Institutional Transitions of Care Policy

Scope: All UW residencies and fellowships accredited by the Accreditation Council for Graduate Medical Education (ACGME) and sponsored by the UW School of Medicine.

Background: Transitions of care are critical elements in patient care. To assure patient safety and continuity of care in residents or fellows’ (hereafter referred to as “residents”) learning and working environment, the Accreditation Council for Graduate Medical Education (ACGME) requires that programs and sponsoring institutions have a documented, structured, and monitored hand-off process in place for ensuring the effectiveness of transitions. The process must be organized such that it minimizes the number of patient care transitions, maximizes effective communication among all individuals or teams with responsibility for patient care in the healthcare setting, and ensures complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients.

Definitions: Transitions of care are defined as the relaying of comprehensive and accurate patient information between individuals or teams in transferring responsibility for patient care in the health care setting. Transitions include changes in providers, whether from shift to shift, service to service, or from hospital/clinic to another institution or home. Transitions also occur when a patient is moved from one location or level of service to another.

Hand-off (Hand-over): A hand-off is the process of transferring information, authority, and responsibility for a patient during transitions of care. It is an active and iterative process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient’s care.

Interprofessional team: A team made up of physicians and other health professionals appropriate to delivery of care in the specialty. A team made up solely of physicians is not an interprofessional team. Teams may include residents, faculty, and other personnel such as nurses, pharmacists, case workers, physical therapists, caregivers, and family, etc., as appropriate, assigned to the delivery of care for an individual patient.

Policy: Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of hand-offs by the program must ensure the following:

- There is a standardized process in place that is routinely followed.
- There is consistent opportunity for the receiver of the information to ask questions or clarify specific issues questions.
- The necessary materials are available to support the hand-off (including, for instance, written sign-out materials, access to electronic clinical information).
- An environment in which distractions are minimized is consistently available for hand-off processes that include face-to-face communication, where possible.
- Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines.
- Patients are only minimally inconvenienced and not endangered by frequent handoffs of their care.
Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure \([CPR \ VI.E.3.a]\), while maximizing residents' learning experience. Programs should have documentation of the process involved in arriving at the final schedule of clinical assignments.

Specific schedules will depend upon various factors, including the size of the program, the acuity of patient care, quantity of the workload, and the level of resident education. Each training program must review schedules regularly to minimize handoffs in patient care within the context of clinical and educational work hour standards. Faculty should be scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.

Schedule overlaps should include time to allow for face-to-face hand-offs to ensure availability of information and an opportunity to clarify issues. Whenever possible, handoffs should occur at a uniform daily time. The handoff process should vary as little as possible between weekdays and weekends.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. \([CPR \ VI.B.5.]\)

Each program must ensure continuity of patient care, consistent with the program’s policies and procedures, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. \([CPR \ VI.E.3.e]\) The procedure for residents to transfer their patient care responsibilities under such circumstances must be solidified in a program policy. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. \([CPR \ VI.C.2]\)

Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. \([CPR \ VI.E.3.d]\) All programs must make schedules that list residents and attending physicians responsible for each patient's care readily available. These must include the providers’ contact information. Call schedules should be provided to the hospital operators.

Programs must ensure that residents are competent in communicating with team members in the hand-over process. \([CPR \ VI.E.3.c]\) This includes communication with members of interprofessional teams that are appropriate to the delivery of care as defined by their specialty residency review committee.

Each program must train residents for competency in hand-off and include the transition of care process in its curriculum. Methods of training to achieve competency may include program orientation sessions, departmental and GME conferences, and on-line training activities.

Programs must systematically assess the resident hand-off process to ensure their residents are competent in the transition of care process. There are numerous mechanisms through which a program might elect to determine the competency of trainees in hand-off skills and communication. These include:

- Direct observation of a hand-off session by faculty, peers, a more senior trainee, or a member of the interprofessional team member.
- Evaluation of written hand-off materials by faculty, peers, a more senior trainee, or a member of the interprofessional team member.
• Didactic and simulation sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment.
• Assessment of adverse events and their relationship to sign-out quality.

Programs should also provide an opportunity for residents to give feedback to peers and faculty physicians about their hand-off skills.

Program Policies:

Programs are required to adhere to general institutional policies concerning transitions of patient care and to have a written program-specific policy for transitions of care. This policy must clearly articulate an effective, structured hand-off process designed to facilitate both the continuity of care and patient safety. All residents and faculty members must be trained in the use of the transition of care program policy. This policy must reflect the heightened awareness of the effects of hand-offs on patient safety and education; explain the system(s) designed; outline the expectations for transfer of responsibility for patient care in all the settings and situations in which hand-offs occur; explain the process for ensuring competency for residents; and explain how the efficacy of hand-offs is monitored.

At a minimum, that policy must address the following:
1. The time and place that routine hand-offs should be expected to occur: The location should be chosen so as to minimize distractions and interruptions and where all needed resources are available (e.g., appropriate information systems). The time chosen should be as convenient as possible for all participants.
2. The structure or protocol for hand-offs: Each program must develop standards that provide for the safe transfer of responsibility for patient care. The format for transfer of care may vary, but each program’s standards must ensure continuous, coordinated delivery of care in settings that are appropriate to patients’ needs, including arrangements that extend beyond the inpatient setting into the community and the home.

The transition/hand-off process must involve both verbal and written communication. Verbal hand-offs should allow opportunity for the receiver of the information to ask questions or clarify specific issues. It is suggested that verbal hand-offs follow a predictable structure. Mnemonics may be helpful in this regard. The I-PASS model (stands for: Illness severity; Patient summary; Action list; Situation awareness and contingency planning; Synthesis by receiver) is a standardized mnemonic of care transitions commonly used by many of our training sites.

Written hand-offs must be structured and organized so that information is provided in a predictable format or is readily available for each patient. Written information must include sufficient information to understand and address active problems likely to arise during a brief period of temporary coverage, or to assume care without error or delay when care is transferred at a change of rotation or service.

For typical inpatient situations, the transition process should include, at a minimum, the following information in a standardized format that is universal across all services:
• Appropriate patient identifiers, such as name, medical record number, and age.
• Identification of patient’s attending of record, family, referring physician, and contact information.
• Diagnosis and current condition (level of acuity) of patient.
• Recent events, including changes in condition or treatment.
• Current medication, pertinent lab results, allergies, anticipated procedures and actions to be taken.
• Outstanding tasks that needs to be completed in the immediate future.
• Outstanding laboratories/studies.
• Changes in patient condition that may occur requiring interventions or contingency plans.

In the case of transitions outside of a hospital setting, such as clinic or nursing homes, the standardized process may need to be modified to fit the needs of such environments. Information on all patients for whom a resident is responsible must be included in the hand-off.

3. Specific processes for hand-over of patient care in all relevant scenarios (night/weekend coverage, rotating off service, vacation coverage, between services and locations (OR – ICU) etc.).

4. The method by which a resident is evaluated for competency in the transition of care process.

5. The procedures a resident should follow to ensure coverage of patient care in the event that they may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.

The program-specific policy must be readily available and accessible for use by the program’s trainees and faculty. Individual program Transitions of Care policies are maintained by the GME Office in GME Residency Management System.