

# SAUSHEC Pediatric Residency Program

## Transitions of Care Policy

### AY 2014-2015

In light of the updated program requirements from the ACGME effective 1 July 2011; the SAUSHEC Pediatric Residency Program has developed a “Transitions of Care” policy. The goal of this document is to provide structure to the process of patient handoffs in the inpatient settings and a method of training and evaluation for residents.

#### **Transitions of Care (ACGME language – Program Policy)**

1. **Programs must design clinical assignments to minimize the number of transitions in patient care**
  - The SAUSHEC Pediatric Residency Program has developed transition of care policies that seek to minimize transitions of care by efficient scheduling of day shift and night shift teams that promote patient care continuity and minimize patient handoffs. While remaining in compliance with duty hour regulations, scheduling will enhance continuity of care of inpatient teams and allow for proper, timely and efficient sign-out.
  
2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety**
  - As detailed below, the inpatient services (Ward, PICU, NICU, and Nursery) will have a structured transition of care process that follows the **SAIF-IR** model (Chu, et.al). This model will be adapted to be used with each units checkout document (sign-out sheet) which will be determined by the medical director of the service.

#### **Program adopted SAIF Handoff Model:**

- **Summary statement(s).** These are one to three sentences summarizing a patient’s hospital stay. These are *not* a repeat of the history of present illness.
  
- **Active issues.** Although the written template lists all issues including chronic conditions, we encourage our housestaff to only verbalize active medical issues.
  
- **If-then contingency planning.** These are clues to the oncoming provider of potential issues arising and what the offgoing provider would suggest on the basis of his or her clinical knowledge of the patient.
  
- **Follow-up activities.** These are the tests, procedures, or therapeutics which need to be reevaluated by the oncoming provider.

## **Oncoming provider makes the handoff SAIF-IR**

- **Interactive questioning.** These are questions to clarify or correct information presented by the offgoing provider.
- **Read-backs.** These are repetitions of important information to ensure understanding.

## **Rotation Specific Guidance**

### **• Inpatient Ward Specifics**

- The pediatric ward will do formal handoffs of patients at 06:00 and 17:00 weekdays and 07:00 and 17:00 weekends. The handoffs will be conducted by the ward PGY 2.
- The handoffs will be attended by the ward residents, the on call resident team and the ward charge nurse.
- An update of patient care should happen at about noon when a resident must turn over their patients to another ward team member, to attend clinic or cover the PICU.
- The ward attending must be present for at least one daily handoff.
- Subspecialists involved with current ward patients are encouraged to attend at least one handoff per day. (Note the handoffs are primarily for patient care issues. They are not a forum for formal lectures.)
- The handoffs will utilize a printed handoff sheet (Appendix 2), to facilitate the SAIF-IR process.

### **• NICU Specifics**

- The NICU will do formal handoffs of patients at 0600 h and 1800 h daily. The handoff will be conducted by PGY 1 in the presence of the PGY 2 or PGY3. If the PGY 2/3 is absent (clinic, day off, other), the handoff will be conducted in the presence of a neonatal fellow, staff, or NNP.
- The handoffs will be attended by the NICU residents, and the on-call resident team.
- An update of patient care should happen at about noon when a resident must turn over their patients to another NICU team member, to attend clinic.

- The NICU attending, , and/or NNP must be present for at least one of these daily handoffs.
- The handoffs will utilize a printed handoff sheet (checkout sheet), to facilitate the SAIF-IR process.

- **Nursery Specifics**

- The nursery will do formal handoff of patients at 0600 and 1700 on weekdays and weekends. The handoffs will be conducted by the nursery PGY 2 unless at clinic.
- The handoffs will be attended by the nursery residents and on-call residents.
- An update of patient care should happen at about noon when a resident must leave for clinic.
- The nursery attending is expected to attend a minimum of one sign-out per day for oversight.
- The handoffs will utilize a printed copy of the Essentris Nursery Status Board, to facilitate the SAIF-IR process.

