DIGNITY HEALTH EAST VALLEY
GRADUATE MEDICAL EDUCATION OFFICE

GRADUATE MEDICAL EDUCATION MANUAL

Title: Transitions of Care	
Policy #: III.B.3	
Date(s) Reviewed and/or Revised: 4/7/21	*Date Approved by GMEC*: 4/13/21

I. Purpose

To establish training and operational standards for transitions of care intended to ensure the quality and safety of patient care. Transitions of care and handoffs between independent providers are vulnerable to error and a clear delineation of training program and provider responsibilities surrounding this activity helps promote and support our institutional culture of safety and ensure the continuity of care.

II. Scope

This policy applies to all graduate medical education programs sponsored by Dignity Health East Valley (DHEV) and all independent practitioners with patient care responsibilities at DHEV.

III. Definitions

» ***Transition of Care:*** the relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting

» ***Handoff***: the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. The handoff process is an interactive communication of specific and essential patient information from one caregiver to another. Handoffs occur during but are not limited to:

  › Change of shift report

  › Temporary transition of patient assignment due to primary care giver leaving the unit for a short time

  › Hand-off of care when transferring from one care setting to another (including post discharge care facilities, radiology, and endoscopy)

» ***SBAR*** – the handoff approach prescribed by Dignity Health locations, includes identifying the Situation, Background, Assessment, and Recommendations for each patient whose care is being transitioned

IV. Policy

The transition of care must follow the SBAR approach and include the opportunity to ask and respond to questions. Adequate time must be allowed for transition communication. Face-to-face transitions are recommended for all residents. Transitions of care must always occur to peers of equal or higher training (never lower). All parties involved in the handoff must have access to an electronic copy of relevant documents and adhere to the SBAR model. The transition process should include the following information at a minimum:

1. SITUATION:
    a. Identify self, unit, patient, and room number
    b. Briefly state the problem or current situation, what it is, when it happened, and current status

2. BACKGROUND:
   Review the following information as applicable to the situation:
    a. Admitting diagnosis, date of admission
    b. List as appropriate current medications, allergies, IV fluids, output, O2 requirements.
    c. Most recent vital signs and relevant trends
    d. Lab results: include the date and time test was done and results of previous tests for comparison
    e. Code Status
    f. Any other pertinent clinical information

3. ASSESSMENT:
    a. Discuss relevant assessment findings with provider

4. RECOMMENDATION: (What the clinician thinks should happen)
    a. For example, I recommend that:
        i. Patient needs to be seen now.
        ii. Patient needs to be transferred to ICU
        iii. Talk to the patient/family about code status.
        iv. Order additional tests
        v. Medication change

Each program is responsible for developing a formal written policy for handoffs and transitions of care that augments this approach for the particular specialty. As residency programs develop at DHEV, each program must develop components ancillary to the institutional transition of care policy that integrates specifics from their field.

Residents will be subject to continuous assessment of their performance during transitions of care. This evaluation will be in the form of direct observation, review of written documentation and ongoing reinforcement/didactic lecture on the subject by faculty as well as senior residents.

Any issues or deficits identified by faculty or senior residents will be constructively addressed immediately via corrective discussion and education, with an emphasis on patient safety. Should faculty or senior residents identify continued issues with a resident's transition of care performance, corrective conversations and required actions will be documented by the faculty and shared with the program director. The program director will decide the next course of action, including but not limited to additional training, remediation and possibly being suspended from any patient care service until the deficit is corrected.

Any repeated challenges with transitions of care will be brought to the GMEC's attention by the program director and the GMEC will decide the appropriate corrective action, including developing an action plan, ongoing monitoring and timeline, possibly updating the transition of care policy and potentially a special review. This heightened expectation will remain in place regardless of the setting or location of the transition of care.

V. Amendments or Termination of This Policy

DHEV reserves the right to modify, amend, or terminate this policy at any time.