Covenant HEALTH | Methodist Family Medicine Residency

Policies and Procedures

Policy MFMR12	Patient Hand-off – Transitions of Care
Effective Date:	10/25/22
Reviewed/Revised Date:	
PEC Approval Date:	10/25/2022; 12/13/2023
References:	

Purpose

The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring care responsibility from one physician to another.

Scope

These procedures apply to all MMC physicians who are teachers/supervisors or learners in a clinical environment and have responsibility for patient care in that environment.

Background

1. In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Hand-off refers to the orderly transmittal of information, face-to-face, that occurs when transitions in the care of the patient are occurring.
2. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift.
3. In summary, the primary objective of a hand-off is to provide complete and accurate information about a patient's clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.

Policy

1. **Transitions of Care**—The sponsoring institution must facilitate professional development for core faculty members and residents regarding effective transitions of care and in partnership with its ACGME-accredited program, and ensure and monitor effective structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites.
2. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
3. Programs and clinical sites must maintain and communicate schedules of Attending physicians and residents currently responsible for care.
4. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in ACGME Common Program Requirement VI.C.2

5. (Resident Well-Being), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency the patient will be handed-off to another member of the team.
6. Programs must ensure that residents are competent in communicating with team members in the hand-off process.
7. Programs in partnership with their sponsoring institutions must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.
    a. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.
    b. A hand-off is a verbal and/or written/structured electronic (e.g. I-PASS) communication which provides information to facilitate continuity of care. A hand-off or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:
        i. Move to a new unit
        ii. Transport to or from a different area of the hospital for care. e.g., diagnostic/treatment area
        iii. Assignment to a different physician temporarily, e.g., overnight/ weekend coverage or longer (e.g., rotation change)
        iv. Discharge to another institution or facility
    c. Each of the situations above requires a structured hand-off with appropriate communication.

Hand-off Procedures

1. Hand-off procedures will be conducted in conjunction with (not be limited to) the following physician events:
    a. Shift changes
    b. Meal breaks
    c. Rest breaks
    d. Changes in on-call status
    e. Contacting another physician when there is a change in the patient's condition
    f. Transfer of patient from one care setting to another
2. Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.
3. Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
4. Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.
5. Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.
6. Each hand-off process must include at minimum a senior resident or attending physician.

7. A resident physician must not leave the hospital until a face-to-face hand-off has occurred with the Attending physician or senior resident coming onto the service. Telephonic hand-off is not acceptable

Structured Hand-off

1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form, embedded electronic form or structured guideline.
2. Hand-offs, whether verbal, electronic or written, should include, at minimum, specific information listed below (as applicable):
    a. Patient name, location, age/date of birth
    b. Patient diagnosis/problems, impression
    c. Important prior medical history
    d. DNR status and advance directives
    e. Identified allergies
    f. Medications, fluids, diet
    g. Important current labs, vitals, cultures
    h. Past and planned significant procedures
    i. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
    j. Plan for the next 24+ hours
    k. Pending tests and studies which require follow up
    l. Important items planned between now and discharge

Unusual resident-initiated extensions – additional duty

1. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house work.
2. However, in unusual circumstances, a resident on his or her own initiative may remain at the clinical site beyond the 24-hour period to provide care to a single patient.
3. In these cases, the additional hours must be counted toward the 80 work-hour limit and the justification for extending work must meet one of the following conditions:
    a. Provision of continuity of care for a severely ill, complex, or unstable patient;
    b. Provision of continuity for a maternity care continuity delivery patient with whom the resident has been involved;
    c. Provision of humanistic attention to the needs of a patient or family to attend unique educational events.
4. The extended work must not exceed four (4) hours.
5. In each circumstance, the following actions must be taken:
    a. The resident must appropriately hand over the care of all other patients to the team responsible for their continuing care.
    b. The resident must document the reasons for remaining to care for the patient in New Innovations.
    c. The program director must review each submission of additional service and track both individual resident and program-wide episodes of additional work.