1. PURPOSE

The purpose of this policy is three-fold:

1. To define transition of care (hand-offs, handovers, sign-out, or changeover) within a graduate medical education program
2. To establish criteria to ensure the quality and safety of patient care when transfer of responsibility occurs
3. To define the standards for program assessment of the transition of care protocol within individual programs

2. POLICY

Transition of care or handoff is defined as the communication of information to support the transfer of care and responsibility for a patient or group of patients from one provider to another. The transition of care process is an interactive communication process and involves the communication of specific and essential patient information from one caregiver to another.

Transition of care occurs under the following conditions:

1. Change in level of patient care, including inpatient admissions from an outpatient procedure or diagnostic area or transfer to or from a critical care unit.
2. Temporary transfer of care to other healthcare professionals within procedure of diagnostic areas.
3. Discharge to home or another facility such as an extended skilled nursing care facility.
4. Change in provider or service change including shift change for nurses, resident sign-out or rotation changes for residents.

The requirements for transition of care include:

1. Programs must design clinical assignments to minimize the number of transitions in patient care.
2. Sponsoring institutions and programs must ensure and monitor effective, structured handover processes to facilitate both continuity of care and patient safety.
3. Programs must ensure that residents are competent in communicating with team members in the hand over process.
4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.
3. SCOPE

This policy applies to all Indiana University School of Medicine (IUSM) GME resident physicians.

4. DEFINITIONS

4.1 ACGME is the Accreditation Council for Graduate Medical Education.

4.2 A resident is an IUSM resident or fellow, or a non-IUSM resident or fellow electively rotating through IUSM and provides clinical care as part of a GME program.

5. PROCEDURE

A. The Process

Face to face interaction with verbal and written or computerized communication is recommended with the opportunity for the receiver of the information to ask questions or clarify specific issues. Because breakdowns in communication are the most common reason for medical errors within teaching hospitals, it is paramount for optimal safe care of patients that residents involved in direct patient care undertake ideal communication with each other, specifically at the time of care transition. Literature has demonstrated reduction in medical errors from the use of ideal resident-to-resident handoff practices. Thus, the transition process should include, at a minimum, the following information in a standardized format that is universal across all services:

1. Identification of patient, including name, medical record number, and date of birth
2. Identification of admitting/primary physician
3. Diagnosis and current status/condition of patient
4. Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
5. Changes in patient condition that may occur requiring interventions or contingency plans

B. Program Requirements

Each residency program must develop components ancillary to the institutional transition of care policy that integrate specifics from their specialty field. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:

1. Residents do not exceed the 80-hours per week duty limit average over four (4) weeks.
2. Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
3. All parties involved in a particular program and/or transition process have access to one another’s schedules and contact information. All call schedules should be
available on department-specific password-protected websites and also with the hospital operators.

4. Patients are not inconvenienced or endangered in any way by frequent transitions in their care.

5. All parties directly involved in the patient’s care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.

6. Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.

7. Programs should provide an opportunity for residents to both give and receive feedback from each other or faculty physicians about their hand-off skills.

C. Program Review and Assessment

Each program must include the transition of care process in its curriculum. Residents must demonstrate competency in performance of this task. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary.

Assessment/evaluation tools for trainee handoffs now exist, and residency programs should strive to insure that each resident be evaluated as a “giver” of a handoff. This evaluation should include an opportunity for feedback to the individual resident on the handover process. This evaluation process may occur either in actual direct patient care or as a simulation exercise.

6. IMPLEMENTATION

The Designated Institutional Official (DIO) for Graduate Medical Education is responsible for implementation of this policy.

7. OVERSIGHT

Policy authority for this document resides with the Graduate Medical Education Committee. The DIO and the Graduate Medical Education Committee are responsible for oversight. This policy will be reviewed every three years or more often if deemed necessary.

8. REFERENCES


