Transitions of Care Policy
Department of Surgery

Handoff communication must occur whenever patient care responsibilities move from one provider (or team of providers) to another. Examples include shift changes and service-to-service or level-of-care transfers of inpatients. The content may include certain standard elements as well as information specific to the clinical setting involved. The handoff tools used by our program is Salar Team Notes, and may also include email, telephone hand-offs and face-to-face interactions.

Each example of handoff communication must include, at a minimum the following information:

- Patient name and date of birth or medical record number
- Patient location
- Name of the physician/licensed independent practitioner responsible for the patient’s care
- Information about the patient’s medical history and current condition, including a primary diagnosis, anticipated changes and what to watch for or do during the next interval of care
- Code status should be included for primary care teams (but not necessarily consultative teams)
- Pertinent labs, imaging and medications

Handoff communication should be interactive, allowing time to ask and respond to questions. It should take place face-to-face whenever possible and be conducted without interruption. When necessary, telephone communication can occur. Leaving written information for the receiving provider is only acceptable if contact information is provided which permits ready access to the transferring provider and if the clinical situation does not require in-person verbal contact between providers.

Residents must also abide by UMass Memorial Medical Center Policy 2215 Handoff Communication

Department of Surgery Specific Protocol for Transfer of Patient Care

**Purpose:** To establish a coordinated, effective and standardized approach to hand-off communication that ensures patient safety and continuity of care.

**Essential elements** of a proper hand-off include:

1. The opportunity to ask and respond to questions regarding patient care, provide time to formulate questions and clarify issues, as well as to verify the information is understood by the recipient.
2. The format should be face-to-face, real-time and interactive. Face-to face is always the preferred method.

Written hand-offs alone in the form of e-mails are insufficient. However, they may be necessary when personnel are not in the immediate vicinity. Written communication must be accompanied by face-to-face or telephone communication and may only be used to supplement patient care information.

The telephone, when necessary, may be used for patient care hand-off of information. A contact number must be provided, in the event that issues of clarification arise.

It is essential that any hand-off situation have the opportunity to ask and respond to questions regarding patient care.

3. Information transmitted about patient treatment plans and conditions must be up-to-date, accurate, clear and relevant.

4. It must include the following patient-specific information:

- Patient name
- MRN
- Location
- Admitting attending, covering attending
- Diagnosis
- Current condition
- Pertinent past medical history
- Current pertinent labs/studies
- Recent changes to patient status
- Anticipated changes (that may occur over the course of the up-coming shift)
- Current treatment plan and goals for the up-coming shift
- Anticipated plan for the next 12 hours, including pending labs and studies requiring follow-up

5. The hand-off should occur in a quiet and non-rushed environment with limited interruptions.

6. The chief resident/senior resident must prioritize the sign-outs to allow for prompt attention to urgent patient issues. (i.e. patient in the ED requiring OR)

Adopted 4/14