

	Name of Policy: Transition of Care (Handoff)	
	Last Approval Date: August 9, 2019	Effective Date: August 9, 2019

A handoff refers to the transfer of information that takes place during transitions in the care of a patient. The purpose of a handoff is to provide complete and accurate information about a patient's clinical status, current problems and recent and/or anticipated treatment. A well-done handoff can prevent errors stemming from failure to communicate changes in the status of patient. Therefore the information communicated during a handoff must be complete and accurate.

A handoff contains verbal and/or written communication which provides information to facilitate continuity of care. Handoffs occur in a variety of transitions, including, but not limited to:

- Outpatient to Inpatient
- Shift to Shift
- Provider to Provider
- Unit to Unit
- Facility to Facility
- Inpatient to Outpatient

IT IS THE RESPONSIBILITY OF PROGRAMS TO:

- Design clinical assignments to optimize transitions in care, including their safety, frequency and structure.
- Maintain and communicate schedules of attending physicians and residents currently responsible for care.
- Ensure continuity of patient care in the event the resident may be unable to perform their patient care responsibilities due to excessive fatigue, illness, or family emergency.
- Ensure that residents and supervisors are competent in communicating with team members in the handoff process.
- In partnership with the Institution, ensure and monitor effective, structured handoff processes to facilitate continuity of care and patient safety. Additionally, programs must identify high risk transitions of care and design processes accordingly.
- Identify a designee within each department to be responsible for monitoring handoffs within the department.
- Provide an evaluation of observed handoffs to the GMEC at a frequency determined by GMEC.

IT IS THE RESPONSIBILITY OF THE INSTITUTION TO:

- Facilitate professional development for resident and faculty regarding effective transitions of care

IT IS THE RESPONSIBILITY OF INDIVIDUAL RESIDENTS AND FACULTY TO:

- Conduct each and every handoff in accordance with the standards outlined in this policy and the handoff processes established by each program or clinical service.
- When receiving a handoff:
 - Thoroughly review a written handoff document and take notes on a verbal handoff
 - Clarify and resolve any unclear issues with the transferring provider

ELEMENTS OF A HIGH-QUALITY HANDOFF

Within each program or clinical service, handoffs will be conducted in a consistent manner, using a standardized form or structured guideline which includes all of the elements listed below. While a single specific handoff tool or instrument is not mandated, programs are strongly encouraged to utilize a standard format (i.e. SBAR, etc.)

- Occurs in a quiet environment without interruptions
- Interactive communication which encourages questioning between the giver and the receiver of patient information
- Has a structured format
- Demonstrates accuracy and comprehension
- Has a process for verification of the received information, including readback* as appropriate
- Supervised as appropriate on a regular basis
- Face to Face whenever possible

The core content expectations for handoffs include the following:

1. Patient demographics
2. Attending Name/Responsible Team
3. Patient's Diagnosis/Problem list
4. Code Status and advance directives
5. Current Status (recent changes, critical labs, safety concerns, allergies, etc.)
5. Decision Maker Status (if not competent)
8. Pending Labs/XRay, etc.
9. Recommendation/Action Plan (If this...then do that)
10. Readback
11. Other (program or service specific)
For IP to OP/Discharge only:
12. Follow-up for each provider involved in the care of the patient (primary plus consultants)
13. Follow up with primary care provider (if different than primary service)

*A method of preventing errors in which information relayed to one person is repeated and verified in a slightly different form as a means of confirming its accuracy - for change of status, pending labs, critically ill patients, etc.

USEFUL HANDOFF FORMATS

<p>SBAR</p> <ul style="list-style-type: none"> • Situation • Background • Assessment • Recommendation 	<p>WEICK</p> <p>Weick KE. Br J Manage; 2002;13:7.</p> <ul style="list-style-type: none"> • Here's what I think we face • Here's what I think we should do • Here's why • Here's what we should keep an eye on • Tell me if you don't understand/can't do it/see something I do not
<p>SAIF-IR</p> <p>Chu, et al. A Structured Handoff Program for Interns. Acad Med. 2009; 84:347–352.</p>	
<p>OUTGOING PROVIDER:</p> <p>Summary: 1-3 sentence summarizing patient's hospital stay. NOT repeated HPI</p> <p>Active issues: only active medical issues, not all chronic or stable conditions</p> <p>If-then contingency plans: clues to oncoming provider about potential issues arising and what the off-going provider would suggest on basis of his or her clinical knowledge of the patient</p> <p>Follow-up activities: test, procedures, therapies which need to be reevaluated by oncoming provider</p>	<p>INCOMING PROVIDER:</p> <p>Interactive questions: clarify or correct info</p> <p>Repeat back important information to ensure understanding</p>
<p>IPASS (The BATON)</p> <p>Agency for Healthcare Quality and Research</p> <p>I: Introduce yourself</p> <p>P: Patient ID</p> <p>A: Assessment CC, vitals, symptoms, diagnosis</p> <p>S: Situation current status, code status, recent changes, treatment</p> <p>S: Safety concerns Allergies, social, critical values</p> <p>B: Background PMH, meds,</p> <p>A: Actions: taken or required</p> <p>T: Timing: level of urgency</p> <p>O: Ownership team members</p> <p>N: Next anticipated actions/changes, plan</p>	

Evaluation of Transition of Care (Handoff)

Reporting Rubric

Program _____

Date _____ Time _____

Evaluator _____

Was the transition of care you observed....(check all that apply)

- Occurs in a quiet environment without interruptions
- Has a structured format
- Demonstrates accuracy & comprehension
- Includes interactive communication which encourages questioning between the giver and the receiver of patient information
- Is supervised as appropriate on a regular basis
- Has a process for verification of the received information, including readback as appropriate

Check all items that were included in the transition of care:

- Patient demographics
- Attending Name/Responsible Team
- Patient's Diagnosis/Problem list
- Code status and advance directives
- Current Status (recent changes, critical labs, safety concerns, allergies, etc.)
- Decision Maker Status (if not competent)
- Pending Labs/XRay, etc.
- Recommendation/Action Plan (If this...then do that)
- Readback
- Other (program or service specific)

For IP to OP/Discharge only:

- Follow-up for each provider involved in the care of the patient (primary plus consultants)
- Follow up with primary care provider (if different than primary service)

Comments: