THE UNIVERSITY of NEW MEXICO

Family Medicine Handoff Policy

The UNM FM Inpatient Service consists of two inpatient teams, who alternate day call. Night admissions are divided in the morning amongst the teams. Each team is staffed by an attending, an upper level resident, 1-2 interns and a PA (during the week).

The night float team consists of one upper level resident and one intern, who each carry one team pager.

I. General Principles

The below terms are sometimes used interchangeably, but probably shouldn't be. On our inpatient service we think of them as different processes, with different goals and important points to stress. We complete verbal, face-to-face sign out, and have a corresponding written handoff report that is updated and printed prior to each sign out.

Sign Out: Refers to the temporary transfer of care and responsibility from the primary (outgoing day resident) physician to the covering (oncoming night or weekend resident) physician.

Transfer of Care: Refers to when the primary caretaker for a patient is changing. This happens most often for residents when they complete an inpatient month and are signing the patient out to another incoming resident. It also happens when we transfer a patient in/out of the ICU. Our attendings do this as well at the end of the week.

Transition of Care: This refers to when the *location* of care is changing, such as when a patient is admitted to the hospital, or discharged home (or to a care facility). Our formal transition of care process involves medication reconciliation as well as communication between providers. "Transitions of Care" focuses on things such as avoiding medication errors and communicating important issues in the discharge documentation. We also have communication with the providers who will be assuming care.

II. Additional Information

The information conveyed in "sign out" is much more focused and concise than "transfers of care," and focuses on the important information needed to provide care to patients overnight, or to relay significant overnight events to the oncoming day team. Transfers of care occur in our **Morning Report**, where we have detailed new patient presentations. The remainder of this document discusses sign out/in. When care is transferred to a new provider who will assume primary care for that patient, the process needs to be much more detailed, and should include a detailed run through of the problem list.

Our system is organized around dedicated, specific times at the start and end of shifts that have been blocked out for face to face overnight and morning sign in/out. The exception to this rule is the non day-call resident, who also calls the NF Resident to give team sign out. It is felt that this generally gives better quality sign out than having a double sign out; i.e. daytime resident signs out to day-call resident, who signs out to NF resident. Interns are not involved in phone sign out.

The system is slightly different weekdays vs weekends due to days off requiring different coverage models

Shift times and durations were created to meet duty hours requirements

The NF Intern receives face to face sign out about the team he/she will cross-cover overnight. The NF Resident is present at this sign-out so he/she will be prepared to offer support/assistance to the NF Intern as questions arise.

Our team list is kept accurate and up to date using the powerchart handoff report. Our teams update the lists daily, including a list of "to-do" tasks for the NF team.

Duty hour restrictions lead naturally to the creation of more shift work and thus handoffs. We are continually evaluating the best ways of communicating information to improve transitions of care within the work hour guidelines.

III. Resident Roles

Day-Call Resident: Alternates between team A and B day to day. On weekdays, the Day-Call Resident stays until 7:15pm. Weekends are handled a little differently.

Non Day-Call Resident: Alternates between team A and B day to day. The non Day-Call Resident stays until 5pm, again weekends are handled a little differently.

Day-Call Intern: Alternates among the interns on the rotation. This intern stays until 7:15pm (instead of 5pm).

Night Float Intern: night shift coverage is provided mainly by interns on the inpatient service, with some off-rotation coverage by interns and residents to prevent >6 nights in a row of night float. Hours are 7:00p-8:15a.

Night Float Resident: Sun-Fri is covered by the resident on the night float rotation. Saturday shift is 24 hours covered by an off-service resident. Hours are 7:00p-8:15a

Saturday 24 hour call Resident: shift done by off-rotation upper level residents on Saturdays, and rounds with day call team. The 24 hour shift is necessary for patient continuity from Saturday to Sunday. Hours are 7:00a-8:15a.

Sunday Day-Call Resident: shift done by off-rotation resident, rounds on day call team. Shift is 6:30am to 7:15pm.

IV. Sign In: Both Teams, Every Day

7:00-7:15am Sign In: 3N Conference Room. Discussion of overnight cross-cover issues: All interns/residents. Pagers handed over. Both teams are present but sign out teams separately.

7:15-8:15am Morning Report: 3N Conference Room. Morning Report educational conference and presentation of overnight admissions by overnight intern and resident. Both teams (including attendings) present

V. Evening Sign Out

A. Day-Call Team Sign out (Mon-Fri)

Intern and Resident NF shifts start at 6:45pm.

