**Transitions of Care on a Cardiothoracic Service:**

**Role of the Thoracic Resident**

Our Thoracic Surgery Residency follows an apprenticeship model as its essential clinical educational approach. Each service has been organized to function without Thoracic Surgery Residents through co-operation between attendings as partners, and through protocolized care executed with the help of Physician Assistants, Nurse Clinicians, as well as General Surgery residents/interns. Other teams may play an important part, such as the ICU team for critically ill patients, or General Surgery night float teams for front-line care during nights and weekends. All these individuals perform their functions as team-members through COMMUNICATION with the attending.

You have two immediate goals:

1. Insert yourself into this communications network in the most valuable way possible
2. Function at the level of a Junior Attending

Remember, these team elements can function without you. It is up to you to show your value. Your value is as a leader- to seek out and receive information, and formulate an attending-quality plan to improve the care of your patients. The validity of your leadership is based on the breadth of your medical training as a surgeon, and because of the closeness of your relationship with the attendings. The speed with which you integrate yourself into the team depends on the degree to which you demonstrate your trustworthiness, work ethic, affability and knowledge base.

Your value as a parallel conduit to the attending depends on your regular contact with him/her. As you will not operate with every attending, every day, you need to make this contact regular:

1. Take every opportunity possible to make physical bedside rounds with the attendings.
2. Have a conversation with every attending about all their respective patients every day. Present the information you have gathered from the team, relay their questions, and PRESENT YOUR OWN PLAN. This allows you to calibrate your thinking with that of an Attending.
	1. TIP: If a member of the team has shown particular skill, or made a good call, be generous in passing along this credit. Part of your future role as an attending is to be a ‘Talent Spotter’, and team members will appreciate your good mention, and be motivated to greater diligence.
	2. Include in these conversations pre-operative patients for the next day, reviewing the pre-operative studies, indications, and YOUR OWN OPERATIVE PLAN, for the reasons described above.
	3. Determine the best method and time to contact attendings: some may prefer text messaging, some pager, some cell telephones. If you have a smart phone, input attending contact information, make their numbers speed dial options.

Regularize your team contacts as well.

1. Establish a consistent time and a location for morning team rounds
	1. CVICU Rounds at 6:30 a.m. with ICU Residents, Nurse Clinicians and floor Nurse Clinicians. BE PUNCTUAL!
	2. Make sure sign-out has been received from any cross-covering service (night-float, ICU).
	3. Be METHODICAL. (i.e, Review radiology studies first, quickly examine and review ICU patients before moving on to the floor, with each patient review vitals, labs, medication lists, events since last round, formulate plans, delegate tasks.
	4. TIP: “A Dull Pencil is Better Than a Sharp Mind”. Take notes of pertinent developments, plans, and questions to direct to the attending later.
2. Establish a RALLY POINT.
	1. Each service has an area where team members will tend to congregate to perform computer based work in between patient care tasks. Visit this area between each of your procedures and your own tasks.
	2. Each meeting with a team member is a chance to COMMUNICATE. Tell them new things you have found out, receive new information from them.
	3. Each meeting with more than one team member at a time is an opportunity to ‘book round’ by running the list.
3. Keep track of the whereabouts of team members.
	1. Who is on vacation? Who is in which OR? Who is available to take on a new task, or scout out an emergency?
	2. Make sure team members are aware of your own general location, and how to contact you.

Transfers between services are extremely rare: there is no separate Thoracic floor and Thoracic ICU service on any rotation. Occasionally, a patient may be transferred to your service from another through the operating room. Your pre-operative note documents that you have discussed the patient and problem list with the original service. Very infrequently, a patient will be transferred from your service to another. In both cases, it is imperative that you verbally communicate with a counterpart on the allied service and document the conversation in a transfer note. Your communication should explain key elements of the surgery, and the implications on patient care, as well as go over the patient problem list. With any transfer of service, medications must be reconciled.

