PURPOSE
Minimize the total number of Patient Handoffs and Transitions in Care and to comply with the Institutional and Residency Review Committee (RRC) accreditation requirements established by the American Council for Graduate Medical Education (ACGME).

GOAL
To facilitate safe, effective and efficient transitions in patient care from initial assessment, admission and discharge from the hospital.

DEFINITIONS
- **Patient Handoff**: Patient centered information discussed between hospital services taking care of the patient. Handoffs typically occur at the end of shifts (AM/PM), upon switching providers, treatment team and/or movement from intensive care or peri-operative units.

- **Transition of Care**: Perspective of the patient transitioning through multiple phases of care within the hospital and throughout their care. This can involve admission, consultation, operative procedures, imaging and discharge to home or other care facilities. It does not always involve a change in providers.

RATIONALE
- Both hospital handoffs and transitions in care are high-risk, high-frequency events in which critical information about a patient’s clinical status, including current condition and recent and anticipated treatment, must be transferred completely and accurately to ensure safe and effective continuity of care.

- By definition, transition of care also occurs when a physician transfers the care of a patient at the end of a rotation and a new physician assumes the care of the patients on that service.

- Effective communication is vital to safe and effective patient care.

- In order to provide consistently excellent care, it is vitally important that face-to-face communication is consistent and effective.
All physicians must demonstrate responsiveness to patient needs.
Under certain circumstances, the best interests of the patient may be served by transitioning a patient’s care to another qualified and rested provider.

It is essential for physicians to abide by current duty hour policy when accomplishing handoffs or transitions in care.

GENERAL POLICIES

• Handoffs should take place in a designated workplace, office or conference room to ensure patient confidentiality and decrease distractions.

• **Handoffs in public places (hallways, elevators or common areas) are strictly prohibited.**

• Patients with significant illness should be seen at the bedside whenever possible.

• Handoffs may occur over the telephone as long as both parties have access to current inpatient lists and computer electronic records.

• All attending physicians and senior residents are responsible to ensure that junior residents and interns are capable of providing thorough and accurate patient handoffs to accepting services.

• Attending physicians are ultimately responsible for all patient care and must provide adequate supervision of residents at all times.

• Direct physician-physician communication between the responsible transferring service and receiving service must be ensured.

• All current electronic patient lists must be available within a secure password protected network on institution computers. Service lists are to be updated twice daily to account for patient admission/discharge flow. Senior residents are to ensure completeness and accuracy.

• Services divided into 12-hour shifts require the sign out checklist for the Day/Night team to be completed prior to shift change.

**ESSENTIAL COMPONENTS (TRANSFERING SERVICE)**

• Patient Name, Age, MRN, Room, Bed, Attending

• Code Status, Advanced Directives

• Admission: Date, Diagnosis, Pathology
• Critical Medical/Surgical History: Neural, Respiratory, Cardiac, Abdominal, Orthopedic
  Allergies, Transfusions etc.

• Critical Medications: Cardiac, Seizure, Anti-Coagulants, Diuretics, Psychiatric

• Procedures/Operations: Date, Complication, Pathology

• Current Condition: Stable, Unstable, Critically Unstable

• Incision, Wound Care, Drains, Splints, Indication for lines (CVC, PICC, Foley, etc.)

• Diet, Activity, Significant Events to Date

• Family/Social: Primary decision maker, Projected discharge to Home, SNF, Other

• Laboratory, Imaging studies pending to follow up

• Relay any possible concerns you may have

• Provide pager, phone number, contact name for further questions

• If possible, write a brief transfer or transition of care note within the patient medical record highlighting the information above.

ESSENTIAL COMPONENTS (RECEIVING SERVICE)
  • Allow ample time to ask appropriate follow up questions and inquire further regarding confusing statements.

  • Exchange contact information for future questions that require immediate attention