

University of Colorado School of Medicine

Graduate Medical Education

Policy: Transitions of Care (Structured Patient Handoffs)		
Original Approval: GMEC: 4/11/2012	Effective date: 4/11/2012	Revision Date: 6/10/2014 (Editorial) 4/18/2018 11/6/2019 (Editorial) 4/20/2023 (Editorial)

Introduction:

The University of Colorado School of Medicine (CU SOM) Graduate Medical Education Committee (GMEC) requires each residency and fellowship program to develop policies to ensure the safe transfer of responsibility for patient care. The format for transfer of care may vary, but program standards must ensure continuous, coordinated delivery of care in settings that are appropriate to patients' needs, including arrangements that extend beyond the inpatient setting into the community and the home.

Definition:

A structured handoff is the process of transferring information, authority, and responsibility for patients during transitions of care. Transitions include changes in providers (shift-to-shift, service-to-service) or when a patient is moved from one location or level of service to home or another level of care. Transitions may also be prompted due to caregiver fatigue.

Policy:

Each residency and fellowship program must develop a Transition of Care (Structured Patient Handoff) Policy that outlines the expectations for transfer of responsibility for patient care in all the settings/situations in which handoffs occur. The amount of information to be included in the process will vary depending on the functional role of the resident or fellow in patient care and the requirements of the clinical setting and facility. Residents and fellows providing continuous and direct care and taking responsibility for order writing require a higher level of information exchange than those with less continuous duties, such as consultative or supervisory services.

Each program must¹:

1. Design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
2. In partnership with their Sponsoring Institution, ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.
3. Ensure that residents and fellows are competent in communicating with team members in the hand-off process.

Transitions of Care Hand-Off Guidelines

1. Time/Place

¹ ACGME Common Program Requirements, Section VI.E.3

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The location should minimize distractions/interruptions and allow access to needed resources (e.g., appropriate information systems). The handoff process must allow the receiving physician to ask questions; thus, verbal handoffs are required as well as written among caregivers assuming primary care.

2. Structure/Protocol

Written information for trainees in a supervisory or consultative role must include sufficient information to understand and address active problems likely to arise during a brief period of temporary coverage, or to assume care without error or delay when care is transferred at a change of rotation or service.

It is strongly encouraged that programs utilize a published handoff mnemonic tool (e.g., SBAR, SIGNOUT, I-PASS etc.)

3. All patients for whom a resident or fellow is responsible must be included in the handoff.

4. Transitions of Service

A transfer note must be provided by the “sending” resident or fellow when a patient is transferred to a different level of care or to a different service. Acceptance of the transfer must be documented by the receiving service. Residents/Fellows are accountable to additional requirements as specified in each institution’s Medical Staff Policies/Rules/Regulations.