


# Title: Graduate Medical Education - Transitions of Care - Policy

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## I. Policy Statement

- a. The purpose of this policy is to establish protocol and standards within the graduate medical education training programs to ensure the quality and safety of patient care when transfer of responsibility occurs during work hour shift changes and other scheduled or unexpected circumstances.
- b. This policy is important because transition of care is essential to patient care and safety. Inclusion of skills in transitions of patient care in the patient safety curriculum for residents is a requirement of the Accreditation Council of Graduate Medical Education (ACGME). Compliance with the ACGME requirements is necessary for continued institutional and program accreditation.

## II. Definitions

- a. Not Applicable.

## III. Process/Content

- a. Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as ensure quality care and patient safety as well as adhere to the general institutional policies concerning transitions of patient care.
- b. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another.
- c. Transition of care occurs regularly under the following conditions:
  1. Change in the level of patient care, including inpatient admission from an outpatient procedure, diagnostic area, or Emergency Department (ED).
  2. Transfer to or from a critical care unit (CCU).
  3. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas.

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4. Discharge, including discharge to home or another facility such as skilled nursing care.
  5. Change in provider or change of service, including change of shift for nurses, resident sign-out, and rotation changes for residents.
- d. The transition/hand-off process must involve face-to-face interaction with both verbal and written communication. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:
  1. Identification of patient, including name, medical record number, and date of birth.
  2. Identification of admitting/primary physician.
  3. Diagnosis and current status/condition of patient.
  4. Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures, and actions to be taken.
  5. Changes in patient condition that might happen and require interventions or contingency plans.
- e. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:
  1. Residents do not exceed the 80-hour per week work limit averaged over four (4) weeks.
  2. Faculty physicians are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
  3. All parties involved in a particular program and/or transition process have access to one another's schedules and contact information.
  4. Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
  5. All parties directly involved in the patient's care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.
  6. Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.
- f. Each program must include the transition of care process in its curriculum. Residents must demonstrate competency in performance of this task.
- g. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary.

## **IV. Attachments**

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- a. Not Applicable.

### **V. References, Regulatory References, Related Documents, or Links**

- a. Not Applicable.