- **PICU Specifics**

- The PICU will do formal handoffs of patients at 06:00 and 16:30 on weekdays and 07:00 on weekends. These are conducted by the PICU PGY-2.
- The morning handoffs will be attended by the post-call PGY-2 and the PICU PGY-2. Afternoon/evening handoffs will be attended by the PICU PGY-2 and the on-call PGY-2 and PGY-3.
- On afternoons when the PICU PGY-2 has to attend clinic, that resident will do formal handoff of patients to the cross-covering PGY-3 (or PGY-2) by noon.
- Afternoon resident handoffs should be done in a targeted manner that highlights the patient's condition in a problem- and systems-based manner. Information should be presented in a direct and efficient manner and be accomplished in a fashion that meets Joint Commission standards of both written and verbal check-out that includes a problem list and medication profile.
- PICU staff must be present for at least one daily handoff.
- The handoffs will utilize a printed handoff sheet (Appendix 3) to facilitate the SAIF-IR process.

## Monitoring

- Structured patient handoffs will be routinely monitored and evaluated by the attending and senior residents.
- A formal evaluation of the resident performing the sign-out, via a MiniCEX (Appendix 1), modeled from Farnan et.al, will be completed weekly during the inpatient rotation by the attending and/or senior resident on service and placed in the resident's portfolio under Interpersonal Communication. Additionally, the attending/senior resident will provide verbal feedback weekly and at the end of the rotation based on the MiniCEX and observed sign-outs.
- All inpatient rotation evaluations will specifically ask for evaluation/comment on the resident's "ability to perform structured patient handoffs that facilitate continuity of care and patient safety."

### **3. Programs must ensure that residents are competent in communicating with team members in the hand-over process**

- Training – As detailed below, all incoming interns and continuing residents will be briefed on the handoff process and evaluation method during intern orientation and transition of care seminars. Additionally, at the beginning of all inpatient rotations, attendings/senior residents will brief oncoming residents on expectations/processes related to structured handoffs.

### **4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care**

- Call schedules are published and available online on the shared drives as well as on New Innovations. The Ward, PICU, Nursery and NICU resident teams carry designated pagers which are made available throughout the institution. Likewise, attendings have designated pagers and each subspecialty has a service pager.

## References

Chu ES, Reid M, Schulz, T et.al. A Structured Handoff Program for Interns. Acad Med. 2009; 84:347–352.

Farnan JM, Paro JM, Rodriguez RM, et.al. Hand-off Education and Evaluation: Piloting the Observed Simulated Hand-off Experience (OSHE). J Gen Intern Med 25(2):129–34

**Attestation Statement:** By signing below, I acknowledge I have read the SAUSHEC Pediatric Residency Program's Transitions of Care Policy. My questions regarding these expectations have been answered to my satisfaction.

\_\_\_\_\_  
**Resident Name (Write Name)**

\_\_\_\_\_  
**Resident Signature**

\_\_\_\_\_  
**Date**

**APPENDIX 1: HAND-OFF CEX INSTRUMENT**

**Sign-out PROVIDER Evaluation**

Evaluator: \_\_\_\_\_ Evaluatee: \_\_\_\_\_ Ward: \_\_\_\_\_ Date: \_\_\_\_\_

Evaluatee:  intern  resident  student  Other: \_\_\_\_\_ Situation:  End of shift  Transfer between services  Admission

Setting ( Not observed)

<i>≥ 5 interruptions; noisy, chaotic</i>	1	2	3		4	5	6		7	8	9	<i>no interruptions; silent</i>
	Unsatisfactory				Satisfactory				Superior			

Organization/efficiency ( Not observed)

<i>disorganized; rambling</i>	1	2	3		4	5	6		7	8	9	<i>standardized sign-out; concise</i>
	Unsatisfactory				Satisfactory				Superior			

Communication skills ( Not observed)

<i>not face-to-face; understanding not confirmed; no time for questions; responsibility for tasks unclear; vague language</i>	1	2	3		4	5	6		7	8	9	<i>face-to-face sign-out; understanding confirmed; questions elicited; responsibility for tasks clearly assigned; concrete language</i>
	Unsatisfactory				Satisfactory				Superior			

Content ( Not observed)

<i>information omitted or irrelevant; clinical condition omitted; 'to dos' lack plan, rationale</i>	1	2	3		4	5	6		7	8	9	<i>all essential information included clinical condition described 'to dos' have plan, rationale</i>
	Unsatisfactory				Satisfactory				Superior			

Clinical judgment ( Not observed)

<i>no recognition of sick patients; no anticipatory guidance</i>	1	2	3		4	5	6		7	8	9	<i>sick patients identified; anticipatory guidance provided with plan of action</i>
	Unsatisfactory				Satisfactory				Superior			

