Transitions of Care and Handoffs

Each training program must have a program-specific policy addressing transitions of care that is consistent with ACGME and UCSF GME policy. With heightened awareness of the effects of handoffs (hand-overs) on patient safety and education, the ACGME common program requirements include specific mandates to design systems, ensure competency for residents and clinical fellows, and monitor efficacy of handoffs. These, along with the Joint Commission patient safety goal regarding handoffs, affect all programs, departments, and clinical settings.

Each training program must design clinical assignments to minimize the number of transitions in patient care. Programs and their faculty must be aware of the hazards of discontinuity and new regulations and best practices to ensure patient safety and to role model effective handoffs. Duty hours requirements shorten the length of shifts for many trainees, particularly PGY1 residents (interns), and this will require careful attention to clinical assignments. Examples of strategies which have successfully minimized transitions include day/night teams, staggering of intern/resident/attending switch times and/or days to maintain continuity, outpatient clinic “pods” or teams, etc. As there is currently no single gold standard for clinical scheduling assignments, all training programs must design call and shift schedules to minimize transitions in patient care. Schedule overlaps should include time to allow for face-to-face handoffs to ensure availability of information and an opportunity to clarify issues.

The institution and each program must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety. Handoffs vary considerably across programs and clinical settings. They may include temporary transitions of direct patient care (e.g. day and night teams on inpatient services, scrubbing out of a procedure), complete transitions of direct patient care (e.g. emergency department shifts, end-of-rotation, end-of-training in outpatient and inpatient services), or transitions of indirect patient care (e.g. laboratory and radiology settings).

Each training programs must develop handoff procedures that are structured, and that reflect best practices (in-person whenever possible, occur at a time and place with minimal interruptions, etc.)

Handoffs should include at least:

- Patient summary (exam findings, laboratory data, any clinical changes);
- Assessment of illness severity;
- Active issues (including pending studies);
- Contingency plans (“If/then” statements);
- Synthesis of information (e.g. “read-back” by receiver to verify);
- Family contacts;
- Any changes in responsible attending physician; and
- An opportunity to ask questions and review historical information.

Faculty oversight of the handoff process may occur directly or indirectly, depending on trainee level and experience. All programs should use the applicable tools (written or computerized) to assist them in this structured process.
Each program must ensure that residents and clinical fellows are competent in communicating with team members in the handoff process. Each training program must assess Interpersonal and Communication Skills competency. Handoff skills are a specific skill within this competency. Programs must deliver focused and relevant training to build these skills, use clear assessment strategies, and document this competency.

Educational resources include:

- “Bridging the Gap: Effective Handoffs for Safe Care”
  - UCSF GME Grand Rounds (online): addresses handoff context and literature and UCSF-specific handoff policies and best practices
  - Available on the GME website: [http://medschool.ucsf.edu/gme/grounds/index.html](http://medschool.ucsf.edu/gme/grounds/index.html)

- Handoffs and Signout Primer: Agency for Healthcare Research and Quality (AHRQ)
  - A literature overview with links to case scenarios and expert discussion that can be used as teaching cases

- Specialty-Specific Tool-Kits
  - Several tool-kits exist that are specific to specialty. One specific one focused on peri-operative handoffs can be found here: [http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/](http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/)

- Teaching Video: “Handoffs: A Typical day on the Wards”
  - A peer-reviewed video on MedEdPORTAL that can be used as a trigger for teaching sessions on handoffs
  - Available here: [https://www.mededportal.org/publication/8331](https://www.mededportal.org/publication/8331)

Assessment strategies include:

- Direct Observation Tools
  - Direct Observations Tools may be modified to document competence in handoffs. There are currently no universally accepted and validated handoff assessment tools. However, for a sample see Fernan et al. (2010) [http://www.ncbi.nlm.nih.gov/pubmed/12639081](http://www.ncbi.nlm.nih.gov/pubmed/12639081)

- Global Assessments of Interpersonal and Communication Skills may include specific items reflecting assessment of competence in the handoff process.

- Peer evaluation tools may be used to evaluate trainees in both giving and receiving handoffs.

The institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care. All clinical staff, should have a mechanism to know which trainee and supervising physicians are responsible for patients and their contact information. UCSF GME supports the use of amion.com for publishing and disseminating schedules. Programs should utilize the pager forwarding system (as applicable and relevant) and the electronic health record handoff tools or equivalent specialty-specific tools.

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