Transitions of Care

The GME Team
Objectives

By the end of this session, participants will be able to:

• List 3 of the barriers to effective transitions of care
• List 3 of the “commandments” of effective transitions of care
Transitions of Care

Joint Commission Definition

“A standardized process in which information about patient/client/resident care is communicated in a consistent fashion.”
Transitions of Care

ACGME Requirements – VI.B.

• “Programs must design clinical assignments to minimize the number of transitions in patient care.”

• “Institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.”
Transitions of Care

ACGME Requirements – VI. B.

• “Programs must ensure that residents are competent in communicating with team members in the hand-over process.”
Transitions of Care

So, programs must:

• **Limit** the number of transitions
• **Develop** structured hand-over processes (i.e., develop a template and script)
• **Teach** both residents and attending physicians how to implement the structured processes
• **Evaluate** residents’ competence in communicating with others during hand-overs
Likely CLER “Transitions of Care” Questions for Faculty/Residents/Staff

• What are University Hospital’s priorities for transitions of care?
• Do you use a common written template of patient information for hand-offs?
• Does your program have inter-professional rounding?
• Do you have a standardized process for transfer of patients between floors and units?
• Do you have a standardized process for transitioning patients from inpatient to outpatient?
• Minimal Literature – the first article on physician handoffs in the English literature was in 1988.
• A recent systematic review of the literature revealed only 46 relevant citations from 1988 – 2008 – most were descriptive and anecdotal.
• However the anecdotes with respect to barriers and effective strategies are consistent across the literature.

• The current literature is “not of sufficient quality and quantity to synthesize into evidence-based recommendations.”

Taxonomy of Sign-Out Omissions

- Current Clinical Condition Omitted
- Recent and Scheduled Events Omitted
- Anticipatory Guidance Omitted
- Task Not Assigned
- Plan Not Provided
- Rationale Not Provided

Barriers to Effective Transitions of Care

- Communication barriers (hierarchy, language, general communication)
- Lack of standard system/requirement (no standardization, no tool, no requirements, no system)
- Lack of training (training, education)
Barriers to Effective Transitions of Care

- Missing information (omitted information, incorrect information)
- Physical barriers (lighting, location, noise, interruptions)
- Lack of time
- Difficulties due to complexity/high numbers
The Ten Commandments of Effective Patient Handoffs

1. Designate a quiet space where handoffs occur.
2. Reduce interruptions (pages, nurses, etc). If an interruption occurs, begin the discussion of the patient over again.
3. Set specific times for handoffs, which allows an overlap of the people involved.
4. Use templates for sign-outs.
The Ten Commandments of Effective Patient Handoffs

5. Empower givers and receivers.
6. Review every patient: anticipated problems, major medical issues, to-do lists to complete (and why each item is needed).
7. Do read-backs on all items on the to-do list.
8. Be as specific as possible and use concrete language.
9. Avoid nonstandard abbreviations.

10. Use if-then scenarios (if patient reacts this way, do X; if patient reacts that way, do Y).

(based on work of V. Arora, M.D., University of Chicago)
Prioritized Information (Schema)

- Emergency Treatment
- Patient Family Awareness
- Medication Reconciliation
- Anticipation: Next Steps
- General Care Plan
- Who is Responsible?
- Safety Concerns
- Time Critical Actions
- Current Status, Circumstances
- Uncertainties
- Critical Info, Values
- Major Risks, Threats, Pitfalls
- Admin Data
- Patient IDs
- Background Medical Data
- Relevant Diagnoses

Major Considerations
Evaluate
Background
Transitions of Care

Fundamentally, a patient handoff is a *process* not just a result

- A process which creates a shared perspective
- A process which allows the assumption of personal responsibility
- A two way communication (conversation)
Transition of Care Conversations (Scripts)
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