

## **Inpatient Medicine Rotation Guidelines**

### **I. Overview**

Inpatient medicine is a core, required rotation for all residents. Overall goals of the rotation include the following:

- a. Residents will provide patient care in the inpatient setting that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- b. Residents will develop knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care in the inpatient setting.
- c. Residents will investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
- d. Residents will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates.
- e. Residents will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- f. Residents will develop an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Rotation goals and objectives specific for PGY-1 and upper-level residents can be found on New Innovations ([www.new-innov.com](http://www.new-innov.com)).

### **II. ACGME and UAFMR-T Requirements for Inpatient Service**

- a. Residents must have at least 600 hours (or six months) and 750 patient encounters dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions.
  - i. Residents must have at least 100 hours (or one month) or 15 encounters dedicated to the care of ICU patients.
    1. ICU encounters must be logged in New Innovations (NI). One patient per admission per log.
  - ii. Residents must provide care to hospitalized adults during all years of the program.
- b. Residents must have at least 200 hours (or two months) and 250 patient encounters dedicated to the care of ill child patients in the hospital and/or emergency setting.
  - i. This experience should include a minimum of 75 inpatient encounters with children.
  - ii. This experience should include a minimum of 75 emergency department patient encounters with children.

- c. Residents must receive training to perform clinical procedures required for their future practices in ambulatory and hospital environments.
- III. Schedules
- a. The inpatient medicine teaching service of the UAFMR-T and CCHS teaching faculty at DCH Regional Medical Center is covered 24/7 by residents.
  - b. Please consult the CCHS intranet for the most up-to-date call and back-up call schedules.
  - c. Prior to the start of the inpatient medicine rotation, a faculty-led introduction and overview to the month will be given, including review of this handbook and expectations for the month.
  - d. On Fridays, the inpatient medicine teams will be joined by a CCHS Behavioral Medicine faculty member to assist with common psycho-social issues that may arise while patients are in the hospital.
  - e. At the end of the rotation, a time for debriefing the month will be led by an Attending.
- IV. Clinical Responsibilities
- a. Refer to **Appendix A** for Mandatory Notification of Faculty
  - b. Day Team PGY-1 Duties
    - i. Admission H&Ps and Consultations – Written in Meditech after discussion with the upper-level resident and Attending. See section XI.d. for further details.
    - ii. Discharge summaries – Dictated or written in Meditech within 24 hours of discharge. See section XI.h. for further details.
    - iii. Daily progress notes. See section XI.e. for further details.
    - iv. Addendums to progress notes. See section XI.g. for further details.
    - v. Check out to the Attending
      - 1. All PGY-1s must check-out all patients to their upper-level resident prior to calling the Attending.
      - 2. Residents will discuss with their Attending all Emergency Department (ED) patients and all in-patients who undergo significant clinical changes during the shift.
    - vi. Take care of up to eight (8) patients on one's team. All ICU patients are included in the cap of eight patients (1 ICU patient = 1 patient).
    - vii. Write orders
    - viii. Manage floor calls; immediately notify upper-level resident of any patient status change
    - ix. Involve medical students in all aspects of patient care, including assigning each student at least 2 patients to follow. Medical student paper notes should be discussed with the student prior to patient presentation to the upper level and/or Attending.
    - x. Arrive on time and participate in Morning Report
    - xi. Participate in all transitions of care.
    - xii. Read/review inpatient & ICU reading list (while on service during PGY-1 year)
  - c. Day Team PGY-2 and PGY-3 Duties
    - i. See ALL patients on the team

- ii. See all ED patients with the PGY-1 and review the assessment, plan of care, and orders before the PGY-1 calls the Attending
  - iii. Teach and supervise PGY-1s and medical students
  - iv. Review all orders
  - v. Notes - Round and write complete progress notes on ALL patients above eight (8) on one's team
  - vi. Addendums to PGY-1 notes - Write addendums to all PGY-1 H&Ps, daily progress notes, ICU notes, and discharge summaries after seeing the patient and reviewing the documentation and orders. See section XI.g. for further details.
  - vii. Contact the PCP via a task within NextGen as notification that his/her patient has been admitted
  - viii. Code and bill all inpatient encounters
  - ix. Oversee and participate in all transitions of care/handoffs
  - x. Prepare and present in Morning Report
  - xi. Review core topics from the inpatient & ICU reading list with PGY-1s and students
  - xii. Write orders to change to the Attending who will be seeing the patient on Monday and update the Patient Tracker Board or similar product on Sundays after rounds
- d. Night Float
- i. Hours - Night Team coverage is from 5:00 pm to 7:00 am.
    1. The Night Team should arrive by 4:15 pm for formal transition of care meeting between Day and Night Teams
    2. The Day Team should arrive by 6:15 am for formal transition of care meeting
    3. Transition of care meetings are mandatory and allow for the respective residents finishing their shifts to leave on time
  - ii. PGY-1 Duties
    1. Admission H&Ps - Written in Meditech after discussion with the upper-level resident and Attending. Dictation is permitted, but discouraged due to availability of the H&P. See section XI.d. for further details.
    2. Check-out to the Attendings
      - a. All PGY-1s must check-out all patients to their upper-level resident prior to calling the Attending.
      - b. Residents will discuss with their Attending all ED patients and all in-patients who undergo significant clinical changes during the shift.
    3. ICU Notes
      - a. At a time after midnight until no later than 4:00 am, the Night Float PGY-1 will pre-round and write progress notes on a maximum of 2 intensive care unit patients from each team

- (including Medical, Surgical, Stroke, and Cardiac critical care units). See section XI.f. for further details.
      - b. All progress notes for critical care patients should include adequate assessments and plans.
      - c. ICU notes should be completed and submitted to the Day Team Attending unless interaction is needed with the on call attending.
    - 4. Write orders
    - 5. Manage floor calls; immediately notify upper-level resident of any patient status change.
    - 6. If available, involve medical students in all aspects of patient care.
  - iii. PGY-2 and PGY-3 Duties
    - 1. Supervise and teach medical students and PGY-1s.
    - 2. ICU Notes
      - a. Discuss acute care, assessment, and plan on ALL ICU patients (including Medical, Surgical, Stroke and Cardiac critical care units) with PGY-1.
      - b. Write an addendum to ALL ICU notes written by PGY-1.
    - 3. Write an addendum to ALL H&Ps after seeing the patient and reviewing the documentation and orders.
    - 4. Assist PGY-1s with new admissions, floor calls, or further duties while ICU patients are being seen.
- V. Morning Report and Rounds
  - a. Timing and Participation
    - i. Morning report occurs Monday-Friday at 8:00 am in Conference Room A or as otherwise designated.
    - ii. Residents will meet with the day's Attending (as well as pharmacy students, clinical pharmacist faculty, and medical students if available) for Morning Report.
    - iii. The length of Morning Report may vary, but rounds should start no later than 9:30 am.
    - iv. Medical students should be released at 11 am for daily lectures or workshops.
  - b. Structure and Content
    - i. The upper-level residents will create a calendar at the beginning of the month of when each team will present a topic for Morning Report.
    - ii. The topic should be a core Family Medicine subject relevant to the current patient census that will also be high yield for medical student and PGY-1 learning.
    - iii. If there are no patients with relevant core topics, a selection from the Family Medicine Inpatient Reading List will be presented instead.

- iv. The team member assigned to lead Morning Report will email the topic and relevant supporting articles for discussion to all of the inpatient adult medicine teams and Attendings the day before his or her presentation.
- v. After the topic concludes, checkout and a brief discussion of the previous night's admissions will occur. This will include pertinent admission details, interventions, prognosis, special needs, and potential barriers to discharge.
- vi. The PGY-1 or upper-level resident will lead the Morning Report topic on Mondays, Wednesdays, and Thursdays-unless other presentations are arranged by faculty.
- vii. Medical students will lead case presentations during Morning Report on Tuesdays and Fridays.

