JOHNS HOPKINS MEDICINE	Johns Hopkins Medicine **Graduate Medical Education (GME)** **Policies and Forms**	*Policy Number*	P&F009
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I. BACKGROUND

It is the policy of the Johns Hopkins University School of Medicine that each residency and fellowship program develops standards that provide for the safe transfer of responsibility for patient care. The format for transfer of care may vary, but each program's standards must ensure 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.

A handoff is the process of transferring information and 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.

Both written and verbal handoffs are important, and each has a different purpose. Written handoffs can provide detailed information that serves as a reference for the receiving provider. Verbal handoffs allow discussion and cross-checking with the receiving provider to be certain that he/she has understood the information being provided.

II. CONDITIONS AND REQUIREMENTS

A. Each residency and fellowship program must develop a handoff policy that outlines the expectations for transfer of responsibility for patient care in all the settings and situations in which handoffs occur. The amount of information to be included in the process will vary depending on the functional role of the resident or fellow in patient care. Residents and fellows providing continuous and direct care and taking responsibility for order writing require a higher level of information exchange than those with less continuous duties, such as consultative or supervisory services. At a minimum, that policy must address the following:

1. **The time and place that routine handoffs should be expected to occur**.
   a. The location should be chosen so as to minimize distractions and interruptions and where all needed resources are available (eg, appropriate information systems). Verbal handoffs are required for PGY1 residents and preferred for all residents and fellows. The handoff process MUST allow the receiving physician to ask questions, so written handoff alone is not acceptable. The time chosen should be as convenient as possible for all participants.
2. **The structure or protocol for handoffs**.
   a. **It is suggested that verbal handoffs** follow a predictable structure. Mnemonics may be helpful in this regard. Appendix A provides an example of a commonly used mnemonic. Time for questions must be a part of all verbal handoffs.

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3. **Written handoffs** must be structured and organized so that information is provided in a predictable format or is readily available for each patient. Written information for residents and fellows providing continuous care and taking responsibility for order writing should include the following:
   a. Identifying information - Name, location, history number, hospital day
   b. Diagnosis, procedures, condition
   c. Problem list
   d. Medications and other treatments
   e. Pertinent laboratory results
   f. Pending laboratory and other studies
   g. Important contact information (e.g., patient's attending of record, family, referring physician)
4. Written information for trainees in a supervisory or consultative role must include sufficient information to understand and address active problems likely to arise during a brief period of temporary coverage, or to assume care without error or delay when care is transferred at a change of rotation or service.
5. **All patients for whom a resident or fellow is responsible must be included in the handoff**.

B. Each residency and fellowship program must inform their trainees about the institutional and program-specific handoff policies. Trainees must be informed about the reasons for these policies and the expectation that the policies be followed.

C. Each program must develop a system for assessing the effectiveness of resident handoffs and for monitoring compliance with handoff policies.

III. TRANSITIONS OF SERVICE

A. 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; when a patient is being admitted from the Emergency Department, the Emergency Department record serves as the transfer note. A "transfer acceptance note" must be documented by the receiving service.

B. 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.

C. When the responsible prescriber (resident) changes, nursing staff and all others who may need to contact the provider promptly must be notified of the change before noon of the day of service change.

IV. DISCHARGES

A. The discharging resident must ensure that prescriptions for discharge medications are written and available at the time of discharge.

B. The discharging resident must ensure that the discharge worksheet is completed and is accurate. The discharge worksheet must not be changed after the patient has been discharged.

C. 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 leaves the hospital is conveyed either to the patient or his/her primary care provider. This contact should be documented in the medical record.

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