Division of Nephrology
Transition of Care Policy

Often, primary services request a nephrology consultation overnight or on weekends where the on–call fellow provides the initial and a few subsequent hospital visits. Furthermore, there are instances where the primary nephrology consultation service needs to inform the on–call fellow of anticipated events on patients overnight (e.g., if the line clots during CRRT, should the individual be re–started?). These are instances where trainees must communicate with those assuming patient care. Hand–offs start with any transition of care. Updated notes require a stated plan for every patient. Every plan must be verbally summarized by the oncoming team. Clarifications and questions should occur at the completion of each patient’s presentation.

The hand–off requires the following: 1) verbal exchange in an environment free of distraction. It should involve as many members of the consult team as possible. 2) written communication, consisting of a patient list (from the primary nephrology consultation team to the overnight or weekend on–call trainees), and 3) transfer of responsibility.

**Training:** Nephrology fellows are graduates of ACGME–certified internal medicine programs, and they understand that duty hour limits have increased the frequency of transitions of care. Therefore, most nephrology fellows (universally ABIM board–eligible in their first year of nephrology training) have some familiarity with hand–offs. Our transition of care tool is provided at orientation. Nephrology faculty or senior fellows will document their competence at the beginning of training by direct observation.

The same elements will be used with changes of service.

1. Initial instruction “up to competency” at start patient care
2. Ongoing monitoring of competency
3. The packet of info–basic load but may customize

The competency test is “show me how you do it.” This can be by email.

Requires:
- The name of the patient, location, and a second, chart–based identifier (e.g., medical record number, last four digits of SSAN).
- Identification of the primary team, or attending physician
- Diagnosis of the patient and a pertinent past medical history as well as the hospital course.
- As necessary, the current status or condition (including code status) of the patient.
- Pertinent clinical information deemed necessary for coverage for the patient. For example, drug allergies, current medications, lab abnormalities, recent procedures or changes in condition.
- Any elements that the recipient must perform, (i.e., the “to–do” list). A clearly stated plan is requisite.
- As necessary, suggested actions to take in the event of a change in the clinical situation, (i.e., an “if–then” list).
i. An opportunity to ask questions or clarification,

The number of hand-offs per period of time should be minimized. Face-to-face hand-offs should occur when possible. If not, telephonic verbal hand-offs will occur, but in either case a recorded hand-off document (written or electronic) will be available to the recipient. The hand-off must include an opportunity for the participants to ask and respond to questions. Hand-offs should occur without interruptions.

Monitoring:
Observations by faculty or senior residents of hand-offs occur daily. At least once during the first 3 months of training, the faculty will formally record an evaluation of the trainee’s handoffs and document this for competency. Ongoing monitoring will determine the need for further feedback and documentation.

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