VI. Admissions and ED Visits

- a. Only Family Medicine, Faculty-Staff, and Internal Medicine clinic patients of University Medical Center (UMC) are admitted to the inpatient medicine service.
- b. If the ER calls with an “unattached” or “unreferred” patient, please discuss this with the Attending on call.
- c. All patients must be admitted under the name of an individual Attending. They may not be admitted to a team name.
- d. The upper-level resident and/or Attending must communicate to the ER physician which Attending the patient will be admitted to, and under what status.
- e. Team designations (e.g. 1, 2, 3, or 4) will be determined internally by the Inpatient Medicine Service, not designated in Meditech. They should be listed on the Patient Tracker Board or similar product. See section XIII.a.
- f. The general weekly admission call schedule is below:

	<b>On call Attending (8am-8am)</b>	<b>Admitting Team</b>	<b>Rule</b>
<b>Monday</b>	Attending A	Team 1	Admit to Team 1
<b>Tuesday</b>	Attending B	Rotates based on PGY-1 who covers in the afternoon (will also do weekend nights)	Admit to covering PGY-1 team (if PGY-1 is from Team 4, then even out the teams)
<b>Wednesday</b>	Attending A	Team 2	Admit to Team 2
<b>Thursday</b>	Attending B	Team 3	Admit to Team 3
<b>Friday</b>	Attending C	Rotates based on team that stays till 9 pm; other two teams leave at 12 noon	Admit to covering PGY-1 team (if PGY-1 is from Team 4, then even out the teams)
<b>Saturday/Sunday (Holiday)</b>	Attending C (Rotate for Holidays)	Rotates	Even out the teams

<b>ALL NIGHTS</b>	As per upper level	Rotates	Even out the teams
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g. Patient Assignment to Teams

- i. Weekday admissions, between 8 am and 5 pm are admitted by the daytime on-call team, as specified by the PGY-1 on-call schedule.
  1. Checkout is given to the PGY-1's team attending, and the patient is assigned to the on-call PGY-1 team for care.
  2. This is to promote resident continuity over attending continuity.
- ii. Weeknight admissions, between 5 pm and 8 am, are distributed under the direction of the upper-level resident to:
  1. Reasonably balance the teams,
  2. Promote continuity with the PCP resident or Attending if they are on service,
  3. Readmit back to the team that cared for the patient if readmitted within 30 days of discharge (if either member of the team is still on service)
- iii. Weekend admissions should be placed on the team of (in order of priority):
  1. The PCP resident or Attending if on service,
  2. The PGY-1 who admitted the patient,
  3. The upper-level resident who admitted the patient,
  4. And under the name of the Attending who will see them first
  5. As determined by the most senior resident on service at the time of admission
- iv. Pediatric admissions (age < 19)
  1. On weekdays will be admitted under a Family Medicine Attending (not Internal Medicine Attending) if on service and making rounds the following day.
  2. On weekends, if an Internal Medicine Attending is the Inpatient Medicine on-call Attending, they will be admitted to the Pediatric Attending on call and rounded on by residents on the Pediatric service. If a Family Medicine Attending is the Inpatient Medicine on-call Attending, they will be admitted to the Inpatient Medicine service, following the Admissions guidelines as above.
  3. Calls regarding these admissions should go to the Family Medicine Attending on call, or on service, as available and otherwise to the pediatric attending.
  4. Patients admitted to Pediatrics in this setting will remain on Pediatrics until discharged.

5. Patients admitted to a Family medicine Attending but transferred to Pediatrics for weekend coverage will transfer back to the Family Medicine Attending team after the weekend.
  - v. The most senior resident on call at the time of admission or during the current shift will have the final say in the distribution of patients, in consultation as needed with the on-call Attending.
- h. Residents MAY NOT accept a patient in transfer from another hospital or institution. All transfer calls from the ER or the DCH Health System operator should be immediately referred to the on-call Attending. The resident should assist the ER staff in finding the appropriate Attending.
- i. The on-call team residents and Attending should be notified when a resident and/or attending admits a patient from UMC to the hospital via the direct admission unit (DACU). The patient should be sent with admission orders to the DACU.
- j. Patients who are readmitted within 30 days of discharge are assigned to the team that originally cared for the patient, except in the following situation. If there has been a rotation block change and the original team is no longer on service, then the patient will be assigned to the admitting team.
- k. The upper-level resident will be notified by the ED physician when there is a UMC patient ready for evaluation for admission. The team will then evaluate the patient and determine if the patient requires admission to the hospital.
  - i. The PGY-1 will review the assessment and plan with the upper-level resident prior to calling the on-call Attending.
  - ii. If the patient requires admission, orders will be entered in Meditech and an H&P will be completed prior to the end of shift.
  - iii. If the patient does not require admission but can be sent home, the ED physician will be notified and a Short Stay Summary must be documented (i.e., an abbreviated H&P with History of Present Illness, Physical Exam, Assessment and Plan, and follow-up instructions) within 24 hours of the discharge. See section XI.i. for further details.

#### VII. Consultations

- a. All consultations should be approved by the Attending and communicated personally.
- b. Writing an order to ask the nurse to communicate the consult leads to poor patient care: the consultant does not know why he/she was called, the urgency of the consultation, or whether the team is asking for advice versus the consultant to manage the problem.
- c. It is customary for the PGY-1 to contact the consulting physician. The upper-level resident should ensure that the intern has a clear understanding of: 1) the patient's clinical diagnostic situation and prognostic status; 2) what the consultant is being asked to help with; and 3) how to efficiently communicate this to a specialist attending.
- d. The first few phone consultation calls should be monitored by the upper-level resident.

#### VIII. Inpatient Procedures

- a. The following hospital procedures must always be supervised by an attending physician with credentials to perform that procedure until the requirements for credentialing are met. The numbers listed beside each procedure are recommended for completion by the end of each PGY-year.
  - i. ACLS/Code blue - 5
  - ii. Initial and ongoing ventilator management - 5
  - iii. Endotracheal intubation and complex airway management issues – 10 by the end of intern year
  - iv. Central line placement - 3
  - v. Acute management of shock - 3
  - vi. Chest tube placement
  - vii. Management of pneumothorax
  - viii. Defibrillation and synchronous cardio version
  - ix. Lumbar puncture
  - x. Newborn circumcision
- b. Residents may become credentialed in the procedures outlined below. The medical staff credentialing process must be followed at DCH Regional Medical Center. This is initiated by the resident and must be approved the Residency Director.
- c. For residents to perform the following procedures unsupervised, they must have completed the indicated numbers of a particular procedure under the supervision of an Attending with privileges for that procedure:
  - i. Central venous line (CVL) placement – 10
  - ii. Intubation – 10
  - iii. Thoracentesis – 5
  - iv. Newborn circumcision – 10
    - 1. It is the preference of the OB/GYN faculty that before a resident performs any neonatal circumcision, he/she must notify an OB/GYN faculty member.
  - v. Lumbar puncture – 3
  - vi. Chest tube placement - 3
- d. Residents certified to do these procedures may teach the procedures to other residents, as outlined by DCH. Before performing an unsupervised CVL or thoracentesis, a resident should know how to do a chest tube placement.
- e. The Attending, a member of the DCH Regional Medical Center staff, must have been granted privileges for the procedures he/she teaches and supervises. The Attending is responsible for any procedure performed by a resident under the supervision of an Attending.
- f. DCH Medical Center bylaws permit any physician in an emergency to perform any procedure necessary to save a patient’s life. Residents are obligated to notify Attending physicians as soon as they are aware that a life-threatening situation exists.
- g. Residents should also notify an Attending if a patient experiences a sudden change in status. These situations (i.e.: the need for transfer of a patient to a more acute setting,



impending cardiac or respiratory failure) should always be anticipated and predicted if possible.

