Department of Orthopaedics
Transition of Care Policy

In response to the heightened interest by the ACGME in ensuring effective hand-offs at change of shift and change of service, the UTHSCSA Department of Orthopaedic Surgery has adopted the following policy on proper handoffs amongst the residents. All residents will have completed the Department of Orthopaedic Surgery's training on hand-offs during the PG-1 year.

Protocol

A resident hand-off report must occur whenever resident responsibility for a patient's care changes. This includes situations such as patient transfers between units and/or services, night call and weekend coverage. Rules regarding transition of care documentation, including medicine reconciliation notes, are governed by the individual institutions.

Change of Shift

The hand-off will consist of verbal exchange (preferably in person), written communication, and transfer of responsibility.

A. Verbal exchange – should be face to face to allow dialogue and must be in relaxed setting without multiple distractions, (i.e. not in trauma bay, ignore pager during hand-off, etc.), should include as many members of the treating team as possible, but at minimum must include the two residents involved in handing off the pager carrying responsibility.

B. Written communication- this will mostly consist of the trauma list for the trauma team, however, it will also consist of individualized cards with pertinent information (PMH, diagnosis/injury list, allergies, medications, etc.) and a to do list for patients that have been recently admitted both by the trauma team as well as the subspecialty teams. The person on call at night must be aware both verbally and in writing of the patients he/she is covering on the subspecialty services.

C. Transfer of responsibility- The person on call must accept responsibility for the care of the patients he/she is covering regardless of whose service said patient is on.

Change of Service

The hand-off will consist of the same three elements. The verbal exchange again should be face to face if possible. Written communication will consist of the last progress note on a given rotation providing a summary of medical/surgical history, a complete injury list, interventions, the hospital course up to that time, as well as anything that is planned during the remainder of the hospital stay or anything that needs to be done related to disposition of the patient. Transfer of responsibility must occur.

Transfers

In the event that a patient is transferred from an Orthopaedic service to another service or vice versa, the same three components of the hand-off should take place. There must be a verbal exchange between services. The written communication should consist of a detailed transfer note written by the transferring team with diagnosis/injury list, past medical and surgical history, current medications, allergies to medications, any disposition related issues (weight bearing type and duration, physical

therapy, antibiotic duration, follow up, etc.), and a brief but detailed hospital course up to that point. The accepting service should then acknowledge in a progress note the transfer of responsibility of care with any pertinent information related to the patients' plan of care.

Quality Assurance

Training: Transitions will be taught during the orientation for the PG1 residents using one of the two mnemonics listed as below. A simulated hand-off may be presented by the faculty or Chief Resident(s) if time allows. Each resident will be observed during a brief simulated hand-off on their own, assuring competency is documented before assuming patient care responsibilities.

The faculty on call and the faculty from each service will periodically call the residents on call to assess the adequacy of the hand-off knowledge transfer. (See spot-check evaluation form).
At least twice during each rotation, the site supervisor (or designee) will observe the hand-off process and provide feedback. (See Transition evaluation form).

Senior residents are responsible for assuring that their call team is current on all aspects of patient care and responsive to consultations from the ER and other services during coverage hours. The attending staff on-call are to be kept up to date on all significant medical decision making. This is especially important when it comes to decisions for major interventions and admissions.

Confidentiality

Care must be taken to maintain patient confidentiality by allowing only those involved with the patient's care to hear or view protected healthcare information. Physicians must be aware of and comply with HIPAA regulations.

Language

Language differences may interfere with the accurate transfer of information. Using standardized medical terminology avoids errors in commination that may occur when colloquialisms are used. The use of abbreviations, other than those that are well-known and widely accepted, is discouraged.

<u>At each sign-out</u>:

<u>Both the checking out resident and the on-call resident need to have the same list.</u>

Additional Communication Methods that May be Helpful

Performing handoffs in a routine time and manner also can improve the sharing of information. Patient handoffs should take priority over all other duties except for emergencies.

The TeamSTEPPS™ developed by the Agency for Healthcare Research and Quality and the United States Department of Defense, is an evidence-based teamwork system to improve communication and teamwork skills among healthcare providers. It includes strategies to enhance information exchange during transitions of care. The TeamSTEPPS™ program includes the "I PASS THE BATON" mnemonic, as shown in Table 1, which may facilitate the process for handoffs and health care transitions.

Table 1 "I PASS THE BATON" Mnemonic for Handoffs and Health Care Transitions

I	Introduction	Introduce yourself and your role or job (include patient)
P	Patient	Name, identifiers, age, sex, location
A	Assessment	Present chief complaint, vital signs, symptoms, and diagnosis
S	Situation	Current status or circumstances, include code status, level of (un)certainty, recent changes, and response to treatment
S	SAFETY Concerns	Critical lab values or reports, socioeconomic factors, allergies, and alerts (eg, falls or isolation)
The		
B	Background	Comorbidities, previous episodes, current medications, and family history
A	Actions	What actions were taken or are required? Provide brief rationale
T	Timing	Level of urgency and explicit timing and prioritization of actions
O	Ownership	Who is responsible (person or team) include the patient or family?
N	Next	What will happen next? Are there anticipated changes? What is the plan? Are there contingency plans?

SBAR Assessment (Situation, Background, Assessment, Recommendation)

SBAR is another standardized way of communicating which promotes patient safety because it helps individuals communicate with each other with a shared set of expectations. Staff and physicians can use SBAR to share patient information in a concise and structured format. It improves efficiency and accuracy.

Table 2

Situation	• Identify yourself, occupation, and where you are calling from. • Identify the patient by name, date of birth, age, sex, reason for report. • Describe the reason for phone call or current status of the patient; if urgent, say so.
Background	• Give patient's presenting complaint • Give patient's relevant past medical history • Brief summary of background
Assessment	• Vital signs: heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, pain scale, level of consciousness • List if any vital signs are outside of parameters; what is your clinical impression • Severity of patient, additional concern
Recommendation	• Explanation of what you require, how urgent and what action needs to be taken • Make suggestions of what action is to be taken • Clarify what action you expect to be taken

Orthopaedic Spot-check Hand-off Form

Observer: _____ Date: _____ Time: _____

Service: _____

On Call Resident: _____ Level: _____1 _____2 _____3 _____4 _____5

	Adequate	**Inadequate**
Could name residents and faculty on-call		
Had information in all inpatients		
Had information on all consults, ER patients		
Index patient query:		
Clarity of index patient presentation		
Clarity of index patient safety concerns		
Clarity of index patient actions required		
Clarity of index patient care plan		
Understanding of rationale behind treatment		

Overall Understanding of the patients	Poor – Unable to articulate or express understanding	Acceptable – missed a few things but not important issues	Excellent – on top of patient info, details & treatment plan

Comments:

Orthopaedic Observation of Transition Evaluation Form

Observer: _____ Date: _____ Time: _____

Service: _____

Check-out Resident: _____ Recipient: _____

	Adequate	**Inadequate**
Structure		
Clarity of patient presentation		
Clarity of safety concerns		
Clarity of actions that are required		
Clarity of residents and faculty that are on-call		
Clarity of care plan		
Recipient was able to express questions/concerns		

Length	Appropriate	Too Short	Too Long

Comments: