

PATIENT HANDOFFS AND TRANSITIONS OF CARE**Rationale**

To assure continuity of care and patient safety, ACGME requires a minimum number of patient care transitions, a structured and monitored handoff process, training for competency by Residents in handoffs, and readily available schedules listing Resident and attending physicians (Faculty) responsible for each patient's care. In addition to Resident-to-Resident patient transitions, Residents must care for patients in an environment that maximizes effective communication among all individuals or teams with responsibility for patient care in the healthcare setting.

Definition

A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting for various reasons. The transition or handoff process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

1. Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
2. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas.
3. Discharge, including discharge to home or another facility such as skilled nursing care.
4. Change in provider or service change, including change of shift for nurses, Resident handoff, and rotation changes for Residents.

Policy

1. Each training program should review call schedules at least annually to minimize transitions in patient care within the context of the other Clinical Experience and Educational Work Hours standards ("Duty Hours"). Whenever possible, transitions in care should occur at a uniform daily time to minimize confusion. Documentation of the process involved in arriving at the final schedule should be included in the minutes of the annual program review meeting.
2. Each residency training program that provides in-patient care is responsible for creating a templated patient checklist and is expected to have a documented process in place to assure complete and accurate Resident-to-Resident patient transitions. At a minimum, key elements of this template should include:
 - Identification of patient, including name, medical record number, and date of birth, and room number.
 - Name and contact number of responsible Resident and attending physician
 - Diagnosis(es) and current status/condition (level of acuity) of patient to include resuscitation status.
 - Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken.
 - Outstanding tasks – what needs to be completed in immediate future.
 - Outstanding laboratories/studies – what needs follow up during the next shift.
 - Changes in patient condition that may occur requiring interventions or contingency plans; i.e., situational awareness.

- Include synthesis of information by the provider being brief such as “read-back” or asking questions to confirm understanding.
 - Other items may be added depending upon the specialty.
3. The transition/handoff process should involve face-to-face interaction* with both verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or clarify specific issues. *Handoffs can be conducted over the phone as long as both parties have access to an electronic or hard copy version of the sign-out sheet. Additionally, all attempts to preserve patient confidentiality are observed.
 4. 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/handoff procedures to ensure that:
 - a. Residents comply with specialty specific/institutional duty hour requirements.
 - b. Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled Residents.
 - c. All parties (including nursing) 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.
 - d. Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
 - e. All parties directly involved in the patient’s care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.
 - f. 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.
 - g. Programs should provide an opportunity for Residents to both give and receive feedback from each other or Faculty physicians about their handoff skills.
 5. Each program must include the transition of care process in its curriculum. Each program is responsible for evaluating that the hand over process is effective and each Resident is competent in the appropriate transitions of care.
 6. Residents must demonstrate competency in performance of this task. There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These may include:
 - a. Direct observation of a handoff session by a supervising Faculty, Chief Resident, or supervising Resident.
 - b. Evaluation of written handoff materials by supervising Faculty, Chief Resident, or supervising Resident.
 - c. Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment.
 - d. Assessment of handoff quality in terms of ability to predict overnight events.
 - e. Assessment of adverse events and relationship to sign-out quality through:
 - i. Survey
 - ii. Reporting hotline
 - iii. Chart review
 7. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:

- a. There is a structured, standardized process in place that is routinely followed such as IPASS (attachment A).
 - b. There is consistent opportunity for questions.
 - c. The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information).
 - d. A quiet setting free of interruptions is consistently available for handoff processes that include face-to-face communication.
 - e. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines.
 - f. Programs must include a standardized question on the end of rotation/assignment Faculty evaluation of Resident. i.e. “Did you or a supervising Resident observe this Resident during a handover process? If yes, is this Resident competent in communicating in the handover process?”
 - g. Handover evaluation template may be used by programs if so desired.
8. The GMEC ensures and monitors effective structured handover processes to facilitate both continuity of care and patient safety through annual review of program specific handover policies and ACGME Resident and Faculty survey results.

*The term “Resident” refers to both Resident and Fellow trainees.

Revised and Approved by the GMEC 5/16/2017. Administrative edits 5/7/2019.

Attachment A - The I-PASS mnemonic can be used as a way to standardize the verbal (oral) handoff process at periods of shift change during in person verbal communication. It can also be used as a framework to standardize the written handoff process by integrating the individual mnemonic elements in computerized handoff tools within word processing documents or, ideally, within the electronic medical record where possible.

Mnemonic Letter	Description	Key Points
I	Illness Severity	<ul style="list-style-type: none"> • Identification of patient’s level of acuity to focus attention appropriately at the start of the handoff communication • Suggest classifying each patient using a standardized language such as stable, “watcher” (a patient where any clinician has a concern that a patient is at risk of deterioration), or unstable • May include code status • Classification may vary depending on unit acuity, provider type, or institutional culture
P	Patient Summary	<ul style="list-style-type: none"> • Describes succinctly the reason for admission, events leading up to admission, hospital course, and plan for hospitalization • Should reflect global plan for entire hospital stay and avoid “to-do” items for next shift • Should be maintained and updated regularly with modification of assessment, diagnoses, and changes in treatment plans as necessary • Events leading up to admission may be truncated with time and diagnostic certainty yet should retain key reason for admission to allow new providers to understand nuances of presentation
A	Action Items	<ul style="list-style-type: none"> • Includes a “to-do” list with specific elements to accomplish over next shift by team assuming care of patient • Should specify timeframe for completion, level of priority, and who is responsible • Specify “nothing to do” if no action items are anticipated
S	Situational Awareness and Contingency Plans	<ul style="list-style-type: none"> • Situation Awareness: knowing what is going on for members of the care team (status of patients, environmental factors, team members) and for each individual patient (status of disease process, progress towards goals for hospitalization) • Contingency Plans: with situation awareness in mind, provide team assuming care of the patient with specific instructions for how to handle anticipated problems. <ul style="list-style-type: none"> • Typically includes “if/then” statements • Specify “no contingencies anticipated” for stable patients • Ensures accepting team is prepared to anticipate changes in patient status and respond to potential events
S	Synthesis by Receiver	<ul style="list-style-type: none"> • Provides a brief re-statement of essential information in a cogent summary by receiving team • Demonstrates information is received and understood • Ensures effective transfer of information and responsibility • Opportunity for receiver to clarify elements of handoff, ensure clear understanding, and play an active role in handoff process • Will vary in length and content depending on acuity level of patient • Should prioritize re-statement of key action items and contingency plans: not a re-statement of the entire verbal handoff