IX. Communication

a. Attending Line

- i. The Inpatient Medicine Attending line is (205) 348-0829. This provides 24/7 access to the Attending physician on-call.

b. Pagers

- i. The beeper/pager is the primary means of communication for nurses and staff in the hospital.
- ii. Residents must have their pager on and carry it with them at all times when on-call or on-duty for the inpatient medicine rotation.
- iii. All pages should be returned within 15 minutes. If the resident cannot return a page within this time-frame, he/she is to have another team member answer the page instead.
- iv. If a resident is paged in error, it is that resident's responsibility to help the person contact the correct resident.
- v. If the resident forgets his/her pager or if the pager stops working, the appropriate personnel (Attendings, upper-levels, Residency Office, etc.) must be notified and given alternate contact information.
- vi. Should reasonable response time to pages become a problem (e.g., 30 minutes), the program director will respond and request a personal meeting with the resident. Any ongoing or repeated instances will be considered unprofessional behavior and disciplinary action may follow.

c. Email

- i. Residents are expected to check their ua.edu email account at least daily, even while in the inpatient medicine rotation, as this is an important means of communication for UAFMR-T.
- ii. All emails regarding patient care must remain HIPAA-compliant. Please have an Attending review the message prior to it being sent if there is any question regarding compliance.

d. Text Messages

- i. Text messages are considered an unsecure and HIPAA-noncompliant form of communication.
- ii. Patient care information should not be sent via text messaging unless it is via a HIPAA-compliant application such as DocBookMD or HipaaChat.

e. PCP Notification

- i. For every UMC patient admitted to the hospital, the upper level resident should send the PCP a task within NextGen as notification that their patient has been admitted.

X. Transitions of Care

a. Transition to Another Facility

- i. The decision to transfer a patient to another facility must be made in consultation with the Attending.
  - ii. All transfers require an Attending to Attending call for transfer of care.
  - iii. Once the decision to transfer the patient is made and the patient is ready for transport, a typed discharge summary must be completed immediately to accompany the patient to the new facility. See section XI.h. for further details.
- b. General Shift Change and Team Hand-off Rules
  - i. Per ACGME Family Medicine Guidelines (VI.B.1-4), transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for that specific patient or group of patients. Programs and institutions are expected to have a documented process in place for ensuring the effectiveness of transitions. Pertinent elements evaluated should include exam findings, laboratory data, any clinical changes, family contacts, and any change in responsible Attending physician.
  - ii. Multiple studies have shown that transitions of care create the most risk or medical errors (ACGME teleconference July 14, 2010.) In addition to the processes defined below, promotion of patient safety is further ensured by:
    - 1. Provision of complete and accurate rotation schedules in New Innovations;
    - 2. Presence of a backup call schedule for those cases when a resident is unable to complete their duties;
    - 3. The ability of any residents to be able to freely and without fear of retribution report their inability to carry out their clinical responsibilities due to fatigue or other causes.
  - iii. Residents receive educational material on Transitions of Care/Handoffs during Intern Orientation.
  - iv. A formal check-out must happen between the Night Float Team and the Day Team at each shift transition. It is expected that each hand-off be face-to-face and substantive, without exception.
  - v. The medical students and PGY-1s must communicate with the upper-level residents regarding patient status and plans prior to morning rounds.
  - vi. Any resident seeing a continuity patient must communicate about that patient to the team caring for the patient.
  - vii. Residents are to familiarize themselves with the I-PASS handoff system. See **Appendix B** for details.
- c. Specific Shift Change and Team Hand-off Rules
  - i. In any instance where care of a patient is transferred to another member of the health care team, an adequate transition must be used. Although transitions may require additional reporting than this process, a minimum standard for transitions must include the following information:

1. Demographics
    - a. Patient Name
    - b. Unit/room number
    - c. Age
    - d. Attending Physician
    - e. Date of birth
    - f. Gender
    - g. Other unique identifier
    - h. Admit date
    - i. Allergies
    - j. Admit date
  2. History and Problem List
    - a. Primary diagnosis(es)
    - b. Chronic problems (pertinent to this admission/shift)
  3. Current condition/status
  4. System based
    - a. Pertinent Medications and Treatments
    - b. IV fluids
    - c. Blood products
    - d. Oxygen
    - e. Respiratory therapy interventions
  5. Pertinent lab data
  6. To do list: Check x-ray, labs, wean treatments, etc - rationale
  7. Contingency Planning – What may go wrong and what to do
  8. ANTICIPATE what will happen to your patient.
    - a. Ex: “If patient seizes > 5 minutes, give him Ativan 0.05mg/kg. If he still seizes load him with 5mg/kg of fosphenytoin.”
  9. Family or Psychosocial Situations
  10. Code status, especially recent changes or family discussions
- ii. The process by which this information is distributed is via Orientation presentations to residents and is found on pocket cards delivered to each resident. In addition, this information is presented in program/departmental meetings.
  - iii. The UA Family Medicine Residency Program regularly monitors transitions, including a sample of a patients chart and interview of incoming team to ensure that key elements are transmitted and have been understood.
    1. An Attending will participate in the evening transition from Day Team to Night Float on a weekly basis. Milestone-based evaluations are completed on participating residents.
    2. The entire team must be present and participate in transitions of care. The upper level residents are responsible for monitoring the transitions.

3. Any deviations are to be reported to the Attending on call that day.
  4. The faculty discuss transitions at monthly faculty meetings to assure compliance and effectiveness.
- d. Outpatient to Inpatient to Outpatient Transitions of Care
- i. On admission, the patient's PCP is to be recorded within the H&P.
    1. For those few patents with no PCP listed, the Attending will assign one or the hospital resident can assume PCP care if desired.
  - ii. The upper-level resident is to contact the PCP by a NextGen task with a brief description of the admission and who will be the residents taking care of the patient. The PCP may be called to discuss care if needed.
  - iii. The PCP, if not on a primary inpatient service, should make every effort to see the patient, but generally may/will leave the bulk of the care to the inpatient team. Any suggestions from PCP regarding patient care in the hospital should be communicated clearly to the caring team.
  - iv. When discharged, the name of the PCP should be included and a copy sent to the outpatient office.
  - v. The upper-level resident is to send a telephone message in NextGen to the PCP notifying them of the following: reason for hospitalization, medication changes, and follow-up instructions.
    1. Ex: "Your patient was admitted for pneumonia and hypokalemia. We increased the potassium to 20mEq daily. Needs a repeat BMP in 1 week."
  - vi. The discharge summary must be completed within 24 hours.
  - vii. At UMC-FM, the receptionists receiving the paper copies of the discharge summary and med lists, send them to medical records to be scanned and then to the PCP's PAQ for review.
  - viii. The patient should be scheduled for hospital follow-up with the PCP. If the PCP is not available, one of the inpatient team members are to see them in clinic for that hospital follow-up visit. The resident may need to be available to approve the patient as an add-on if at all possible.
  - ix. The patient can be considered for the upcoming, new transition of care clinic for Medicare patients if he/she has multiple comorbidities or readmissions.
  - x. Summary:
  - xi. PGY-1s: responsible for discharge summary (with PCP name included).
  - xii. PGY-2 and -3s: responsible for PCP notification upon admission and discharge NextGen telephone message to PCP.

#### XI. Documentation

- a. Meditech is considered the active patient chart and is the EHR used for daily notes, orders, etc.
  - i. All Attendings for UMC Family Medicine and Internal Medicine are listed within Meditech as rounding group #19.
  - ii. If and when a mnemonic is needed, please use UAMED.

- b. ChartMaxx is considered the archived patient chart. Notes are officially “signed off” in ChartMaxx, therefore it must be checked on a regular basis.
- c. Hospital Orders
  - i. Attendings generally leave the writing or entering of orders to residents.
  - ii. Orders should be entered electronically in Meditech. If Meditech is not functioning, then written orders will be accepted.
  - iii. Admission orders must be sent to the Day Team Attending who will be seeing the patient, not the Attending on-call at night. All admission orders at all hours should go to the Day Team Attending, who will be seeing them, not the on-call night Attending who did not or will not see the patient.
  - iv. If orders are needed from the Attending, the resident should communicate this during rounds or in the progress note.
  - v. Verbal orders must be signed within 24 hours, either in the chart or in Meditech.
  - vi. When a patient is being admitted to Inpatient Medicine (not Pediatrics or OBGYN), then a “Y” should be checked in the appropriate box on the Admissions Order template in Meditech. See below.

Enter/Edit Responses : Admit Patient Order

Procedure Ordered  
Admit Patient Order

Problem/Diagnosis Click below to Enter/Edit/View

Atlas Information: \_\_\_\_\_

Is this an admission for a UA Physician?  Specify MD: \_\_\_\_\_

Attending MD: \_\_\_\_\_

Status\* \_\_\_\_\_

Level of Care\* \_\_\_\_\_ Monitored Bed Required

Information for Bed Control - This is not an order for a cardiac monitor.

Facility\Location Comment: \_\_\_\_\_

- vii. When giving a verbal order, the resident must ask that the order be read back to him/her to ensure accuracy.
  - viii. Orders written by medical students are invalid until countersigned by a physician.
- d. History and Physicals (H&Ps)
  - i. Templates are available in Meditech for H&Ps.
  - ii. H&Ps should be sent to the Attending on-call and the Day Team Attending who will see the patient. The H&P is the only thing that goes to the Attending with whom the patient was checked out.

- iii. H&Ps should be dictated or written in Meditech after discussion with the upper-level resident and Attending. All patients admitted will have an H&P in Meditech by the admitting resident. The H&P must be completed as soon as possible once the patient is seen, at the latest by the end of the shift. The written H&P must take priority if a specialist is being consulted so that he/she will have the pertinent information for decision-making.
  - iv. All H&Ps must be completed by the end of the shift. If the admitting resident is unable to complete the H&P due to committing a duty hour violation, he/she will appoint another resident to complete it. PGY-1s stop seeing new patients 30 minutes before the end of the shift, except for emergencies and code blues. Therefore, all H&Ps should be complete prior to the end of shift.
  - v. H&Ps should incorporate not only information from the current visit, but also notable information from previous visits/notes in Meditech and in NextGen, pertinent past diagnostic studies, lab values and historical trends, consultant notes, and more. All available resources should be utilized (PCI, ChartMaxx, and scanned documents in the Categories tab of NextGen) to obtain the whole clinical picture.
  - vi. For Medicare patients, inpatient status vs outpatient with observation status is very important. For any patient admitted under inpatient status, statement along these lines MUST be present in the H&P: "Care for this patient is expected to surpass at least two midnights. The patient is at risk of an adverse event, including (sepsis, respiratory failure, death, etc)."
  - vii. Before moving onto the next patient admission, the upper level resident should send the Primary Care Physician (PCP) a task within NextGen as notification that his/her patient has been admitted.
  - viii. The decision to order a specialist consultation for any patient must be discussed with the upper-level resident and approved by the attending prior to the order/request being entered, except in the case of an emergency.
- e. Progress Notes
- i. Templates are available in Meditech for daily progress notes.
  - ii. Progress notes should be written daily according to the SOAP method. Notes should be clear, readable, and accurate. **These should be signed and submitted to that day's Attending before rounds.** Draft forms are not acceptable. It is okay if the plan for that patient changes during rounds from what was written. The progress note may then be updated with an addendum.
  - iii. Every patient needs a progress note on the day of discharge in addition to a discharge summary.
  - iv. Attendings will sign the notes and write comments at appropriate intervals.
  - v. The assessment and plan section of the progress note should account for all active and/or significant inactive problems.
  - vi. For non-ICU patients, the assessment and plan should be organized by problems, with the most pertinent problems listed first.

- vii. No extraneous material should be carried forward in daily notes. The assessment and plan from the previous day will carry forward but must be reorganized and prioritized for that day's work/patient status prior to finalizing the note. As diagnoses are updated, they should replace the initial problem (e.g. acute CVA should replace altered mental status).
    - 1. When inserting lab results, insert only the most pertinent results.
    - 2. When inserting radiology results, do not insert the interpreting physician's name as this may cause signature errors in Meditech.
  - viii. On the day of discharge, especially for Medicare patients, at least one progress note timed before the time of the discharge order must give a follow-up plan for the patient. Ex: "Pt is to follow up with Dr. S at UMC 1 week from discharge".
  - ix. Discuss the quality of progress notes with the upper-level resident and Attending by requesting regular feedback on documentation content and accuracy.
- f. ICU Notes
- i. The UMC ICU Note template is available in Meditech for daily ICU notes, which should be written according to the organ-system method.
  - ii. Resident pre-rounds should start in the ICU. It is standard of care in the medical community to see an ICU patient and document that visit at least twice a day.
  - iii. Night Float residents must write daily progress notes on a maximum of 2 ICU patients per team (see section on Night Float). ICU notes should be completed and submitted to the Day Team Attending.
  - iv. Day Team residents must write a daily revisit note or addendum to the Night Float ICU note after rounds in order to update the plan of care.
  - v. All progress notes for critical care patients should include adequate assessments and plans.
- g. Addendums to Progress Notes
- i. A daily revisit note or addendum must be written to the Night Float ICU note after rounds in order to update the plan of care.
  - ii. All patient encounters must be documented in Meditech. This includes, but is not limited to, calls to the floor to evaluate a patient, family conferences, medication changes, and/or conversations with consultants. The encounter must be documented in the patient's chart as an addendum to that day's progress note.
- h. Discharge Summaries
- i. Per hospital policy, discharge summaries must be typed or dictated at the time of the patient's release or within 24 hours. Every patient needs a progress note on the day of discharge in addition to a discharge summary.
  - ii. The discharge summary must be copied (via transcription) to the PCP and to all consultants involved in the case.
    - 1. State at the beginning of the dictation that a copy should be sent to Dr. (name) at (address).

2. A patient's PCP will get a copy of the discharge summary only if his/her name is stated at the beginning of the dictation.
- iii. Discharge summaries should be concise yet thorough. All diagnoses should be listed as part of the summary, including all diagnoses for which the patient received treatment in the hospital as well as the patient's chronic conditions.
- iv. Abbreviations and initials for diseases, procedures, etc are common sources of error in transcription. Dictation of whole words rather than abbreviations is preferable. Residents are to familiarize themselves with the "Do not use abbreviations" at DCH Regional Health System.
- v. Please refer to the "discharge medication list" as opposed to listing the medications one-by-one.
- vi. All new or changed medication must have printed and signed prescriptions upon discharge.
- vii. If a patient who was originally thought to be stable for discharge is not discharged, the on-call Attending must be notified as to the situation. Also, if a discharge summary was dictated, DCH medical records must be notified of the change in status/situation.
- viii. Discharge summaries should be sent to the Attending who saw the patient last.
- i. Short Stay Summaries
  - i. If a patient is seen and sent home from the ED, a Short Stay Summary must be documented within 24 hours from the discharge.
  - ii. The summary should be an abbreviated H&P with history of present illness, physical exam, assessment and plan, and follow-up instructions.
  - iii. Multiple addendums to the progress note are allowed.
- j. Procedures
  - i. A signed consent form must be documented in the chart prior to the performance of any procedure.
  - ii. The discussion of risks, benefits, and alternatives to the particular procedure must be documented in the medical record.
  - iii. A procedure note should follow and include the indication, procedure note itself, estimated blood loss, and follow-up instructions.
  - iv. All procedure notes must be signed off by the Attending.
- k. Death Summaries and Death Certificates
  - i. Should a patient die while in the hospital, a death summary must be typed or dictated prior to the end of the shift.
  - ii. The death summary should be sent to the Day Team Attending.
  - iii. The death certificate is the permanent legal record of the patient's death and is important in court, epidemiological studies, and to the family. Death certificates are important legal documents, which may not be spindled, folded, mutilated, erased, stapled, or have lines struck through.
  - iv. Death certificates must be completed and mailed to the Health Department (or completed online) within five days. They are never given to the family.



