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

II. Scope
This policy applies to all graduate medical education residency and fellowship programs with reference to transitions of care within the institution.

III. Definitions
- **Resident**: any physician in an accredited graduate medical education program, including interns, residents, and fellows.

- **Transitions of care**: the transition of care referred to in this policy is the handover of responsibility for patient care from one provider to another, most commonly at the time of sign out to on-call teams. However, the same principles apply to other transitional settings, including transfers between one clinical care setting to another, or the scheduled change of providers (e.g. end of month team switches).

- **Handover**: transfer of essential information and the responsibility for care of the patient from one health care provider to another.

- **Patient safety practices**: habits and routines that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions.

IV. Policy Statement
A. **Key patient safety practices are critical to the effective transition of care**:

1. **Interruptions must be limited**
   - Participate in hand-off communication only when both parties can focus attention on the patient-specific information (i.e. quiet space).
2. **Current, minimum content must be conveyed**
   - Patient name, location and a second chart-based identifier (e.g. MRN or DOB)
   - Identification of primary team or attending physician

3. **Standardized Process must be followed:**
   Programs are encouraged to use the I-PASS format when care is being transitioned to another provider(s)
   a. **Illness severity:** Stable, “watcher”, Unstable
   b. **Patient Summary:** Summary statement: events leading to admission, hospital course, ongoing assessment, plan, code status
   c. **Action list:** to do list; timeline and ownership
   d. **Situation Awareness & Contingency Planning:** Know what is going on, and plan for what may happen
   e. **Synthesis by Receiver:** Information for each patient is paraphrased by receiver to confirm understanding and answer all questions

4. **A hand-over document (written or electronic) must be available to the receiving provider**
   - Handover documents must be HIPAA compliant and follow a standardized format (i.e., I-Pass - see above)

5. **The opportunity to ask and respond to questions must be provided**
   - Allow adequate time for handover communication and maximize opportunities for face-to-face or verbal handoffs:
     - Face-to-face handovers should occur when possible
     - If not possible, telephone verbal handovers may occur

**B. Office of GME Responsibilities**

1. The Sponsoring Institution must monitor programs to ensure that each program has a handoff/transitions of care policy that applies specifically to their specialty. These policies must be submitted to the Office of GME at least annually and whenever requested.
C. Training Program Responsibilities

1. Each program must have its own policy for transitions of care/handoff. These policies must address any specialty-specific tasks necessary for a safe and effective transition of care.

2. All schedules and call-schedules must be made available to nurses, attendings, and other House Staff Officers through New Innovations or other appropriate methods.

3. The Training program must ensure that the schedule of House Staff Officers minimizes the number of transitions of patients to maintain patient safety and continuity of care, and also allow House Staff Officers to comply with ACGME and New York State Duty Hour regulations.

D. Responsibilities of the Residency and Fellowship Program Directors:

1. Ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

2. Ensure that residents are competent in communicating with team members in the hand-over process.

3. Design clinical assignments to minimize the number of transitions in patient care.

Approved by GMEC: 8/3/2016, 1/14/19