Day call team sign out: **7:00-7:15pm** 3N Conference room. Day-call intern and resident as well as intern/resident NFs are present. NF Intern takes the powerchart generated team list and pager for the day-call team.

B. Non Day-Call Team (Mon-Fri)

5:00pm: Non Day-Call Resident signs out team briefly to Day-Call Resident, and gives handoff list and team pager.

7:15pm: Non Day-Call Resident calls NF Resident and gives sign out via phone.

C. Saturday Procedures

Day-call intern carries his/her team's pager during the day, signs out to NF Intern at 7:00pm in presence of upper level resident.

Team Resident on non day-call team signs out team to Saturday 24 hr call resident when ready to leave, gives team list. Non day-call resident later calls Resident NF (Saturday night shift is sometimes covered by resident) at 7pm to give overnight sign-out.

Non day-call team list is handed from Saturday 24 hr resident to NF Resident.

D. Sunday Procedures

Day-call intern carries his/her team's pager during the day, signs out to NF Intern at 7:00 pm.

Non Day-Call: Team Resident rounds on Non Day-Call team and signs out to Sunday Day-Call Resident when ready to leave. Non day-call resident later calls NF Resident. Team list is handed from Sunday Day-call Resident NF Resident.

VI. Information to Include in Verbal Sign out and the Corresponding Handoff Report

As part of our standardized approach to sign out, our residents sign out using a mnemonic called IPASS. The order our patients are signed out is according to their severity of illness, which allows the sickest patients to be signed out first. This method provides our residents with structure so that patients are presented in a systematic way. The mnemonic we use stands for the following:

I= Illness Severity. Each patient's illness severity is mentioned first. Patients are categorized into A, B, or C categories. C is defined as a stable patient, B is defined as a patient who is a patient who needs to be "watched more closely," and A is defined as a patient who is unstable.

P= Patient Summary. Summary statement of the events leading up to the patient's admission, hospital course; ongoing assessment; plan. Specifics include; Patient Name, location, code status, list active medical problems, admitting diagnosis and any other problems which are requiring active intervention.

A= Action List, this is a to-do list, which defines timelines and ownership. This section outlines specific concerns which the primary team has for the next 24 hours – e.g. pending consults, pending diagnostic tests (including whether or not the receiving physician is expected to pursue these results or if they should expect to be called), patient leaving AMA (are they competent to do so), etc.

S= Situation Awareness & Contingency Planning, this is a to-do list for the night team. It includes intervention of anticipated problems. For example, residents explain what's going on, and provide the oncoming resident with a plan for what might happen, with a statement such as, IF…THEN… Recent changes or issues such as new medications, change in mental status, fever pattern, oxygen requirement, urine output, etc. are also mentioned at this point in sign out. Obviously, it is impossible to anticipate every possible problem, but these items should focus on things which are likely to be issues given the primary team's level of concern, the patient's active medical problems, and recent issues.

S= Synthesis by Receiver. The receiver summarizes what was heard, asks questions, and restates key action/to do items. This should be done for all Category A patients.

VII. Attending Sign Out/In

PM: Daytime attendings sign-out any unstable patients in the evening to the overnight call attending.

VII. Monitoring of Process and Education

AM sign-in takes place at 7am. Faculty are present for the start intermittently, and are all present by 7:15.

Best Practices for information on handoff reports is gone over yearly in orientation. All our new interns, and current residents are trained to use the IPASS Systematic Approach to Sign Out.

For patients with particularly important sign-out information, attendings go over the specifics of the information with the signing-out team, to ensure the information will be communicated effectively.

VIII. Resident Fatigue

At times a resident may feel that the quality of their care is compromised by fatigue. Even though we have limited the amount of shifts greater than 16 hours (one person on one shift on each of our main services per week), things can come up that create resident fatigue, such as obstetrical continuity deliveries. If a resident ever feels the quality of their patient care is being compromised by fatigue, they should alert the upper level (for an intern), or the attending. At that point a plan can be made which may include moving the workload around, creating the space for a nap, or calling in resident backup or additional faculty. We also have a dedicated back-up rotation to ensure someone is available to be called in, and a backup faculty designee who can also be called in to provide clinical support.

An important part of any fatigue coverage is recognition of the fatigue by the resident and willingness to bring it up to others. A resident should never feel punished for this kind of open and honest self-assessment.