”, or ask to clarify (QVV), or use this as your moment to stop-the-line if you have safety concerns.
  + If you need to get additional information from a provider or consult another nurse (ARCC), ask that you call the sending RN back with clarification in 5-10 minutes.