**UTMB Anesthesiology Residency Transitions of Care and Handoff Protocol**

 **Purpose:**

 This policy incorporates and expands on the **UTMB GME Institutional Handbook, Section** XI. **Transitions of Care and Hand-offs:**

*The hand-over processes of each program must facilitate both continuity of care and patient safety. Hand-offs vary considerably across programs and clinical settings. They may include temporary transitions of direct patient care (e.g. day and night teams on inpatient services, scrubbing out of a procedure), complete transitions of direct patient care (e.g. emergency department shifts, end-of-rotation, end-of-training in outpatient and inpatient services), or transitions of indirect patient care (e.g. laboratory and radiology settings).*

*3. Hand-offs should include at least:*

 *a. Patient summary (exam findings, laboratory data, any clinical changes)*

 *b. Assessment of illness severity*

 *c. Active issues (including pending studies)*

 *d. Contingency plans (“if/then” statements)*

 *e. Synthesis of information (e.g. “read-back” by receiver to verify)*

 *f. Family contacts*

 *g. Any changes in responsible attending physician*

 *h. An opportunity to ask questions and review historical information*

**Definition:**

A transition of care (“handoff”) is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one individual, service and/or team to another. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another.

What is a Handoff?

Handoffs occur anytime there is a transfer of responsibility for a patient from one caregiver to another. The goal of the handoff is to provide timely, accurate information about a patient’s care plan, treatment, current condition and any recent or anticipated changes.

Transition of care occurs **regularly** for **anesthesiology residents** under the following conditions:

* Perioperative change in anesthesia provider, including resident sign-out for temporary relief of coverage to allow for breaks or transfer of care at end of duty hours.
* Transfer of a patient from the OR or other remote anesthesia care site to the appropriate Post Anesthesia Care Unit (PACU) or Critical Care Unit personnel.
* Change in provider due to rotation changes or call relief for residents providing consultative in-patient care as in critical care and acute pain rotations.
* Transfer of a patient into or out of the SICU.
* Transfer of care after consultation for an acute intervention outside the OR setting (emergent airway management, intubation, central line placement, assistance with hemodynamic management, etc.) back to primary team or rapid response team.

Even though Anesthesiology residents rarely admit patients, anesthesiology residents in their role as consultants may be involved (with faculty supervision) in:

* Change in level of patient care, including inpatient admission from the ambulatory setting, outpatient procedure, or diagnostic area. (Victory Lakes Ambulatory Surgery Center, Radiology Special Procedures or MRI, Endoscopy Suite, etc.)
* Transfer of care to other healthcare professionals within procedure or diagnostic areas (L&D, Cardiac Cath lab, ER, etc.)

**Policy:**

Anesthesiology residents will adhere to departmental guidelines for transfer of care/ handoffs. These guidelines are based on the “SBAR” approach and accessible to residents and faculty on-line via the Anesthesiology Intranet, <http://anesth.utmb.edu/intranet.htm>.

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| **S** | Situation | Complaint, diagnosis, treatment plan and patient’s wants and needs |
| **B** | Background | Vital signs, mental and code status, list of medications and lab results |
| **A** | Assessment | Current provider’s assessment of the situation |
| **R** | Recommendation | Identify pending lab results and what needs to be done over the next few hours and other recommendations for care |

SBAR is a communications technique that is modeled after a process used on nuclear submarines. It facilitates the consistent, concise exchange of information. Hospitals are adopting SBAR to improve communication exchanges among clinicians and to standardize the exchange of information during the handoff process.

Residents must document transfer of care electronically or on the paper intraoperative Anesthesia Record (as EMR not available). As stated in Departmental Policy, “Documenting in the chart a transfer of care (even temporarily) **implies** that all the relevant information from the list below was fully discussed:” In the OR/ Remote anesthesia setting this transfer of care takes place **face-to-face.**

**UTMB Anesthesiology Transition of Care/Handoff Policy**

Documenting in the chart a transfer of care (even temporarily) implies that all the relevant information from the list below was fully discussed:

**Situation:**

* Patient demographics (name, age, gender)
* Type of surgery
* Type of anesthesia (regional, general, combined)

**Background:**

* Review of H&P data in CPA, emphasizing anesthesia-relevant information
* Allergies
* Pre-operative medications
* Co-morbidities, including relevant preoperative tests
* Code status
* Intraoperative events
* Difficult line placement

**Assessment:**

* Physical tour of the patient and environment
* Lines
* LOCATION OF AVAILABLE PORT FOR PUSHING EMERGENCY DRUGS
* Airway
* Infusions and pumps
* Fluids, blood products
* Monitors
* Positioning issues and concerns
* Warming apparatus
* Current phase of surgery
* Expected lengthy of surgery
* I/O balance, including EBL
* Transfusion status
* Blood product availability
* Latest labs
* Abx (type, last dose given)
* Paralytics (type, last dose given)
* Pain medication (type, last dose given)

**Recommendations:**

* Procedure-specific tasks completed/requested by surgical team, such as:
* Tubes and lines
* Perioperative BP goals
* CVP goal
* Transfusion thresholds
* Disposition (extubation, PACU, ICU transfer)
* Postoperative

**Other case-specific information:**

In situations where a lot of specific information is transferred between services or with complex patients, specific checklists may be used.

**PACU**: Transfer of care to PACU personnel: in this area a check list is used. The resident documents in the PACU box on the anesthetic record and gives a face-to –face verbal report following check-list (located at each patient station) to PACU nurse. The PACU nurse records information.

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| **Steps of PACU report from Anesthesia Provider** |
| 1. Alert RN of any special precautions | 6. Allergies  | 11. Positioning used | 16. Fluid totals  | 21. PACU pain orders?  |
| 2. Are you ready for report?  | 7. Significant medical history | 12. Relaxed? / Reversed? | 17. Blood loss | 22. Any questions?  |
| 3. Patient's name | 8. Type of surgery  | 13. Narcotics given | 18. Urine output  |   |
| 4. Age | 9. Type of anesthesia  | 14. Antibiotics /c time | 19. Anesthetic complications |   |
| 5. Weight  | 10. Total anesthesia time | 15. Antiemetics | 20. Other significant information |   |

**SICU:** Face-to-face verbal handoff report is given to SICU nurse and ideally to SICU resident. Transfer of care note to SICU team should be documented in EPIC using Smart Text “ANS SICU TRANSFER REPORT” which facilitates documentation in SBAR format.