

TRANSITIONS OF CARE/HANDOVER

Purpose: The purpose of these guidelines is to establish standards within the UConn-sponsored Graduate Medical Education programs to ensure that Transitions of Care and Handover occur in such a manner that the quality and safety of patient care is not compromised.

The term “Transitions of Care” refers to the movement patients make between health care practitioners and/or settings. Examples of Transitions of Care include:

- Admission to the hospital from an outpatient setting, including but not limited to the Emergency Department, a medical office, a procedure center, or a diagnostic area such as the Radiology Department.
- Admission of a patient to the hospital from another healthcare facility, including but not limited to an outside hospital or skilled nursing facility.
- Transfer of a hospitalized patient to a different level of care within the hospital (i.e.: from the floor to the stepdown unit or ICU or vice versa).
- Transfer of patient care responsibilities from one practitioner to another. This includes but is not limited to the transfer of care that occurs: at the time of shift/duty hour changes for practitioners (handover or “sign out”); at a time when a patient is transferred from one service to another; at a time when a patient is to have a procedure or diagnostic study
- Discharge, including discharge to home or to another facility such as a skilled nursing facility or rehabilitation facility

“Handover” refers to the transfer of information and of responsibility for patient care from one practitioner to another. The Handover process must include, at a minimum, written communication from one provider to the next. Verbal plus written communication is preferred as this allows for the opportunity for the accepting provider to ask questions or to seek clarification when necessary.

The content of the information provided during the Handover process should include, at a minimum, the following information in a standardized format that is universal across all services:

- Identification of patient: name, medical record number, and date of birth
- Location of patient (i.e.: hospital room number)
- Identification of responsible attending of record
- Diagnosis and current status/condition of patient
- Recent events, including changes in condition or treatment, current medication status, recent lab tests
- Potential issues that may arise with anticipatory guidance where possible (Use “if/then” statements whenever possible)
- List of tasks to complete with a plan and a rationale
- Allergies
- Code status

Standards: Individual training programs must adhere to institutional policies concerning transitions of patient care. Each program must supplement these institutional Transition of Care/Handover guidelines with requirements relevant to and specific for their specialty.

Individual training programs must design schedules and clinical assignments to maximize the learning experience for residents while minimizing the number of Transitions of Care/Handovers for patients. Programs are required to develop scheduling and Transitions of Care/Handover processes to ensure that:

- Residents do not exceed the 80 hour per week work hour limit averaged over 4 weeks.
- Faculty members are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
- All parties involved in a particular program and/or Transition/Handover process have access to one another's schedules and contact information. All call schedules are available electronically.
- Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
- All parties directly involved in the patient's care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.
- Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, and emergency.

Each program must include the Transition of Care/Handover process in its curriculum. Residents must be directly supervised in their ability to Transition/Handover patient care until such a time that they have demonstrated competency in the performance of this task. Programs must develop and utilize a method of monitoring the Transition of Care/Handover process and update as necessary.

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