Sign Out

INTERN BOOT CAMP
2017
Objectives

- Review importance of sign outs
- Touch on less than ideal examples of verbal and written sign outs
- Review the IPASS system of sign outs
- Review disease-specific details helpful for sign outs
- Offer suggestions for both parties involved in sign out
Before we start

- **Ask yourself the following:**
  - Have you ever received a sign out you felt was incomplete?
  - Have you ever wished a night float resident would have responded differently overnight?
  - If yes, what could have been done differently?
Why Should We Care?

- Cross coverage is an independent predictor of potentially preventable adverse events
  - An Australian study found that communication errors were the leading cause of adverse events
  - A review of medical malpractice claims 2009-2013 found that ~1/3 involved a communication failure
- The Joint Commission requires it
  - “implement a standardized approach to handoff communications including an opportunity to ask and respond to questions”
Example #1 (GM)

71 y/o male with HTN, HL, DM, SCC s/p chemo/XRT, admitted for confusion.
- Afebrile, cx pending.
- CT head neg.
- Stable.

On Call:
[ ] 1600 lytes, cbc

Nursing call:
- “Pt more confused and tired, SBP 72, HR 86, afebrile. Cr 6.5, hgb is 8.3 from 9.”

Chart review (takes 20 minutes to gather info):
- Has ESRD on HD, was dialyzed today, 2 L taken off
- Chemo/XRT was given many years ago, not active issue
- Chronic AMS, likely undiagnosed dementia
- Family considering hospice/stopping dialysis
- Patient is DNR/DNI
I-PASS Handoffs

- **I**llness Severity status
- **P**atient Data (appropriate) and Summary
- **A**ction plans
- **S**ituation Awareness Contingency Plans
- **S**ynthesis by Receiver
  - Should be “conversational”

<table>
<thead>
<tr>
<th>I</th>
<th>Illness Severity</th>
<th>Stable, “watcher,” unstable</th>
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<tbody>
<tr>
<td>P</td>
<td>Patient Summary</td>
<td>• Summary statement</td>
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<tr>
<td></td>
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<td>• Events leading up to</td>
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<td>admission</td>
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<td>• Hospital course</td>
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<td>• Ongoing assessment</td>
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<td></td>
<td>• Plan</td>
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<tr>
<td>A</td>
<td>Action List</td>
<td>• To do list</td>
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<td></td>
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<td>• Time line and ownership</td>
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<tr>
<td>S</td>
<td>Situation</td>
<td>• Know what’s going on</td>
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<tr>
<td></td>
<td>Awareness and</td>
<td>• Plan for what might happen</td>
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<tr>
<td></td>
<td>Contingency</td>
<td></td>
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<td></td>
<td>Planning</td>
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<tr>
<td>S</td>
<td>Synthesis by</td>
<td>• Receiver summarizes what</td>
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<tr>
<td></td>
<td>Receiver</td>
<td>was heard</td>
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<td></td>
<td></td>
<td>• Asks questions</td>
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<td></td>
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<td>• Restates key action/to do</td>
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<tr>
<td></td>
<td></td>
<td>items</td>
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</table>
**Sign-out Components**

**I:** “Stable today.”

**P:** 72 y/o male with PMH of HTN, CAD, HFrEF (EF 30%), Afib on coumadin, COPD not on home O2, CKD (base Cr 2.0), admitted on 5/6/15 with resp distress and urinary retention, volume overloaded. Treating for both COPD & CHF exacerbation. Foley placed, optimally diuresed, getting nebs (q6hr), prednisone, & azithro. Flomax started 5/7 for likely BPH. Overall improving.

**Today:**
- O2 requirement improved
- Appears euvolemic—lasix to home dose 40 mg PO daily
- Day 3 of prednisone and azithromycin
- Passed voiding trial, Foley removed at noon

**A:** On Call (To Do List):

[ ] Check 1600 lytes, replace prn (was diuresing, has CKD)
[ ] Check UOP at 1800--check PVR if still appears to be retaining, replace foley if >300cc)

(S--contingency plan):
**SBP runs low (80-90s/50s is okay), can give 250cc bolus if SBP<80 and please assess patient**
**Family requesting updates (call POA/daughter, Linda 708-547-8988 if any major changes)**

**FULL CODE**
Example 2

- Are you ok with this information?

- Do you think you have all you need to take care of this patient overnight?

- What can you do to improve this communication?

- What if the nurse calls you and states pt is needing more oxygen?

**I: “Stable today.”**

**P: 72 y/o male with PMH of HTN, CAD, CHF (EF 30%), Afib on coumadin, COPD not on home O2, CKD (base cre 2.0), admitted on 5/6/15 with sob, cough, wheezing. Also has urinary retention, foley placed on admission. Vol overload on admission as well. Treating for both COPD & CHF exacerbation. Optimally diuresed, getting nebs (q6hr), prednisone, azithro. Flomax started 5/7 for likely BPH and urinary retention. Overall improving.**

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**FULL CODE**
The final question brings out the critical piece of contingency planning – what to do if something does not go as planned.

- Should the overnight intern be worried if the patient desats? Has it happened before?

Contingency planning saves time and allows the covering physician to provide better patient-specific care without having to “figure it out” from scratch.
Example #3 (Saturday/MICU)

45 y/o F with multiple sclerosis, HTN, HL transferred from ortho service to MICU service for UGI bleed following R knee replacement, with elevated INR. Surgery was on 7/1; uncomplicated and placed on routine coumadin protocol. Hematemesis on evening of 7/6 with drop in Hb from 11 to nadir 6; INR 3. Since transfer to MICU has received 3U PRBCs and 2 U FFP. GI plans to scope later today.