Humanistic qualities/professionalism ( Not observed)

<i>hurried, inattentive inappropriate comments re: pts, family, staff</i>	1	2	3		4	5	6		7	8	9	<i>focused on task; appropriate comments re: patients, family, staff</i>
	Unsatisfactory				Satisfactory				Superior			

Overall sign-out competence ( Not observed)

1	2	3		4	5	6		7	8	9
Unsatisfactory				Satisfactory				Superior		

Evaluation time: Observing: \_\_\_\_\_ min Providing feedback: \_\_\_\_\_ min

Evaluator satisfaction with evaluation:

Low	1	2	3		4	5	6		7	8	9	High
-----	---	---	---	--	---	---	---	--	---	---	---	------

Evaluatee satisfaction with evaluation:

Low	1	2	3		4	5	6		7	8	9	High
-----	---	---	---	--	---	---	---	--	---	---	---	------

Comments: \_\_\_\_\_

## Appendix 2: Ward Check-out Template

**STAFF:** Name: cell XXX-XXXX pager XXX-XXXX **RESIDENTS:** Name: pager XXX-XXXX, Name: pager XXX-XXXX

- Demographics	Systems (issues, pertinent labs/rads, etc.)	Meas	Labs	Day/Dispo issues:	Goals/Overnight:
Name FMP/SSN DOB Age Diag All: Admit date Rm	CNS: HA (post-LP and meningitis), neck pain, afebrile. CV: HDS, PIV, MIVF fluids Resp: SORA FEN/GI: regular diet Renal: routine I&Os Heme/ID: meningitis, likely viral	DHE 0.25mg q8hr Metoclopramide 10 mg IV q8hr Oxycontin 10 mg PO BID (10am/pm) Benadryl 50mg Miralax Dilaudid 0.2mg IV x 1 Morphine 4mg IV q4h Rocophin Vancomycin Fioricet pm (50-325-400) Dilaudid PCA 200mcg q8min	4/1: BHCG neg, throat cx: neg, UA neg CSE: RBC 1, WBC 2, gm stain neg, prot 18.7, glucose 58; VDRL and fungal cx pending Monospot: neg 5.1-12.1/36.6-198 137/4/107/22/12.2/0.77-87 Ca 8.7 P 4.6 Ophtho: no chorioretinitis/optic n compression- reeval after precautions lifted Pain Sv: Change to fentanyl PCA 4/6: 139/4.0/106/25/16.3/0.78-76 Ca 8.5 4/7: 139/4.1/105/24/14.8/0.68-95		[ ] qAM Chem [ ] monitor for dystonic reaction, chest pain [ ] Adolescent fru - needs consult placed
Name FMP/SSN DOB Age Diag All: Admit date Rm	CNS: Afebrile. HA-Percocet PRN, nausea CV: HDS, broviac access Resp: SORA FEN/GI: NPO. Post-hydration IVF Renal: Strict I&Os Heme/Onc: B-cell lymphoma. Induction phase. (Prednisone Day 0-4) Day 0 (4/5)- vincristine, MTX, prednisone, leukovorin Day 1- IT, Cyclophos, Doxorubicin	Vincristine Prednisone-taper on day 5 Methotrexate Cyclophosphamide Zofran 8mg PO IV q6hr Tylenol PRN Ativan 1mg IV q8hr PRN Morphine 2mg q3 PRN Percocet q6h PRN Colace	4/3: 7.5-10.6/31.1-239 4/4: 139/3.5/97.0/ /10.8/0.50-101 Ca 8.7 4/5: 136/3.7/96/35/9.3/0.58-87 Ca 8.6 Uric acid 3.4, LDH 99 UA (2130) SG 1.009, pH 8.5 4/6: 126/4.0/91.0/28/8.6/0.54-147 130/4.2/93/29/9.3/0.59-146 Ca8.9 Uric Acid 3.0, LDH 273 24h MTX level -4.3 UA (1909): <1.005, pH 7.5 4/7: 135/4.2/100/28/10.2/0.54-147 Ca 8.6	[ ] REMEMBER taper of prednisone: Day0=4/5 40mg Day0-4 Order 30mg BID Day5 20mg BID Day6 10mg BID Day7 [ X] Echo tomorrow per Dr. Bush-normal	[ ] Chem. 7 qAM [ ] UA qshift [ ] UA: SG<1.010, pH<7.0 [ ] CBC- 4/8 [ ] MTX level at hour 48 (1000 7Apr11) and q6h after til <=0.1
Name FMP/SSN DOB Age Diag All: Admit date Rm	CNS: Afebrile. No current pain. CV: HDS, PICC Resp: SORA FEN/GI: regular diet. Post-hydration D51/2NS@510 (increased). bolus x2 for decreased PO. Renal: Strict I&Os Heme/Onc: Synovial cell R calf Day 1,2- Doxorubicin Day 1-3- Ifosfamide (Radiation Thurs)	Doxorubicin Ifosfamide Mesna Zofran Emend Kit Nexium 20mg PO qDay Nicotine patch	4/3: 8.1-12.3/36.2-232 137/4.6/102/26/12.7/0.98-131 Ca 8.9, Alb 4.3, Alb P 60, AST/ALT 28/28, Tbili 0.2 4/4: UA(2300): 1.016, pH 5.5 Gm 30 Ket-50 4/5: 139/3.8/108/26/5.3/0.85-107 Ca8.3 UA (2130) SG 1.008, pH 7.0 4/6: 140/3.9/108/27/9/0.78-114 Ca 8.6 CBC-5.7-12/35.7-233 4/7: 139/3.9/104/27/5.7/0.71-119 Ca 8.9 UA(0425): <1.005, pH 7.5	[ ] Call Rad-Onc-he's in house	[ ] Chem 7 qAM [ ] UA: =2cc/kg/hr, SG <1.010
Name FMP/SSN DOB Age Diag All: Admit date Rm	CNS: Afebrile. Oxycodone/tylenol CV: Aortic root dilation. PICC. Lisinopril Resp: SORA, IS, FEN/GI: Reg Diet . Renal: strict I/O Heme: s/p transfusion 3/29- 4/1. ID: Wound cx +MDR enterobacter. Possible colitis	Cefepime 2gm IV q12hr Flagyl 250mg PO q6hr Zofran 8 mg IV q8h pm Tylenol 650mg q6h pm Oxycodone 5mg q4h pm Lisinopril 10 mg po qday Miralax 1 pkt qdaily Ferrous sulfate	4/3: 12.3-8.7/26.3-382 IT: 0.03 Fecel leuk/c: diff: neg 6.7-8.9/26.5-738 CBC- pending	[ ] Call Mary E prior to dispo for home health- 916-5983 [ X] ID and Adol appts	[ ] Cefepime Day 6/1mo course. Flagyl Day 6/10d course [ ] ortho to pull 2nd drain [ ] d/c Fn??
Name FMP/SSN DOB Age Diag All: Admit date Rm					

