IV.A.4.a).(2)

HANDOFFS AND TRANSITIONS OF CARE

I. 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 residents and attending physicians 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.

 II. Policy

A. Each training program should review call schedules at least annually to minimize transitions in patient care within the context of the other duty hour standards. 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.

B. Each residency training program that provides in-patient care is responsible for creating a template 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:

- Patient name;
- Age;
- Room number;
- ID number;
- Name and contact number of responsible resident and attending physician;
- Pertinent diagnoses;
- Allergies;
- Pending laboratory and X-rays;
- Overnight care issues with a "to do" list including follow up on laboratory and X-rays;
- Resuscitation status.
- Other items may be added depending upon the specialty.

C. There must be a structured face-to-face, phone-to-phone, or secure intra-hospital electronic handoff that occurs with each patient care transition. At a minimum this should include a brief review of each patient by the transferring and accepting residents

with time for interactive questions. All communication and transfers of information should be provided in a manner consistent with protecting patient confidentiality.

D. Each training program is responsible for notifying the hospital telephone operators about its call schedule so that the entire health care team (staff physicians, residents, medical students, and nurses) know how to immediately reach the resident and attending physician responsible for an individual patient's care.

E. Each residency training program is responsible for assuring its residents are competent in communicating with all caregivers involved in the transitions of patient care. This includes members of effective inter-professional teams that are appropriate to the delivery of care as defined by their specialty residency review committee. Methods of training to achieve competency may include annual review of the program-specific policy by the program director with the residents, departmental and GME conferences.

F. Programs 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.

III. GME Monitoring and Evaluation

A. To evaluate the effectiveness of transitions, monitoring will be performed using information obtained from electronic surveys in E*value. Programs are to create an evaluation for resident and faculty to complete at least quarterly on the effectiveness of the handoff system.

B. The results of the monitoring will be reported to the GME Committee. The GMEC will review elements of the hand-over process and make appropriate recommendations in order to continuously improve quality of care and patient safety. Repeated deficiencies will result in a more detailed monitoring review which could result in direct intervention by the GME Committee.

 C. Monitoring of the Handoff process by the program must be documented in Program's Annual Review and Improvement Meetings. During the Program Director and Department Chair Annual Meeting with the DIO, this documentation will be reviewed to confirm the Transition of Patient Care process is being monitored by the program.

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