Policy on Transition of Care

Transition of care is defined as when a physician transfers the care of a patient to another physician. This includes sign-out as well as sign-in. It also includes the transfer of a patient from one level of care to another, e.g. transfer of a patient from the wards to the ICU or vice verse. By definition, transition of care also occurs when a physician transfers the care of a patient at the end of a rotation and a new physician assumes the care of the patients on that service.

Effective communication is vital to safe and effective patient care. Many errors are related to ineffective communication at the time of transition of care. In order to provide consistently excellent care, it is vitally important that we communicate with one another consistently and effectively when the care of a patient is handed off from one physician to another. This policy is meant to define the expected process involved in transition of care, and applies to each of our teaching sites where we provide inpatient care.

A.) Daily Sign-in and Sign-out

1.) There must be a formal sign out daily by each resident on an inpatient service. Sign out must include direct communication between residents and should be face to face. If a code pager is handed off, the hand off must be face to face. It is unacceptable to leave a code pager in a prearranged spot to be picked up by the oncoming resident.

2.) Residents who are directly responsible for patients on an inpatient service, whether ward or ICU, must sign out their patients to the resident on call that night. The resident signing out must provide a formal sign-out sheet that includes, at minimum, the following information:

- Patient name, age, sex, and room assignment
- Relevant diagnoses
- Active problems
- Code status
- Follow up and/or required actions, e.g. check H/H, volume status, etc.

3.) Residents that are post-call must communicate the events of the preceding night to the resident(s) coming on that day. All new admissions to a service must be listed on the board or called to the resident that will assume the patient's care. Any significant developments overnight must be shared with the resident providing care for that patient. Residents on call at the VA will include the name of the resident who will assume care of the patient the next day as a co-signer on the initial admission note.

B. Transfer to Another Level of Care

1.) When a patient is transferred from one level of care to another, e.g. the wards to the ICU, or vice verse, **and** a different resident physician or group of physicians assumes the care of that patient, there must be documented communication between resident physicians that includes the information that

summarizes relevant information and provides the information necessary to provide effective care.

2.) The resident physician that "sends" the patient to the service providing a different level of care must write a note that summarizes the clinical events preceding the transfer, and should also communicate verbally with the resident that "receives" the patient. That note should include a brief history, relevant exam findings, relevant labs and/or imaging studies, advanced directives, current medications, and a brief assessment and plan.

3.) The resident physician that "receives" the patient must write a note that summarizes the patient's condition and includes an assessment and plan that is reviewed and approved by the faculty physician.

4.) Any decision to transfer a patient from one level of care to another must be made with the knowledge and consent of the attending faculty physician. In the event of an emergency, this may be obtained during or after the transfer.

C. End of Rotation

1.) On completion of an inpatient rotation, the resident physician must communicate with the resident physician that is coming on service to assume the care of his or her patients. This will ensure that each patient on the service continues to receive continuous, high quality care without interruption.

2.) Communication must include an off-service note written by the resident rotating off service. The off-service note must briefly summarize the patient's course to date, and include any active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan.

3.) Communication should also include a face-to-face hand off that provides an opportunity to discuss each patient and allow questions and clarification of any issues. If for some compelling reason this is not possible, then the residents should at least review the list of patients over the telephone and a patient list must be left by the resident rotating off service for the incoming resident in a prearranged location.

Any questions regarding this policy should be directed to the Program Director or his or her designee.

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