Pediatrics Foundations EPA # 11

Coordinating transitions of care for non-complex pediatric patients

Key Features:

- This EPA focuses on transferring patients from one hospital setting to another or to other healthcare facilities, and discharging patients.
- This includes summarizing the hospital course and any remaining issues, coordinating ongoing care/follow-up and providing all needed documentation (e.g., summary, prescription etc.) in a timely manner.
- This also includes oral or written transfer of information and responsibility of patient care from one practitioner to another.
- This EPA does not include complex patients (Core).

Assessment Plan:

Direct observation and/or case review by pediatrician, fellow, senior resident, nurse practitioner or other with expertise in transitions

Use form 1. Form collects information about:

- Transition type: transfer; discharge

Collect 4 observations of achievement.

- At least 1 of each transition type
- At least 2 different observers

*can be used in 5J

Pediatrics: Foundations EPA #9
Coordinating transitions of care for non-complex pediatric patients

Key Features:

This EPA includes:
- Transitions, including the following:
  - Transfers between services (intensive care, surgical services, etc.)
  - Transfer between healthcare facilities (eg. to/from community sites, rehabilitation hospital etc.)
  - Discharge
- Communication to optimize patient safety
  - Coordination and collaboration with broader services (school, community supports, primary care provider, other health care providers, subspecialists)
  - Communication with family
  - Discharge planning, discharge or transfer summary
- Advocacy to ensure appropriate resources available
  - Prescriptions (medication coverage)
  - Equipment
  - Community resources

This EPA does not include:
- Complex patients (technology dependent, chronic complex medical issues)
- End of life care
- Transition to adult care

This EPA may be observed in all settings
- Inpatient
- Outpatient
- Community
- In Emergency Department
- In PICU/NICU

Assessment Plan:

Context:
1. Who is doing the assessment (e.g. supervisor, other health professionals, mentor)?
   a. ...by an entrusted senior resident / fellow, nurse practitioner, paediatrician, and other with expertise in transitions
2. Is it based on:
   a. Direct or Indirect observation
3. Context:
   a. Family feedback incorporated? y/n
   b. Transition type: within hospital, to alternate care environment, discharge home
   c. Setting:
4. What form should be used?
   a. Form 1: supervising MD, NP, receiving physician, other health care professionals (or delegate)
5. What does the Competence Committee need to see to make a decision about whether a resident can be entrusted with this EPA in the future?
   a. Transfer within hospital OR
   b. Transfer to alternate care environment AND
   c. Discharge to home

Competence
Collect 6 observations of achievement, of which 3 observations of achievement (with at least 2 different assessors) come from within each of A/B and C (transfer hospital; transfer alternate care; discharge).

Relevant milestones:

1 F ME 1.6 Develop a plan that considers the current complexity, uncertainty, and ambiguity in a clinical situation

2 C ME 2.4 Develop and implement management plans that consider all of the patient's health problems and context in collaboration with the patient and family and, when appropriate, the interdisciplinary team

3 F ME 5.2 Use cognitive aids such as procedural checklists, structured communication tools, or care paths, to enhance patient safety

4 F COM 5.1 Document clinical encounters/course in an accurate, complete, timely, and accessible manner, in compliance with regulatory and legal requirements in a manner that enhances intra-and interprofessional care (modified)

5 F COL 3.1 Identify patients requiring handover or transfer to other physicians or health care professionals (mod)

6 F COL 3.2.1 Communicate with the receiving physicians or health care professionals during transitions in care, clarifying issues after transfer as needed

7 F COL 3.2.2 Communicate with the patient's primary health care professional about the patient's care

8 F COL 3.2.3 Summarize the patient's issues in the transfer summary, including plans to deal with the ongoing issues

9 C HA 1.1 Facilitate timely patient access to health services and resources