Residents must consult with an Attending, who will check for accuracy before online submission or mailing.

- v. The Health Department will list the name of the physician it assumes should complete the certificate. It should be completed by the physician who has the most knowledge about the patient's death. For a UMC patient, this will typically be the patient's PCP or the Attending to whom the patient was admitted.
- vi. If the patient died in the hospital and was cared for by others, the Attending who cared for the patient in the hospital should complete the death certificate.

I. Signatures

- i. All handwritten signatures should be followed with one's legible printed first and last name and DCH physician ID/dictation number.

m. Delinquent Hospital Charts

- i. Delinquency is defined as any hospital H&P or discharge summary not dictated or typed within 24 hours of admission or discharge.
- ii. Any resident found to have a significant number of delinquent charts and/or a repetitive pattern of delinquency is subject to disciplinary action.
- iii. All charts are to be completed prior to taking annual leave.

XII. 401 Calls

- a. These are "after-hours" telephone calls from the UMC answering service.
- b. The upper-level resident on-call for Peds/OB receives these from 5:00 pm - 7:00 am on weekdays, weekends, and holidays.
- c. The upper-level resident on Pediatrics is assigned to receive these calls from 7:00 am - 8:30 am on weekdays.
- d. The upper-level resident on inpatient medicine may be asked to assist with returning these calls if the other teams are busy.
- e. All of these encounters must be documented with the "Telephone Call" template in NextGen and may be tasked to the appropriate PCP.
- f. Attendings are available for questions and discussions about the proper advice and recommendation for care.

XIII. Miscellaneous Inpatient Processes

a. Patient Tracking – the Board

- i. The Patient Tracker Board is one of the monitors in the residency lounge. It is color coordinated:
  - 1. Blue = new patient
  - 2. Black= current patient
  - 3. Purple= trying to discharge
  - 4. Red= discharged/papers on chart
  - 5. Red with strikeout= patient has passed away
  - 6. Green = Patient eloped
- ii. The team is responsible to keep the Board as accurate and up-to-date as possible since it can be viewed by other residents and Attendings who are coming in on-shift.

- b. Physical Findings Board
  - i. Team members are expected to record any interesting or abnormal physical findings on the small white board in the resident lounge.
  - ii. These will be used for weekly Physical Findings Rounds for the medical students.
- c. FM Case Presentations/Safety & System Improvement Case
  - i. Each month during academic afternoon, the previous month's inpatient medicine teams will present 3-5 cases from their month on service.
  - ii. At least 1 case will be a Safety & System Improvement case discussion
  - iii. All members of the previous month's team are recommended to be present to facilitate case discussion and answer audience questions.
  - iv. Upper-level residents should provide hospital coverage so that presenting PGY-1s may attend.
  - v. A standard PowerPoint template is available for resident use.
    - 1. Located on the desktop of the second computer on the left in the 5<sup>th</sup> floor resident computer lab room.
    - 2. The template is designed to be interactive, meaning the audience could ask for a lab and presenter could push a button and be taken to the end of the slides to the lab values then push a button to go back to the original slide.
- d. Continuity Clinic
  - i. All residents will have at least 1 continuity clinic session per week while on this rotation.
  - ii. Before leaving for clinic, all patients must be transitioned to the resident who will be covering. This transition must be face-to-face.
- e. Continuity Inpatients
  - i. Every effort should be made to ascertain the patient's PCP and notify him/her that the patient has been admitted to the hospital.
  - ii. If a difficult situation occurs after-hours requiring a call to the PCP for patient information, such a call should be made after consultation with the upper-level resident and/or Attending on call.
  - iii. Most UMC patients expect and anticipate a visit from their PCP, so please do not neglect to notify the PCP as soon as possible.
  - iv. It is the responsibility of the admitting PGY-1 to notify the PCP of the admission. The upper-level resident should verify that the PCP was contacted.
- f. Outside Learners
  - i. At times, there may be outside learners on rounds. These may include pharmacy students and/or residents (Pharm.Ds), social work or psychology students.
  - ii. Residents are encouraged to utilize them for this unique collaborative learning experience that is not yet standard at other medical centers.
- g. Code Blue and Trauma Calls

- i. The in-house medicine team is required to attend and manage all code-blue situations, under the supervision of the Attending (if still in-house) or the ER physician (if available).
  - ii. The upper-level resident is expected to supervise or “run” the code.
  - iii. The PGY-1 is expected to participate and assist in the code, as directed by the upper-level resident.
  - iv. The team should attend and assist in all trauma alerts, unless patient care issues prevent this.
  - v. The code link phone must be carried at all times by the team upper-level resident and should never be left unattended.
- h. Moonlighting
  - i. See the [Sponsoring Institution Policy](#).
- i. Annual Leave
  - i. Residents are not allowed to take annual leave while on the inpatient medicine rotation.
  - ii. In extraordinary circumstances, the resident must provide written justification as to why the leave should be approved.
- j. Sick leave
  - i. On the morning of an absence, the resident must notify via phone or email his/her team and Attending, his/her suite, and the Residency Office as soon as possible.
  - ii. Residents should arrange coverage for responsibilities as able. Sick leave must be submitted for weekends on the Monday following leave. This leave will have to be made up.
  - iii. Unexpected illness occasionally occurs. All days taken for sick must be claimed upon return to work. Any sick leave in excess of 72 hours must be accompanied by a physician’s statement and release to return to work.

#### XIV. Third year medical students

- A. Third year Internal Medicine students will be working with residents on the Inpatient Medicine service. It is the resident’s responsibility to assist in the education of these students.
- B. Student requirements
  - a. Lectures and other learning sessions (weekly schedule is emailed)
  - b. Attendance at Morning Report, prerounding, attending rounds.
  - c. Following patients and writing notes
    - i. Please get students involved as early in the admission process as possible
    - ii. Please read progress notes and monitor student presentations and assist with improvement
    - iii. Goal is to follow at least two and not more than four patients at a time
    - iv. Students are **not** to follow children during this clerkship.
  - d. Observed H&Ps. Can be observed by attending or resident. Please be strict but fair in the review and complete the form for the student.

- e. When on-call, students should be in-house until 7 pm. Students are expected to perform H&Ps on new patients and attend to assigned continuity patient follow-up and duties.
  - f. When no on-call, students should be available until 5 pm.
- C. Resident responsibilities
- a. Meet with students before rounds and review patients with them.
  - b. Assist with patient assignments and continuity.
    - i. Help students to see new patients when on call in such a way that they will be able to follow the patients in-house. We try to put the students on call with their intern whenever possible.
    - ii. On weekend call, the students are assigned to be on with their attending, intern and/or resident. (It's kind of a moving target.)
      - 1. Please make sure student is rounding on his/her usual patients.
      - 2. Remember that night students should round with night team and day students should round with day team.
      - 3. Students follow the same duty hour restrictions as interns.
  - c. Please meet with students at other times and review patient care, pertinent knowledge or patient-care topics, or other important learning topics. The students enjoy learning from **you**. Remember that the students have a tremendous amount of reading and studying to do during this clerkship so try not to assign them too much "busy" work.
  - d. MedHub grading. Please complete online grading form when link is emailed to you. Resident grades do count. Please contact IM clerkship coordinator for any problems.
  - e. Report student problems. Whether knowledge, patient care or professionalism issues, please report and problems to the clerkship director as soon as the concern arises. Do not wait until evaluations.