OnCall:
[ ] CT head
How can we improve?

- **I:**
  - Is this patient stable?
  - Is there hemodynamic compromise?
- **P:** Hospital course summarized with plan
  - Is hgb still dropping? When was blood last transfused?
- **A:**
  - Do we need to continue to check hgb?
  - Why are we getting CT head and what do we do w/ result?
  - Will there be GI recs to f/u?
- **S:**
  - If continued bleeding what do we do?
  - What level of hgb should we transfuse?
  - Code status?
Handoff videos

- Video 1
  - http://www.youtube.com/watch?v=nGIsY1D1asA
- Video 2
  - http://www.youtube.com/watch?v=MDJWe7CVL_g
- Video 3
  - https://www.youtube.com/watch?v=IhKVXGPdmtA
Handoff Pitfalls

- The receiver may not think critically about the information being given, assuming that the sender will give all the pertinent information.
- Studies show that the more familiar the sender and receiver are with each other, the more potential for missed information.
Important Facts for Sign Out

DISEASE BY DISEASE
Asthma or COPD

- The current respiratory status with recent exam
- **Exact amount of supplemental oxygen** being given
- The current medications and their frequency or method of delivery
  - Albuterol nebs or MDIs? Oral or IV steroids?
- Any past respiratory complications or acute problems this hospitalization?
  - H/o intubation from asthma exacerbation
  - Does not tolerate BiPAP
Psych Patients

- Are they certified?
  - Allowed to leave AMA?
- Best suggestions for management
  - Haloperidol, olanzapine, lorazepam?
- Which meds have worked?
- Restraints?
- When should psych be called?
Heart Failure

- Always classify the heart failure
  - Systolic → give a recent LVEF%
  - Diastolic
- Give impression on current volume status
  - Diuresing? Net negative/positive? Goal?
- Acceptable BP or HR if different from norms
- Volume you can give if hypotensive
CKD

- Always indicate degree of renal disease (baseline Cr)
- Indicate if on dialysis, type, access, and current schedule
- Impact of electrolyte and volume replacement
  - E.g. “don’t replace K unless < 3”
- Any medication restrictions
Disease Specific Tips

- **Septic patients**
  - Present culture w/u
  - Current ABX and plan
  - What to do if pt spikes a fever
    - Do they need to be recultured? Broaden ABX?

- **Chemotherapy pts**
  - Current regimen
  - Suspected toxicity/complications
  - Transfusion thresholds

- **ICU pts**
  - More baseline data is better
  - Drip rates, MAP, Vent settings, VS ranges, current access
  - Trends observed
Disease Specific Tips

- **Sickle Cell**
  - Any complication (acute chest?) or transfusions
  - Pain plan, rules for escalating, or limits on escalating
- **Pain Patients**
  - Suspected abuse? Manipulative behaviors?
  - Limits that have been set
- **EtOh withdrawal**
  - Time of last drink
  - H/o complicated withdrawal
  - Current medication plan
- **Other “do nots”**
  - No IV Benadryl
  - No sleep meds
Practical Guidelines

- Develop a system including all components
- **Where** to start:
  - Use most recent A/P for a start
  - Modify to include current problems with status and current treatment
  - Update daily!
  - Add the day’s events
  - Update [ ]’s
  - Confirm code status is listed
  - Think about anticipated events and contingency plan
Practical Guidelines

- Develop a routine for creating your signout
- **When** to start:
  - Perhaps, after the progress note
  - Perhaps, every patient vs. splitting the list
  - Perhaps, after all daily notes complete
  - Don’t wait until the very last minute
  - Always review each patient at the end of day prior to printing
<table>
<thead>
<tr>
<th>When You are Receiving Sign Out</th>
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<tbody>
<tr>
<td><strong>Don’t be afraid to ask questions</strong></td>
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<tr>
<td>- Even if talking to a senior or a fellow</td>
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<tr>
<td><strong>Make sure you know when and/or know to call if needed</strong></td>
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<tr>
<td>- CHF attendings</td>
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<td>- Lung transplant attendings</td>
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<tr>
<td>- On call fellow</td>
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<tr>
<td><strong>Overnight</strong></td>
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<tr>
<td>- Write down</td>
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<tr>
<td>- What happens</td>
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<tr>
<td>- When it happens</td>
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<tr>
<td>- What you do about it</td>
</tr>
<tr>
<td>- Write cross-cover note in chart for significant events</td>
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<tr>
<td>- Change in management</td>
</tr>
<tr>
<td>- New or worsening symptom requiring escalated care</td>
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</tbody>
</table>
Give each other feedback!

Night intern ➔ Day intern
- “Mr. X’s family is really clueless about what’s going on, someone should talk to them”
- “You forgot to order the 1600 lytes, I did it for you yesterday.”
- “Ms. X has gotten Ambien 2 nights in a row, can she have a standing order?”

Day intern ➔ Night intern
- “Can you not give sleep aids after 10pm? Mrs. X was zonked this morning on rounds.”
- “Mr. X is neutropenic, so we take favers seriously. He should have been started on meropenem last night.”
- “Remember to be cautious about K repletion in ESRD patients. Mr. L shouldn’t have gotten that 80mEq dose of KCl.”
Try to avoid...

- Uncommon abbreviations
  - E.g. AP, hTN, EEW, PPP
- Forgetting to order labs to f/u on
- Letting meds fall off
- Unclear code status
- Unnecessary or excessive [ ]’s
- Not giving instruction on what to do with results
Sign Out Review

QUESTIONS/ COMMENTS?