RUTGERS HEALTH

Policy Name:	Transitions of Care			
Section #:	3.3	**Section Title:**	Clinical Learning Environment	
Approval Authority:	GMEC		**GMEC Approved:**	1/17/2025
Responsible Executive:	DIO		**Revised:**	12/4/2024, 1/8/2025
Responsible Office:	Office of Clinical and Health Affairs, Rutgers Health		**Contact:**	Institutional Coordinator

1. Reason for Policy

To establish compliance that meets Rutgers, state, federal, and accreditation regulations

2. Applicable ACGME Institutional Requirements

III.B.3

3. Resources

i. Accreditation Council for Graduate Medical Education Institutional Requirements
ii. Accreditation Council for Graduate Medical Education Common Program Requirements
iii. Committee of Interns and Residents (CIR) Collective Bargaining Agreement
iv. Rutgers University Policies
v. New Jersey Board of Medical Examiners
vi. American Board of Medical Specialties

4. Scope

The scope of this policy applies to all Rutgers Health residents and fellows.

5. The Policy

I. **Purpose**: To establish protocol and standards within Rutgers Health residency and fellowship programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

II. **Definition:** A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

a. Change in level of patient care, including but not limited to inpatient admission from an outpatient procedure, diagnostic area or Emergency Department, transfers to or from a critical care unit, and transfers to or from outside hospitals.
b. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas.
c. Discharge, including discharge to home or another facility such as skilled nursing care.
d. Change in provider or service change, including change of shift for nurses, resident

sign-out, rotation changes for residents, and subspecialty service changes.

III. Procedure:

a. The transition/hand-off process should be face-to-face interaction* with the opportunity for the receiver of the information to ask questions or clarify specific issues. The transition process should include information in a standardized format that is universal across all services but may vary depending on trainee level, level of care, or EMR tool used. Some common examples include:
   i. Identification of patient, including name, medical record number, and age
   ii. Identification of admitting/primary/supervising physician and contact information
   iii. Diagnosis and current status/condition (level of acuity) of patient
   iv. Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
   v. Outstanding tasks – what needs to be completed in immediate future
   vi. Outstanding laboratories/studies – what needs follow up during shift
   vii. Changes in patient condition that may occur requiring interventions or contingency plans

   *Hand-offs can be conducted over the phone provided both parties have access to an electronic or hard copy version of the sign-out sheet, and all attempts to preserve patient confidentiality are observed.

b. Each residency program must develop components ancillary to the institutional transition of care policy that integrate specifics from their specialty field. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:
   i. A quiet setting free of interruptions is consistently available, for handoff processes.
   ii. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines.
   iii. The program uses a standardized process with consistent opportunity for questions and all necessary materials available (for example written sign-out materials and/or electronic clinical information) to support the handoff.
   iv. Residents comply with specialty specific/institutional duty hour requirements
   v. Faculty are scheduled and available for appropriate supervision according to the requirements of the scheduled residents.
   vi. All parties (including nursing) involved in a particular program and/or transition process should have access to one another's schedules and contact information. All call schedules should be readily available.
   vii. Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
   viii. All parties directly involved in the patient's care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.
   ix. Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.
   x. Programs should provide an opportunity for residents to both give and receive feedback from each other or faculty physicians about their handoff skills.

c. The Sponsoring Institution must facilitate educational programming for core faculty and

residents/fellows on structured hand-over processes to facilitate both continuity of care and patient safety. For example, training residents in commonly used transitions of care tools like SBAR or iPASS.

d. Programs must ensure that residents/fellows are competent in communicating with team members in the hand-over process. There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These include:
    i. Direct observation of a handoff session by a licensed independent practitioner (LIP)-level clinician familiar with the patient(s)
    ii. Direct observation of a handoff session by an LIP-level clinician unfamiliar with the patient(s)
    iii. Either of the previous, by a peer or by a more senior trainee
    iv. Evaluation of written handoff materials by an LIP-level clinician familiar with the patient(s)
    v. Evaluation of written handoff materials by an LIP-level clinician unfamiliar with the patient(s)
    vi. Either of the previous, by a peer or by a more senior trainee
    vii. Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment
    viii. Assessment of handoff quality in terms of ability to predict overnight events
    ix. Assessment of adverse events and relationship to sign-out quality through:
        1. Survey
        2. Reporting hotline
        3. Trigger tool
        4. Chart review

IV. Oversight and Monitoring:

a. Each program must submit a protocol for their transitions of care process which must be reviewed and approved by the DIO or designee every five years, or sooner if necessitated by accreditation or safety standards. Issues regarding transitions of care may be reported via surveys, evaluations, safety reporting systems (e.g., hotlines, apps, etc.) and other as detailed in RH Mechanisms for Confidential Reporting policy.