## Appendix A

### Process on Mandatory Notification of Faculty

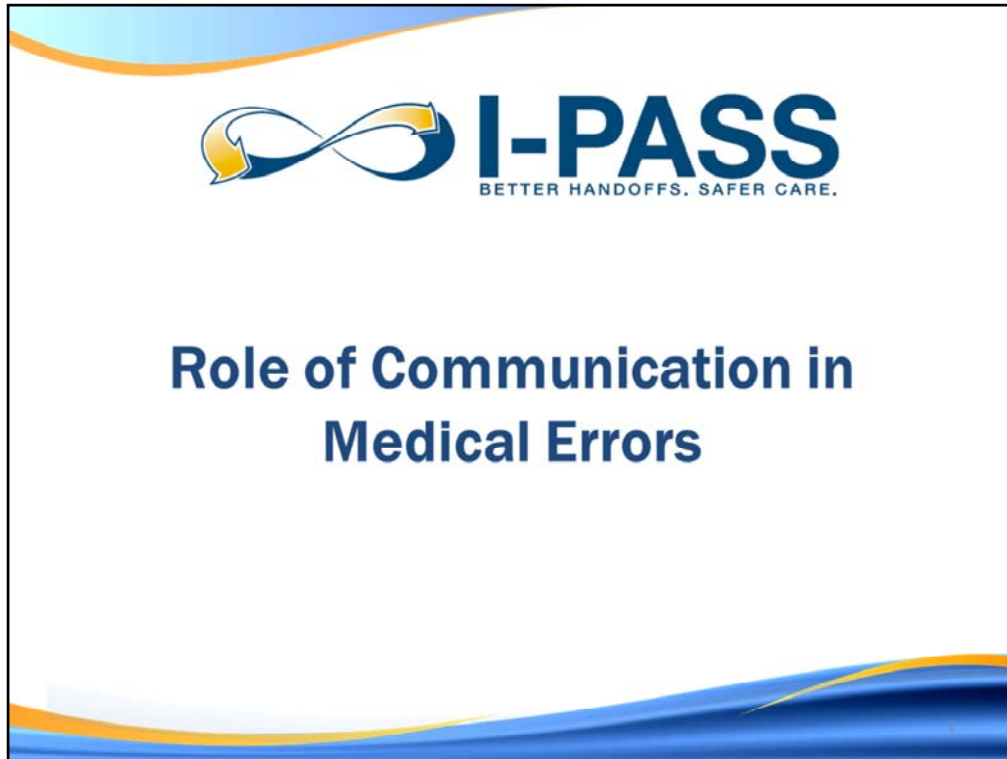
#### Process

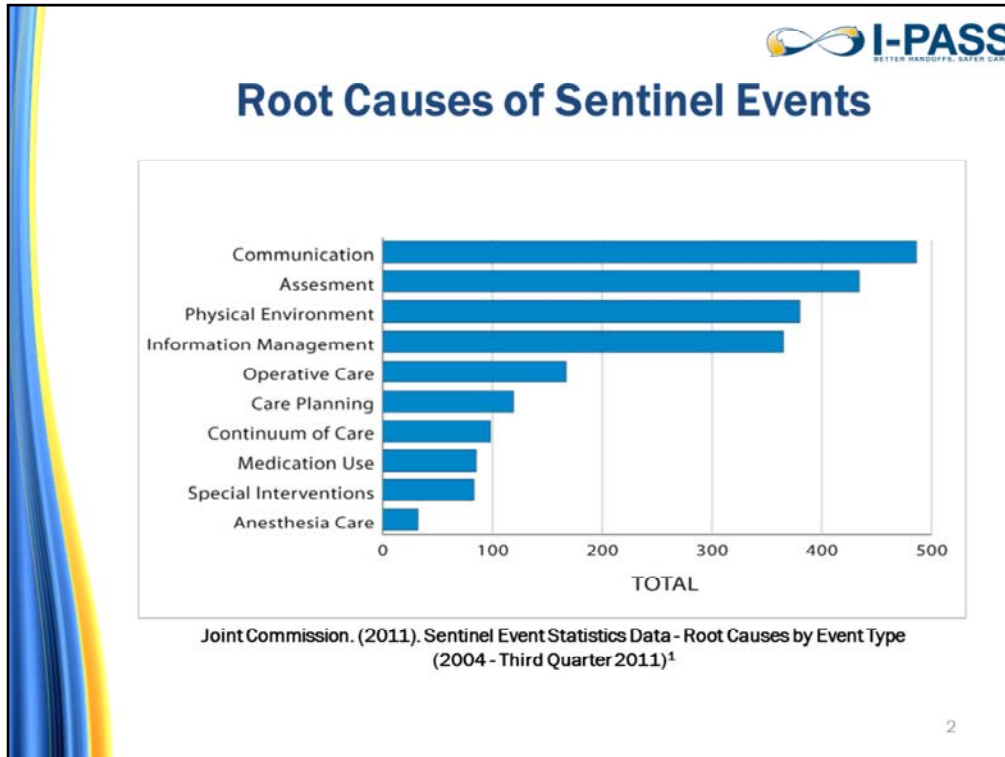
In the cases below, faculty must be notified of a change in patient status or condition. The table below outlines those instances in which faculty must be called.

Condition	PGY 1	PGY2	PGY 3 and above
OB	x	x	x
Transfer to ICU	x	x	x
DNR or other end of life decision	x	x	x
Emergency surgery	x	x	x
Acute drastic change in course	x	x	x
Unanticipated invasive or diagnostic procedure	x	x	x

#### How monitored

Chief Residents, faculty, and programs will monitor by checking for proper implementation on daily rounds, morning reports, and other venues as well as solicitation of reports from faculty on lack of appropriate use of the policy.





Disclaimer: The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

Improving caregiver communication is essential because, as you can see, communication failures are the primary root cause of sentinel events – that is, **the most serious— often fatal— preventable adverse events in hospitals.**

**ADDITIONAL INFORMATION AND REFERENCE MATERIAL:**

The reason that improving caregiver communication has been so heavily emphasized within the patient safety movement becomes apparent when one looks at the underlying causes of medical error. Using root cause analysis to determine contributing factors shows that of sentinel events that were voluntarily reported to JCAHO over a ten year period, the top contributing factor representing nearly 2/3 of all cases was found to be inadequate communication amongst providers.

## New ACGME Training Requirements

- Teamwork training
- Communication skills during transitions of care
- Supervision and monitoring of handoffs

3

As you are well aware, ACGME duty hour standards have changed, especially for interns. These changes have created more transitions in care, necessitating an even greater need to improve our communication skills at the time of handoffs. In fact, the ACGME has now mandated that residency programs provide training in teamwork, communication, and safe transitions in care.

### *ADDITIONAL INFORMATION AND REFERENCE MATERIAL:*

Despite the introduction of the first duty hour restrictions for residents by the ACGME in 2003, however, national data samples have failed to show that their implementation has had a positive effect on the quality and safety of inpatient care. At the same time, we know that with shorter work hours comes an increase in patient care handoffs, and that this increased number of handoffs carries associated risks for patient safety. Because of this concern, the ACGME's common program requirements which are applicable to all specialties, have been revised to include not only further restrictions in work hours, but mandates for training in teamwork, communication, and safe transitions of care as well.



