The Canadian Orthopaedic Association
L'Association Canadienne d'Orthopédie

COA GUIDELINES: ORTHOPAEDIC SURGERY PATIENT TRANSFER OF CARE

The concept of a physician workday has changed and will continue to evolve. Physician work hours are not static and have been modified by physician lifestyle and government mandates. As many doctors move to what is seen as shift work, more physicians ultimately become involved in each patient's care. Many hospitals are trying to anticipate this by converting to multidisciplinary care teams. With this changing facet of medicine, the orthopedic team, not the individual, is seen as the 'care-giver'. This trend enhances the need for comprehensive patient handover.

The transfer of patient care from one surgeon to another is necessary in both trauma and elective care. It comprises the transfer of professional responsibility and accountability for some or all aspects of care for a patient on a temporary or permanent basis. The legal and medical implications of misinformation are profound for our patients. Continuity of patient care through the transfer of high quality, concise, pertinent information is vital to patient safety. When a standardized approach to transfer of care is adopted, medical errors can be reduced, limiting iatrogenic morbidity and mortality events. Similarly, system inefficiencies can be curbed and replication of investigations/tasks limited; if handover is accomplished appropriately. This goal is to ultimately reduce system costs and increase satisfaction for our patients.

Most Canadian hospitals and orthopaedic work groups have no formal transfer of care policy and many do not consistently hand over patient information at all.

The COA recommends that each hospital or orthopedic practice group develop a standardized, inclusive transfer of care process that is suited to their particular group practice, and includes learners and appropriate ancillary staff. It must be clearly outlined and available to all team members.

Although the content, format, and team members involved may vary between practice sites, some components should be consistent:

1. Transfer of care should be done at a designated time, with appropriate time allocated (whether in person, over the phone or via electronic transfer)
2. It MUST be appropriately documented (eg. both verbal and written transfer)
3. The patient information should include: diagnosis, co-morbidities, patient stability, associated injuries, mechanism of injury, surgery (performed or planned/OR readiness), outstanding issues or investigations
4. Patient and /or family notification that handover has or may occur is imperative, perhaps in the form of an information sheet available on admission.
5. Transfer of care information MUST be confined to the normal caregiver population and where documented, must be on a secure system.

In summary, the COA recommends that each hospital and certainly each orthopedic working group should have a formal transfer of care policy. It can be individualized based on orthopaedic group or individual practice patterns and can be tailored to suit both academic and community practice styles. The transfer of care process should, however, have clear goals and expectations for all involved and be readily modifiable if patient care needs to be optimized.