Section 4	General Policies & Procedures	Effective:	June 2013
Policy 4.7.	**Transition of Care (Hand-off) Policy**	Revised:	August 2015
		Responsibility:	Designated Institutional Official

Transition of Care Policy

Purpose	To establish training and operational standards to ensure the quality and safety of patient care. Transitions of care (the "hand-off") between providers are vulnerable to error, and a careful delineation of the UTHSCSA training programs' and the residents' responsibilities will help to minimize the number of errors that may occur following those transitions.
Definitions	The "transition of care" referred to in this policy is the hand-off of responsibility for patient care between one provider to another, most commonly at the time of "check-out" to on-call teams. However, the same principles apply in other transitional settings, especially when transfers occur between levels of care (e.g., ward to or from ICU level of care), the scheduled change of providers (e.g., end-of-month team switches), or upon change of status from inpatient to outpatient or vice versa.

Policy

1. Program Directors must perform training on hand-offs up to a level of competency before residents are assigned responsibility for patient care. Multiple resources for such training are available and the mechanism of training will be deferred to the Program Director's judgment. (2011 CPR VI.B.3)
2. Program Directors must monitor the performance of hand-offs to both ensure their ongoing performance, as well as to determine the residents' competency for same, after initial training is done (2011 CPR VI.B.2). The mechanism for such monitoring will be deferred to the Program Director's judgment.
3. A defined structure for the hand-off exists, and must include at least:
    a. The name of the patient, location, and a second, chart-based identifier (e.g., medical record number; last four digits of SSAN).
    b. Identification of the primary team, or attending physician.
    c. Diagnosis of the patient.

   d. As necessary, the current status or condition, including code status, of the patient.
   e. Pertinent clinical information deemed necessary for coverage for the patient (e.g., drug allergies, current medications, lab abnormalities, recent procedures or changes in condition, etc.)
   f. Any elements that the recipient must perform (the “to-do” list).
   g. As necessary, suggested actions to take in the event of a change in the clinical situation (the “if-then” list).
   h. Augmentations to the above elements are encouraged, and should match the needs of the particular training program.
4. The following general guidelines should be followed:
   a. The number of hand-offs, per period of time, should be minimized as much as possible.
   b. Face-to-face hand-offs should occur if at all possible. If not possible, telephonic verbal hand-offs will occur but in either case a recorded hand-off document (written, or electronically displayed) will be available to the recipient. The hand-off must include an opportunity for the participants to ask and respond to questions. Ideally, hand-offs should occur without interruptions, and discreetly.
5. Participating training institutions must depict call schedules such that the current resident(s) and attendings (i.e., even the on-call teams) are visible to all members of the health care team.