## Handoffs

- Transfer of:
  - Information
  - Authority
  - Responsibility
- Occur during transitions in care
  - Shift changes
  - End of service block
  - Unit transfers
  - Discharges



4

Finally, it is also helpful at this point to think of handoffs *as yet another global team communication strategy* with clearly defined elements that— if executed properly— contribute to their success.

Handoffs can be defined as transfer of . . . **<read bullet points>**. They occur during transitions in care, for example. . . **<read bullet points>**

### *ADDITIONAL INFORMATION AND REFERENCE MATERIAL:*

Handoffs include the transfer of knowledge and information about the degree of uncertainty or certainty (about diagnoses, etc), response to treatment, recent changes in condition and circumstances, and the plan, to include contingency plans. In addition, both authority and responsibility are transferred. Lack of clarity about who is responsible for care and for decision-making has often been a major contributor to medical errors.

## Global Elements of Handoffs

- Unambiguous transfer of
  - Information
  - Responsibility
- Protected time and space
  - Quiet location
  - Interruptions minimized
- Standardized format
- Importance of the leader
  - Assign roles, ensure quality

5

Certain global elements apply to both verbal handoffs and printed handoff documents. A handoff does need to have someone designated as leader. Generally this is the most senior person involved in giving the handoff. We will get to the details of the I-PASS handoff process shortly.

## Elements of Verbal Handoffs

- Structured format
  - Begins with high-level overview
- Appropriate pace
- Closed-loop communication → shared mental model
  - Solicit check back of salient points
  - Prompt for clarifying questions
  - Be aware of non-verbal communication
    - Nodding approval, eye rolling, puzzled look

6

The key elements for performing a verbal handoff are depicted here.

For a high level overview you will want to describe the current situation of team (e.g. number of sick and unstable patient and pending admissions or discharges - this is essentially a BRIEF)

Closed-loop  
communication: ensures  
a shared mental model

## The Printed Handoff Document

- Supplements the verbal handoff
  - Allows receiver to follow
  - Provides more comprehensive information
- Creates efficient information transfer
- Requires daily updates
  - High-quality information
    - Don't copy and paste
  - Senior/supervising resident should edit and ensure quality

7

All of us have printed documents – whether they exist in an EMR or on a computer on a Word or Excel document.  
What is important is that...


The printed handoff document allows the receiver to follow along as the verbal handover is communicated. It also provides more comprehensive information than what is presented in the verbal handover such as medications, allergies, room number etc.


Creates efficient information transfer – what information is best included on the printed handoff document?

This document needs to be regularly updated by the supervising resident.

### ***ADDITIONAL INFORMATION AND REFERENCE MATERIAL:***

It is important to include an active problem list and up-to-date to do list. The printed handover can also serve as a back up for the verbal and vice versa. For example, verbally one may forget to communicate something that should be done overnight but if present on the written document the receiver can ask about this task. Omissions are known to be a problem with communication and the written handover adds to redundancy which can be protective against adverse patient events.





## Verbal Handoff Complements Printed Handoff Tool

- Printed handoff is foundation
- Content / length of verbal handoff depends on
  - Level of training
  - Prior contact with and knowledge of patients
  - Length of time on rotation
    - Verbal summary is more lengthy during handoffs on the first few days of the rotation
- Should provide an opportunity for discussion
  - Creates a shared mental model
  - Facilitates active participation by receiver

8

Verbal handoff and the printed handoff document are complementary

## The I-PASS Mnemonic

- I** **Illness Severity**  
Stable, “Watcher,” Unstable
- P** **Patient Summary**  
Summary statement; events leading up to admission;  
hospital course; ongoing assessment; plan
- A** **Action List**  
To do list; timeline and ownership
- S** **Situation Awareness & Contingency Planning**  
Know what’s going on; plan for what might happen
- S** **Synthesis by Receiver**  
Receiver summarizes what was heard; asks  
questions; restates key action/to do items

9

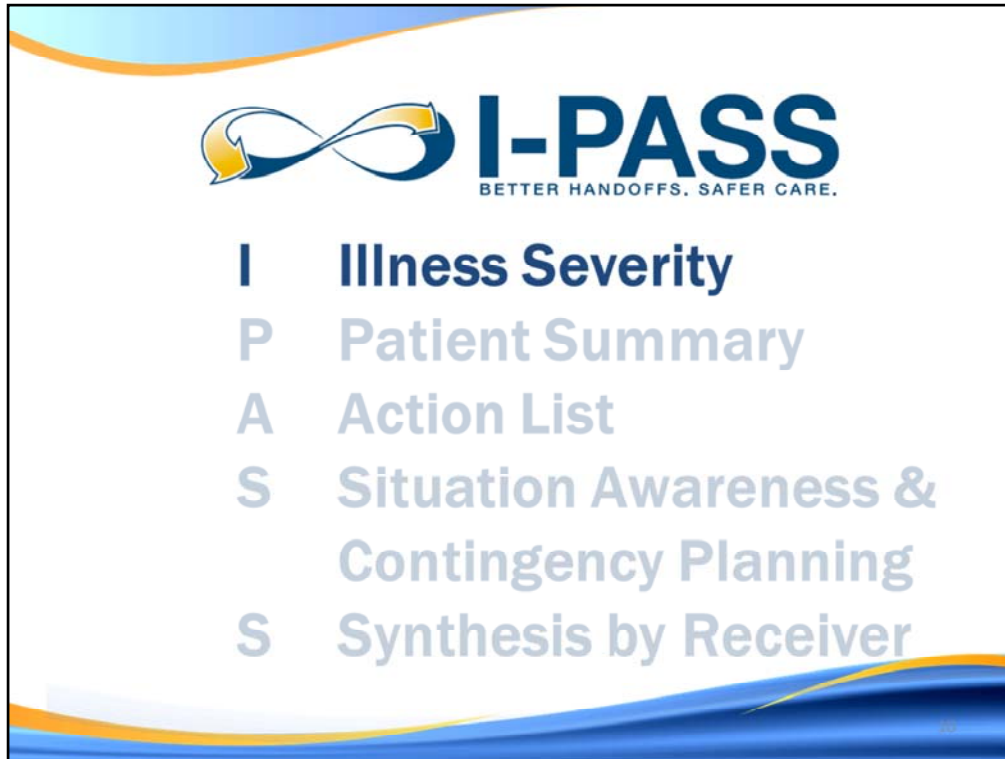
Now we have a very special gift for all of you. Drum roll please! The introduction of the IPASS mnemonic and your own pocket cards

We will now distribute a laminated I-PASS Pocket Card.

You are now in possession of the IPASS Pocket Card. Let me go over what this mnemonic stands for...

Helpful Reference:

Starmer, A.J., Spector, N.D., Srivastava, R., Allen A.D., Landrigan C.P., Sectish T.C., et al. "I-PASS, a Mnemonic to Standardize Verbal Handoffs." *Pediatrics*. 129.2 (2012): 201-204.



Now we get into the IPASS mnemonic itself.

This mnemonic was created with input from pediatric residents from the Boston Combined Residency Program in Pediatrics. They originally used another mnemonic but it had too many letters and they could not remember what each stood for.

If you cannot remember the elements of a mnemonic, it is not a good mnemonic.

