YALE-NEW HAVEN MEDICAL CENTER
(YNHMC)

POLICIES AND PROCEDURES

Subject: Transitions of Care

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Introduction:

Transitions of care are the relaying of complete and accurate patient information between individuals or teams during the transfer of responsibility for patient care in the healthcare setting. Transitions of care are also known as handoffs, handovers, and sign offs in this policy and in the healthcare setting.

Programs must design clinical assignments to minimize the number of transitions in patient care. YNHMC and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of residents/fellows and attending physicians currently responsible for each patient's care.

Policy:

Design of clinical assignments to minimize transitions
Programs must design clinical assignments that minimize multiple transitions within a short time period, particularly when this results in handoffs being conducted by trainees unfamiliar with the patients. For example, it is strongly suggested that the primary team responsible for a patient directly hands off to the night float team.

Types of handoffs involving trainees

- Shift to shift handoffs among peers (day to night, night to day, weekend, brief coverage for clinic or other obligations)
- End of rotation handoffs among peers
- Admission handoff from Emergency Dept or Outpatient physician to admitting team
- Discharge handoff from the inpatient team to outpatient physician
- Inter-service handoffs from one service to another
- Change in level of care handoff (floor to step-down or ICU or vice versa, OR to PACU or vice versa), PACU to floor.

Monitoring handoffs
All of the aforementioned types of handoffs are appropriate to monitor. At a minimum, programs involving trainees with primary clinical responsibility for patients **must** routinely

monitor shift to shift transfers as these are the most common and formalized. Also, programs **should** assess the quality of handoffs between levels of care. For programs involving trainees with consulting responsibility for patients, monitoring the end of rotation handoff or weekend coverage handoff **should** occur.

At a minimum, the handoff process **must** be monitored for each resident at least once a year in each type of patient care setting for which the training program is responsible.

Method of monitoring

It is recommended that for each type of handoff monitored, the program ensure:

1. There is a standardized process in place that is routinely followed.
2. There is consistent opportunity for questions.
3. The necessary materials are available to support the handoff (including written sign out materials and access to electronic clinical information).
4. A quiet setting, free of interruptions, is consistently available for handoff processes that include face to face communication.
5. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines.

A checklist for ensuring and monitoring effective structured handover processes is attached to this policy.

Ensuring competency

There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These include:

1. Direct observation of a handoff session by a licensed independent practitioner (LIP) – level clinician familiar with the patient.
2. Direct observation of a handoff session by an LIP-level clinician unfamiliar with the patient.
3. Either of the previous, by a peer or by a more senior trainee.
4. Evaluation of written handoff materials by an LIP-level clinician familiar with the patient.
5. Evaluation of written handoff materials by an LIP-level clinician unfamiliar with the patient.
6. Either of the previous, by a peer or by a more senior trainee.
7. Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials, and/or knowledge assessment.
8. Assessment of adverse events and relationship to sign-out quality through survey, reporting hotline, trigger tool, and/or chart review.

Direct observation and feedback of either verbal or written sign-out **is recommended to** be included in the yearly competency assessment for each trainee, including those primarily serving in a consultant capacity.

The following evaluation forms are attached to this policy:

- YNHMC Oral Sign-Out Evaluation
- YNHMC Written Sign-Out Evaluation

Attachment: YNHH Policy – Handoff Communication and Transfer of Care

Policy

1. Program Directors must supervise the training of residents on hand-offs up to a level of competency before residents are assigned responsibility for patient care. Multiple resources for such training are available and the mechanism of training will be deferred to the Program Director's judgment. (2011 CPR VI.B.3)
2. Program Directors must monitor the performance of hand-offs to both ensure their ongoing performance, as well as to determine the residents' competency for same, after initial training is done (2011 CPR VI.B.2). The mechanism for such monitoring will be deferred to the Program Director's judgment.
3. A defined structure for the hand-off exists, and must include at least:

a. The name of the patient, location, and a second, chart-based identifier (e.g., medical record number; last four digits of SSAN).

b. Identification of the primary team and attending physician.

c. Diagnosis of the patient.

d. As necessary, the current status or condition, including code status, of the patient.

e. Pertinent clinical information deemed necessary for coverage for the patient (e.g., drug allergies, current medications, lab abnormalities, recent procedures or changes in condition, etc.)

f. Any elements that the recipient must perform (the "to-do" list).

g. As necessary, suggested actions to take in the event of a change in the clinical situation (the "if-then" list).

h. Augmentations to the above elements are encouraged, and should match the needs of the particular training program.

4. The following general guidelines should be followed:

a. The number of hand-offs, per period of time, should be minimized as much as possible.

b. If possible, face-to-face hand-offs should be performed. Otherwise, telephonic verbal hand-offs are required. However, in either case a recorded hand-off document (written or electronically displayed) will be available to the recipient. The hand-off must include an opportunity for the participants to ask and respond to questions. Ideally, hand-offs should occur without interruptions and discreetly.

5. Participating training institutions must depict call schedules such that the current resident(s) and attendings (i.e., even the on-call teams) are visible to all members of the health care team.