Policy	Source
HS 24.0 Transition of Care (TOC)	Graduate Medical Education Office

1.0 Purpose

The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring care from one physician to another.

2.0 Background

2.1 In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Transition of care (TOC) refers to the orderly transmittal of information, verbal and/ or written, that occurs when transitions in the care of the patient are occurring.

2.2 Proper TOC should prevent the occurrence of errors due to failure to communicate the status of a patient. In summary, the primary objective of this policy is to ensure complete and accurate information is communicated during a TOC so to ensure safe and effective continuity of care.

3.0 Scope

These procedures apply to all GME House Staff (interns/residents/fellows).

4.0 Characteristics of a High-Quality TOC:

4.1 TOC must follow a standardized approach.

4.2 TOC must include up-to-date information regarding the patient to include at least:

- Patient name, location, MRN, date of birth
- Patient clinical status: diagnosis (including differential), other demographics, vital signs, code status and advance directive, social issues, religious/other care issues
- Allergies: medication and other allergies (food, latex, etc.)
- Precautions: safety-isolation status, fall status, risk of skin breakdown
- Important prior medical history
- Medications (current, last given, precautions needed before next dose), fluids, diet
- Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
- Equipment and other special needs: vent dependent, oxygen, pacemaker, drains, traction, etc.
- Important current labs/cultures
- Past and planned significant procedures - NPO status, consents signed, pre-operative checklist done, blood availability/consent
- Plan for the next 24+ hours
- Pending tests and studies which require follow-up
- Important items planned between now and discharge
- Recommendations of provider transferring care to new provider

4.3 TOC are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information. House Staff must thoroughly review a written TOC form or receive a verbal TOC and take notes. House Staff must resolve any unclear issues with the transferring physician before acceptance of a patient. A process for verification of the received information, including repeat-back as appropriate, must be used.

4.4 Interruptions during TOC should be limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

4.5 Each TOC process ideally includes an upper-level House Staff and/or attending physician as appropriate per service.

5.0 TOC Procedures

5.1 TOC should follow the aforementioned characteristics of a high-quality TOC.

5.2 TOC procedures will be conducted in conjunction with (not be limited to) the following physician events:

- Shift changes
- Meal and rest breaks
- Changes in on-call status
- When contacting another physician regarding a change in the patient's condition
- Transfer of patient from one care setting to another

5.3 TOC forms and policies for physicians are developed and implemented by each service/program according to the needs of that service/program. The TOC forms or policies may be in paper or electronic format and must include information agreed upon by physicians on that service as being integral to the provision of safe and effective patient care for that patient population. House Staff should be orientated regarding TOC forms, procedures, and policies at the start of a rotation.

5.4 House Staff must not leave the hospital/patient care setting until an effective TOC has occurred.

6.0 Program Responsibilities

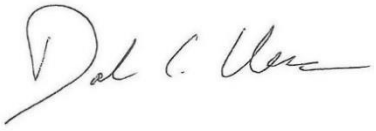
6.1 Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.

6.2 Programs, in partnership with the Sponsoring Institution (i.e., MCG), primary clinical site, and participating sites, must ensure and monitor effective, structured handover processes to facilitate both continuity of care and patient safety.

6.3 Programs must ensure that House Staff are competent in communicating with team members in the handover process.

6.4 Programs and clinical sites must maintain and communicate schedules of attending physicians and House Staff currently responsible for care.

6.5 Each program must ensure continuity of patient care, consistent with the program's policies and procedures, in the event that a House Staff may be unable to perform their patient care responsibilities due to excessive fatigue, illness, and/or family emergency, etc. Program-specific policies should be developed to address this requirement and ensure these policies are implemented without fear of negative consequences for the House Staff who are or were unable to provide the clinical work.



5/24/24

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