Transitions of Care Policy #0.20

I. Purpose

To establish guidelines to ensure an environment that maximizes effective transitions of care and the safety of patients.

II. Definition

Transitions in care are defined as the relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the health care setting. Transitions of care are necessary in the hospital or healthcare institution setting for various reasons. The transition of care process is an interactive communication process of passing specific, essential patient information from one caregiver or team to another. Transition of care occurs regularly under the following conditions:

a. 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.
b. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas.
c. Discharge, including discharge to home or another facility such as skilled nursing care.
d. Change in provider or service change, including change of shift, resident hand-off, and rotation changes for residents.

III. Policy

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.

Programs must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.

Programs must ensure that residents/fellows are competent in communicating with team members in the hand-off process

Programs must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents/fellows currently responsible for each patient's care.

Programs should provide an opportunity for residents/fellows to both give and receive feedback from each other or supervising faculty about their handoff skills.

Each program must include the transition of care process in its curriculum.

Programs are required to develop scheduling and transition of care procedures to ensure:

- Residents/Fellows comply with clinical and educational work hour requirements.
- Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents/fellows.
- Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
- Continuity of patient care in the event that a resident/fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.

IV. Procedure

The transition of care process should involve face-to-face interaction with both verbal and written/computerized communication (when applicable), with opportunity for the receiver of the information to ask questions or clarify specific issues. Transitions of care can be conducted over the phone as long as both parties have access to electronic or hard copies of the sign-out sheet. Additionally, all attempts to preserve patient confidentiality must be observed. The transition process should include, at a minimum, information in a standardized format that is universal across all services for each program.

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