The mental effort required by this sort of co-ordination takes a physical toll, as do the academic requirements of your training role. In order to take full advantage of the restorative properties of the home call that is utilized on all of your rotations, you must “tuck your service in” each night by mastering the art of the sign-out, or hand-off. The hand-over process is particularly key as you prepare to take off one day in every seven entirely off of any clinical duty, or leave for vacation.

In some rotations you may be handing off the service to another thoracic resident or a senior general surgery resident for the night or for your day(s) off. In some situations, you may be handing off ICU patients to an SICU resident or fellow. Make sure you confirm the identity of your coverage as early in the day as possible by reviewing Plan of the Day on the electronic medical record, or the call calendars on Med-Hub, or Google at Stroger.

The foundation of the hand-off process is your rounding list. All of the EMR systems on any of your rotations will generate a service or a unit specific patient list. If your writing is legible, you may have annotated it during the day. Make a copy for the person to whom you will be handing off your patients.

1. Go over each of the patients on the list
	1. Critically ill patients should be discussed first, and in the greatest detail.
	2. If a patient is in crisis, and circumstances absolutely require you to hand off their care, try to discuss the patient at a discreet physical proximity to the bedside, and try to include the attending in the conversation. A contact link between the attending and your hand-off partner should be established by you, or in your presence.
2. Do NOT refer to patients by number or by procedure. Apart from its dehumanizing aspect, it too often leads to mistake and confusion. Either of these pieces of information can supplement, but not replace the patient name. The rounding list will have the MRN to distinguish those with similar names, and special attention must be paid to this situation in the hand-off process.
3. Encourage your sign-out partner to annotate his/her copy of the rounding list.
4. Sign out important tasks that need follow-up (check labs, check drain output, etc.). Your hand-off partner should denote these tasks with a check-box.
	1. For each such element, make sure you have communicated a PLAN, with contingencies for the information (i.e., IF drain output exceeds X, THEN call the attending).
5. Make sure your sign-out partner knows which attending is covering, and their contact information. Make sure they write this on their copy of the sign-out rounding list.
6. The better you know your own patients, the faster this process will go.
7. As above, so below. An attending going out of town will be performing a parallel sign-out to the attending who will be covering. The hand-off process is a skill you will exercise throughout your professional life, and the more effective you become, the better the opinion your partners will have of you, and the safer your patients will be.

Another key example of this process is when you change rotations. Before the day you change service, contact the individuals who will assume your service, and those whose service you will assume, and go over the list. It may not always be possible, but it is preferable to go through the list physically rounding at the bedside.

NO SURPRISES

This rule is well known to you from your earlier surgical training, and is particularly important in our apprenticeship model. Close communication between you and the attending staff is encouraged and expected. Though you will be treated as a partner as soon as your skills and dependability permit, the fact is that good partners enjoy good communication. No-one will be displeased with frequent communication from you, nor will you be judged ‘weak’, particularly if you demonstrate your skills by accurately assessing a patient, and by presenting YOUR OWN PLAN which can then by adjusted with the attending.

 1. The sicker the patient, the greater the communication.

2. SAVE THE PATIENT FIRST, then communicate with the attending. If the crisis requires your continuous attention, make sure one of your first acts is to detail a reliable team-member to notify the attending.

3. Any change in status that requires transfer of a patient to the ICU, OBVIOUSLY requires notification of the attending.

4. Though you should aspire to the role of an attending, and though you will be treated by the faculty as one, Do Not Resuscitate orders can only be made by an actual attending, and require attending co-signature within 24 hours. Similarly, End-of-Life discussion and decisions are the exclusive province of the attending, though you will be invited to these discussions with family members whenever possible, as these are important educational opportunities.

5. Should any issue require attending notification, but circumstances do not allow the attending to return your call, please call another attending. Faculty is all partners, and therefore support each other, and should be able to support you. Though you should try contact attendings on the same service if the responsible attending cannot be reached, if circumstances require, feel free to ask advice from any Attending, and they may be able to temporarily take over for the patient if their privileges and credentials permit. You are never alone.