**STAFF:** Name: cell XXX-XXXX pager XXX-XXXX **RESIDENTS:** Name: pager XXX-XXXX, Name: pager XXX-XXXX

Name FMP/SSN DOB Age Diag All: Admit date Rm					
---	--	--	--	--	--

**Surgery:**  
Name: 1mo M w/ pyloric stenosis  
Name: 8 y/o F, s/p Adenoidectomy/PETs w/ aspiration  
Name: 3yo F Neck mass "plunging ranula"  
Name: 11yo F L supracondylar fracture

Ward surgery patients are discussed and potential problems identified.

**PICU:**  
Name: 20yo F Hx CP, global delay. Increased sz activity- septic shock  
Name: 2mo found unresponsive, NAT

PICU patients and potential transfers to the ward are discussed.

Appendix 3: PICU Check-out Template:

PICU Check out MM/DD/YYYY hh:mm am/pm

Staff: XXXXX (o) 916-xxxx (p) 513-xxxx (c) xxx-xxx-xxxx  
 3<sup>rd</sup> yr pager 513-xxxx  
 Ward workroom 916-xxxx/xxxx

Name: Allergies: NKDA Admitted:  
 FMP/SSN: wt = HD # 1

HPI:  
 Overnight Events:

VS/Exam: Ins:  
 Tmax Outs:  
 P Net:  
 BP  
 R  
 SpO2

Meds: Labs:

Treatments:

Lab Schedule: Rads:

Resp:		CV:	
CNS:		FEN/GI:	
Renal: strict I's and O's	Heme: No current issues	ID:	Social:

Dispo:

