Transition of Care/Patient Handover
University Hospital

Purpose:
Patient handover refers to the orderly transmittal of information, face to face, that occurs when transitions of the care of the patient are occurring, such as when the on-call physician is taking charge of the patient from the current physician. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. The purpose of this policy is to establish an orderly protocol for the handing off of patient care to the next shift. The Neurosurgery Residency Training Program recognizes that a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being.

Background:
Previous studies from a variety of industries have shown that errors can occur when transitions of care occur only through telephonic communication. Face to face interaction allows each party to ask questions, and clarify information about the status of pending test results, acute problems with the patient, or other matters.

Serious errors in patient care that affect patient safety can occur due to inadequate hand-off. For this reason, the hospital administration, as well as the department chair, residency director and supervising faculty all place great importance on these issues of transition of care from one house staff physician to the other. Failures in this hand-off which results in lapses of patient cared will be investigated and disciplinary procedures can be invoked. These would be considered lapses in professionalism and lapses in patient care responsibility, which could have serious adverse consequences for the resident involved.

Procedure:
Check-Outs occur every day at 6AM and 4PM in the NSU call room.
All members of incoming and outgoing teams should be present.* Residents must not leave the hospital until face to face hand off has occurred with the physician coming onto the service at the shift transition.
Telephonic or electronic hand off are not acceptable.

- Updated patient list is printed and distributed for conduction of patient hand-off verbally.
- In am, the overnight on-call resident updates the list for the existing patients and adds all new patients.
- In pm, each team updates the assigned patients in the list and prints it for the incoming overnight team.

NSU census list is maintained in the UTHSCSA Department of Neurosurgery Intranet. It is updated daily and as necessary. The list contains all pertinent information necessary to the NSU team for daily rounds.

Sample:

<table>
<thead>
<tr>
<th>Location Bed #</th>
<th>Patient’s Name/ NSU Faculty</th>
<th>Date of Birth, Age and Sex</th>
<th>MR #</th>
<th>Diagnosis (Specific NSU Diagnosis)</th>
<th>Admitting Service</th>
<th>Operative Procedure and date</th>
<th>Medications</th>
<th>Miscellaneous</th>
</tr>
</thead>
</table>

Reviewed and approved by GMEC, August 11, 2015
- **New Consults** are presented by the *consult resident*. Item discussed:
  - Pertinent history of illness, NSU issues, imaging studies and labs, and type of procedure performed/needed
  - If patient requires ICU care, ICU format for check out is used
  - If patient is intermediate or floor status, floor format is used
  - Plan of care and questions are discussed with faculty.

- **Post-operative patients** are presented by the *resident surgeon*. Item discussed:
  - Pertinent history of illness and type of procedure performed
  - If patient requires ICU care, ICU format for check out is used
  - If patient is intermediate or floor status, floor format is used

- **Surgical ICU patients** are discussed by systems, led by *outgoing ICU team*. For each patient discuss:
  - Pertinent history and procedures performed along with wound status
  - Primary NSU or Consult status**
  - Code status and allergies
  - Overnight or during the day events
  - **Neuro**: Current Neurologic status/exam with review of pertinent films and tentative plan of action made for decline in exam
  - Presence of ICP/EVD monitoring identified and goals with plan of action is made for pressures falling outside of normal range
  - **Electrolytes**:
    - Sodium level goal and treatment plans with frequency of lab draws and current medications/drips (hypertonics, mannitol, etc)
    - Other electrolytes as K, Mg, etc, with medications/drips and treatment goals
  - **Medications**:
    - AED and their levels identified along with frequency of lab draws
    - Other medications/drips as steroids, analgesia, sedation, paralytics, etc.
  - **Pulmonary** status and goals. Ventilatory management and plan of action for changes in status.
  - **Cardiovascular** status: Goals/parameters for CVP, BP, CPP, MAPs, along with current medications/drips discussed and plan of action for values falling outside the goal range
  - **FEN/GI** status:
    - NPO status and goals with type, rate and route of feeds and plan of action for changes in status or residual feeds falling outside parameters
  - **Endocrine**: Blood glucose parameters and plan of action for abnormal values
  - **Renal** status and plan of action for abnormal UOP, specific gravity. BUN, Cr
  - **Hematologic** status:
    - H/H, coagulation goals/parameters identified. Related medications/drips discussed.
    - DVT prophylaxis with plan of action for type of prophylaxis and/or timing of administration for chemical prophylaxis
    - Frequency of lab draws and plan of action for abnormal values
  - **Infectious/Isolation** status and body temperature goals identified
    - Antibiotic regimen
    - Plan of action for body temp falling outside normal range
    - CSF results (if send)
  - **Imaging**: All studies performed are reviewed. Those to be ordered and followed are identified and plan of action for abnormal findings is made

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Check List Reviewed and Other Problem Areas Discussed

- **Pediatric ICU patients** are discussed as above

- **Neonatal ICU patients** are discussed as above.

- **Intermediate and regular ward** patients are presented by *outgoing floor team*. Discuss:
  - Pertinent patient history and procedures performed along with wound status
  - Primary NSU or Consult status**
  - Overnight or during the day events
  - Code status and allergies
  - **Neuro:** Neurologic status/exam and plan of action for decline in exam
  - **Other:** Sodium and other labs along with frequency of lab draws
  - **Medications:** AED, Analgesics, AEDs, steroids, antibiotics, etc. Plan of action for changes in status
  - **Imaging:** Imaging studies performed are reviewed. Those to be ordered and followed are identified and plan of action for abnormal findings is made
  - **GI status** Identified and changes for any planned procedures
  - **DVT prophylaxis** and plan of action for abnormal findings
  - **Other systems** as necessary
  - **Placement and rehab/physical therapy** status and plan of action for placement assistance (social work needs, medical records, etc.)

- Check List Reviewed and Problem Areas Discussed.

- **Pre-Operative (next day) patients** are discussed by *chief resident*
  - Imaging studies to be checked and ordered
  - Labs to be ordered along with appropriate parameters
  - Other pre-op procedures to be done
  - NPO status
  - Plan of action for lab/imaging abnormal values
  - Assignment of cases to each resident

- All pagers (consult/floor/ICU and chief calls) transferred to on-call team

*All residents are excused from OR for check-out. In the rare case the chief resident is required to stay in the OR or is addressing an emergency, the incoming chief will discuss major problems with the outgoing chief prior to checking out with the team. The incoming chief will then check out with the team and have full check-out with outgoing chief after emergency/surgery addressed.

**For primary NSU patient the discussion is performed as outlined above. For Consult patient, the discussion is limited to the pertinent NSU issues.