BAPTIST MEMORIAL MEDICAL EDUCATION

Graduate Medical Education
POLICY AND PROCEDURE MANUAL

Effective Date: January 2015	**Handoffs / Transitions of Care**
Last Review/Revision: July 2017; August 2021, April 2025	
Reference: BMME 0016	

HANDOFFS AND TRANSITIONS OF CARE

I. Rationale

To assure continuity of care and patient safety, the ACGME requires a structured and monitored handoff process, training for competency by resident/fellow in handoffs, and readily available schedules listing resident/fellows and attending physicians responsible for each patient's care. In addition to resident/fellow-to-resident/fellow patient transitions, resident/fellow must care for patients in an environment that maximizes effective communication among all individuals or teams with responsibility for patient care in the healthcare setting.

II. Policy

A. Each training program should minimize transitions in patient care within the context of the other duty hour standards. Whenever possible, transitions in care should occur at a uniform daily time to minimize confusion.

B. Each residency training program that provides in-patient care is responsible for creating a template patient checklist and is expected to have a documented process in place to assure complete and accurate resident/fellow-to-resident/fellow patient transitions. At a minimum, key elements of this template should include:

- Patient name
- Age
- Room number
- ID number
- Contact info for the primary resident/fellow and attending physician
- Diagnoses
- Allergies
- Overnight care issues including a “to do” list with follow-up lab/ rad pending
- Code status
- Other items as necessary

C. There must be a structured face-to-face, phone-to-phone, or secure intra-hospital electronic handoff that occurs with each patient care transition. At a minimum this should include a brief review of each patient by the transferring and accepting resident/fellow with time for interactive questions. All communication and transfers of information should be provided in a manner

consistent with protecting patient confidentiality. ED and Outpatient transitions should be performed face-to-face as appropriate.

D. In compliance with the Graduate Medical Education Supervision Policy, communication with appropriate supervising faculty must occur in the following situations:
    - ICU admissions to the inpatient service
    - Transfer of patients to a higher level of care, e.g. from the floor to the ICU or a critical change in the patient's status, e.g. cardiac or respiratory arrest
    - Change in code status (DNR)
    - Patient or family dissatisfaction
    - Patient requesting AMA discharge
    - Patient death

E. Each training program is responsible for notifying the hospital telephone operators about its call schedule so that the entire health care team (staff physicians, resident/fellows, medical students, and nurses) know how to immediately reach the resident/fellow and attending physician responsible for an individual patient's care.

F. Each residency training program is responsible for assuring its resident/fellows are competent in communicating with all caregivers involved in the transitions of patient care. This includes members of effective interprofessional teams that are appropriate to the delivery of care as defined by their specialty residency review committee. Methods of training to achieve competency may include GME orientation sessions, annual review of the program-specific policy by the program director with the resident/fellows, departmental and GME conferences, and on-line training activities.

III. GME Monitoring and Evaluation:

GMEC will evaluate the effectiveness of transitions through monitoring of resident surveys, annual program evaluations, and direct observation, when warranted. Programs are expected to develop and follow departmental specific transition of care policies. Each program will evaluate residents in their ability to perform an effective transition of care.