I. Purpose: This policy aims to define a safe process for conveying important information about a patient’s care during transfer of responsibility from one resident physician to another. Its intent is to ensure that patients receive continuous, coordinated delivery of care in settings that are appropriate to patients’ needs, including arrangements that extend beyond the inpatient setting into the community and the home.

I. Background: Transitions of care are defined as the relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.

A handoff is the active process of transferring information, authority and responsibility for a patient during transitions of care. Transitions include changes in providers, whether from shift to shift, service to service, or hospital or clinic to home. Transitions also occur when a patient is moved from one location or level of service to another. In providing patient care that is compassionate, appropriate, and effective residents must demonstrate the ability to provide transfer of care that ensures seamless transitions.

Both written and verbal handoffs are important, and each has a different purpose. Written handoffs provide detailed information that serves as a reference for the receiving provider. Verbal handoffs provide “big picture” communication about the patient and should include discussion and cross-checking with the receiving provider to be certain that he/she has understood the information being provided.

II. Expectations: Although clinical assignments are made to to minimize the number of transitions in patient care there will be routine and special circumstances where transitions will have to occur and standardization of this process optimizes safety and efficacy. All interns are required to attend the “handoff” training session at boot camp during orientation. During this session, initial performance and feedback on handoff will be documented by observing simulated hand-offs as well as with subsequent observed OSCE handoff during the first quarter of the intern year. Feedback is also provided for all interns and residents on an ongoing, periodic and regular basis using IPASS Feedback tools in appendix.

1. Handoff Mechanics
   - Handoffs should take place in a location that minimizes distractions and interruptions.
   - All needed resources must be available and accessible (EMR, PACS, STACPad).
   - Handoffs should be both verbal and written in all settings. The handoff process MUST allow the receiving physician to ask questions.
   - Face-to face verbal handoffs are required for
     - shift change handoff (day to night and night to day)
     - change in level of service handoff (Floor to PICU and vice versa)
   - Telephonic verbal handoff in addition to written format is allowed for change of block team handoff.

2. Structure for handoffs: structured hand-over processes facilitate both continuity of care and patient safety
   - **Verbal handoffs** should follow a predictable structure using the IPASS Mnemonic found in Appendix A.
     • The “watcher” or “unstable” patients should be noted.
     • The “Action List” and “Situation Awareness & Contingency Planning”, should be explicitly discussed as should the rationale behind the task.
     • The “receiving” resident must have the opportunity to summarize and prioritize received information.
Handoff length will vary based on the complexity and severity of illness for each patient as well as the extent of the resident’s prior knowledge of the patient.

**Written handoffs** must be structured and organized so that information is provided in a predictable format for each patient following the same **IPASS** Format. The information must be updated at least daily and be current at time of handoff. Written information should include the following:

- Identifying information -- Name, age, weight, location
- Diagnosis and condition (particularly if unstable or evolving). Code status.
- Recent important events
- Problem list (active/chronic)
- Medications and other pertinent treatments
- Pertinent laboratory results
- Pending laboratory / studies that the “receiving” resident will need to review
- Important contact information- providers/subspecialist
- To do tasks
- Anticipated problems/guidance

Residents on Inpatient services will use STAC Pad or the **IPASS** templated Word document OR specific formatted templates available there as long as they include all the information listed above.

3. **Handoffs are always supervised by senior or supervisory residents.**

   “Transferring” Interns will provide handoff on their own patients to either the “receiving” intern or upper level assuming care of the patient. A senior resident (team supervisory PL2 or 3 or a cross covering SR3) will be present to oversee. (i.e. intern to intern handoff alone is not permissible).

   Senior residents are expected to give feedback to interns on their handoff skills at least monthly.

4. A formal handoff must take place for all patients for which the resident is assuming responsibility.

5. A formal handoff must take place whenever a new resident assumes responsibility for a patient.

6. Rotation specific attendings must ensure that residents are competent in communicating with team members in the hand-over process. Handoffs are supervised by faculty or fellows at regular intervals (at least 2-3 x week) on inpatient services. Supervisors are expected to provide feedback, ensure adherence to policy and format, and offer modeled behaviors.

III. Other transitions of service:

1. **Transfers:**

   - Except for transfers in emergency situations, a transfer note must be provided by the “sending” resident when a patient is transferred to a different level of care or to a different service. No transfer note is required if a patient is being relocated but will be cared for by the same service. A “transfer acceptance note” must be documented by the receiving service.
2. Change of team:
   - An “off-service” note must be written by the responsible resident when the entire resident care team rotates off service on the same day and the team has cared for the patient for more than 48 hours (24 hours for ICU care). This note should provide a sufficient summary of the patient’s hospitalization and proposed plans so that the next resident(s) can assume knowledgeable care of the patient in an efficient manner.

3. Discharges:
   - The discharging resident must ensure that the discharge note/summary and orders are completed and accurate.
   - The discharging resident is responsible to ensure that the receiving physician (PCP, Subspecialist or accepting physician at another location) is updated verbally and given the opportunity to ask questions.
   - The discharging resident is responsible for ensuring that information about clinically important laboratory, radiologic, or other results that come to a prescriber after a patient is discharged are conveyed either to the patient, his/her primary care provider, or any appropriate provider. This contact should be documented in the medical record.

4. Fatigue:
   All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. While rotational and call schedules are constructed to mitigate issues of fatigue and residents are educated on and encouraged to use alertness management strategies, it is true that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. It is the expectation that residents will sign out their clinical duties when they cannot perform them in a safe and effective manner, and available residents or faculty will assist them in this handover of care while adhering to the following maximum duty period of length guidelines:
   - Duty periods of PGY-1 residents must not exceed 16 hours in duration.
   - Duty periods of PGY-2 /3 may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
   - Residents may be allowed to remain on-site in order to accomplish these tasks for a maximum additional period of four hours.
   - In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient for reasons limited to required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Further information on annual faculty, intern and resident development opportunities around issues of sleep and fatigue can be reviewed in separate policy.
### Appendix A

#### I-PASS Handoff Essentials

**Better handoffs. Safer Care**

**Structured Verbal Handoff**
- Begin with overview of entire service
- Need proper environment – limit interruptions
- Use IPASS mnemonic
- Employ closed loop communication
- Printed Handoff Document
- Supplements verbal handoff
- May import elements from EMR
- Keeps information current with updates

**High Level Skills**
- Patient Summary
  - Be concise and focused
  - Establish working diagnosis
  - Include semantic qualifiers
  - Ensure check-back with receiver
- Contingency Plans – “If this happens, then...”
  - Problem solve before things go wrong
  - Know potential therapies or interventions
  - Identify most worrisome patients
  - Articulate chain of command

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**Illness Severity**
- Stable, “watcher,” unstable

**Patient Summary**
- Summary statement
- Events leading up to admission
- Hospital course
- Ongoing assessment
- Plan

**Action List**
- To do list
- Timeline and ownership

**Situation Awareness & Contingency Planning**
- Know what’s going on
- Plan for what might happen

**Synthesis by Receiver**
- Receiver summarizes what was heard
- Asks questions
- Restates key action/to do items

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Contingency Plans – “If this happens, then...”
✓ Problem solve before things go wrong
✓ Know potential therapies or interventions
✓ Identify most worrisome patients
✓ Articulate chain of command
Observer Information:
Name:__________________ Date: _ _ / _ _ / _ _ (mm/dd/yy) Obs. Start Time: _ _ : _ _ am/pm Obs. End Time: _ _ : _ _ am/pm

How well do you know the patients whose handoff you are evaluating? Very well Somewhat well Not at all

Resident Information:
Name:___________________ PGY Level:_________ Total number of patients discussed during the handoff ______

Type of Handoff
1. Please indicate the type of handoff you observed (check one):
   Individual Team

How frequently did the resident receiving the handoff do the following:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Verbalize a concise, accurate summary of each patient</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Appear focused, engaged, and demonstrate active listening skills.</td>
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</tbody>
</table>

4. Rate your impression of the number of clarifying questions asked by the receiver:
   Insufficient number of questions Appropriate number of questions Excessive number of questions

5. What was especially effective about the handoff?

6. What aspect(s) of the handoff could be improved?

7. Additional comments:

8. Was resident given feedback within 24 hours of observing sign-out? Yes No
### Observer Information:

Name: ___________________ Date: __/__/__ (mm/dd/yy) Obs. Start Time: __:__ __:__ am/pm

How well do you know the patients whose handoff you are evaluating? Very well Somewhat well Not at all

### Resident Information:

Name: ___________________ PGY Level: __________ Total number of patients discussed during the handoff: __________

### Type of Handoff

1. Please indicate the type of handoff you observed: Individual Team

### Situational Overview (Big Picture)

2. Was a situational overview provided by the resident giving the handoff (e.g. description of the “big picture” of what will need to be prioritized by the receivers of the handoff):

   Yes No

### Indicate the frequency that the specific element of the mnemonic was used throughout the handoff.

<table>
<thead>
<tr>
<th>Verbal Mnemonic</th>
<th>Description</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Illness Severity</td>
<td>Identification as stable, “watcher”, or unstable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Patient Summary</td>
<td>Summary statement, events leading up to admission, hospital course, ongoing assessment, plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Action List</td>
<td>To do list; timeline and ownership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Situation Awareness/Contingency Planning</td>
<td>Know what’s going on; plan for what might happen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Synthesis by Receiver</td>
<td>Ensures receiver summarizes what was heard, asks questions, restates key action/to do items</td>
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</tr>
</tbody>
</table>

### Rate the frequency with which the resident who gave the handoff did the following:

8. Actively engages receiver to ensure shared understanding of patients (Encouraged questions, asked questions, considers learning style of receiver)

9. Appropriately prioritizes key information, concerns, or actions

### Rate the frequency with which the resident who gave the handoff did the following:

10. Miscommunications or transfer of erroneous information

11. Omissions of important information

12. Tangential or unrelated conversation

### 13. Rate your overall impression of the pace of the handoff:

   Very slow pace/Very inefficient Slow pace/Inefficient Optimally paced/Efficient but not rushed Fast/pressured pace Very fast/pressured pace

### 14. What was especially effective about the handoff?

### 15. What aspect(s) of the handoff could be improved?

### 16. Additional comments:

### 17. Was the resident given feedback within 24 hours of your observation?

   Yes No