## Illness Severity

### Why is it important to classify?

- Focus attention appropriately
- Use standard language
- May vary based on
  - Unit acuity
  - Provider type
  - Institutional culture
- Helps develop shared mental model

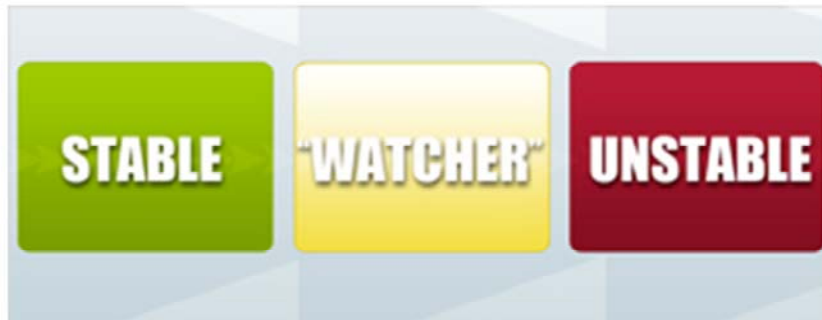
11

Language has to be customized to institution and monitoring systems available.  
Sick or not sick may be the simplest way to think about the patients.

However, some institutions use standardized scoring systems, like PEWS or CHEWS scores.

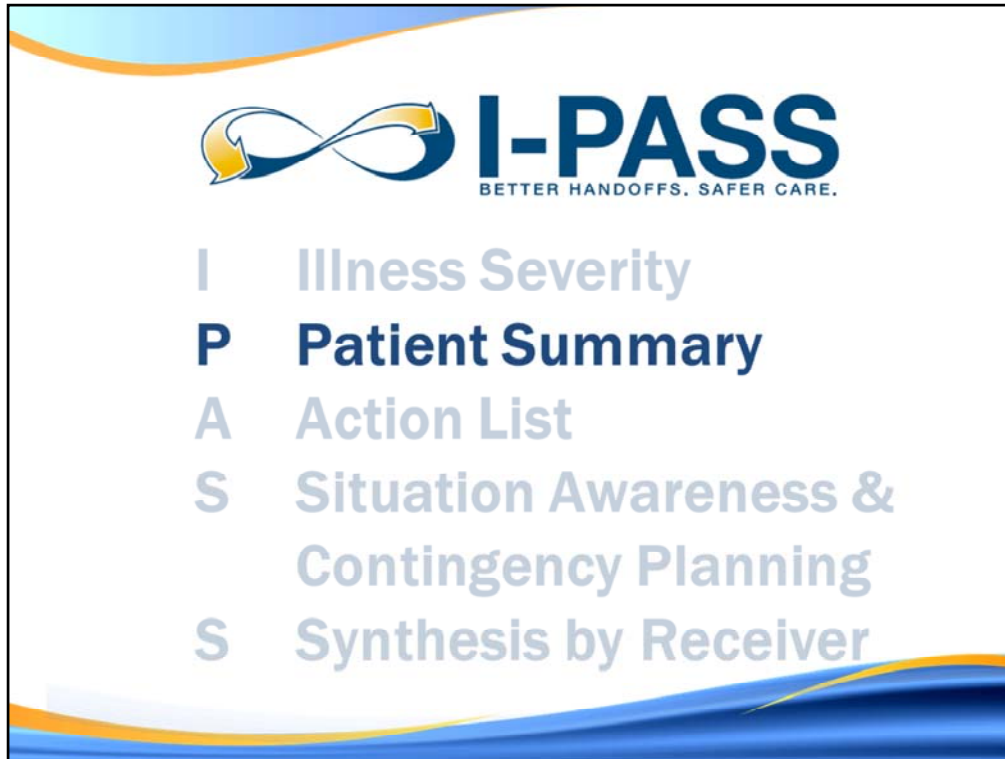


## Illness Severity A Continuum



- **Watcher** : *any* clinician’ s “gut feeling” that a patient is at risk of deterioration or “close to the edge”

Here is an example of a graded system of classification.  
Watcher is a new term for some of you.  
It is defined here.



Patient summary is one of the most important elements in the handoff process. We feel that the skill of providing a succinct, yet rich and descriptive, patient summary is a very high level cognitive skill. Therefore, we feel that this needs to be learned and modeled.

## The Patient Summary Why is it Important?

- Describes succinctly
  - Reason for admission
  - Events leading up to admission
  - Hospital course by problem/diagnoses
  - Plan for hospitalization
- Communicates concerns and nuances
- Anticipates expected course
- Creates a shared mental model

14

Your role as a giver of a handoff is to transfer information and responsibility to the receiver. The patient summary provides the basis for creating a shared understanding, so the next caregiver is prepared to carry out the treatment plan and can anticipate what may happen, or what may go wrong!

***ADDITIONAL INFORMATION AND REFERENCE MATERIAL:***

When mentioning the shared mental model refer back to the earlier TeamSTEPPS training slide on this topic.

Concerns that will be included in the patient summary should not only include physician concerns, but ALSO those that the patient, family, or nursing will have.

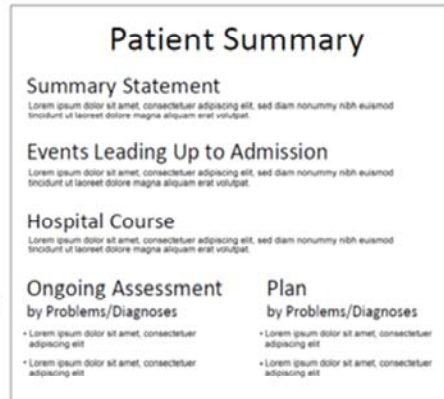
When articulating the expected course it is important to consider what you think is the expected trajectory or the patient's illness – i.e. will they get better, stay the same, or get worse during the period another will be caring for them.

We've had an expert panel of program directors & hospitalists thinking about this. We have come up with what we think is the best combination of succinctness and high-quality information for the I-PASS project. This is a QI project, to improve over time, we need your feedback and help as we go through this in our institution.

The problem: this has been an evolutionary process, but with I-PASS it will be revolutionary.

## Sections of a Patient Summary

- Summary statement
- Events leading up to admission
- Hospital course
- Ongoing assessment
  - Organized by problems/diagnoses
- Plan
  - Organized by problems/diagnoses



15

There are 4 - 5 main sections of an effective patient summary.  
We will review each of these in more detail on subsequent slides

Helpful Reference:

Kaplan DM. Perspective: Whither the Problem List? Organ-Based Documentation and Deficient Synthesis by Medical Trainees. *Academic Medicine*. 2010;85(10):1578-1582.

## Summary Statement Section

- “One-liner”
- Sets the clinical context
- Contains critical identifying information
  - Name
  - Age
  - Gender
  - Pertinent past history
  - Reason for admission

### Patient Summary

**Summary Statement**  
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**Events Leading Up to Admission**  
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**Hospital Course**  
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## Events Leading Up To Admission Section

- Lists chronologically
- Includes essential history & physical exam/lab findings
- Should be bulleted
- *Section can be truncated when high level of diagnostic certainty is attained*

### Patient Summary

Summary Statement  
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**Events Leading Up to Admission**  
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Hospital Course  
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This section describes the way the patient presents to the hospital and should be maintained in the patient summary section until a high level of diagnostic certainty is attained.

## Hospital Course Section

- Lists key events and updates
- Highlights special considerations
  - Family/social issues
  - Nursing concerns
  - Chronic medical conditions

### Patient Summary

**Summary Statement**  
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**Events Leading Up to Admission**  
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**Hospital Course**  
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<b>Ongoing Assessment by Problems/Diagnoses</b> <ul style="list-style-type: none"><li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li><li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li></ul>	<b>Plan by Problems/Diagnoses</b> <ul style="list-style-type: none"><li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li><li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li></ul>
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Hospital course provides a section in the patient summary for key findings, changes in status, events, or special considerations or concerns.

## Ongoing Assessment Section

- Provides diagnostic reasoning
- Offers differential diagnosis and assessment
- Uses appropriate organizational framework

**Patient Summary**

**Summary Statement**  
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**Events Leading Up to Admission**  
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**Hospital Course**  
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<div style="border: 1px solid blue; padding: 5px; background-color: #e6f2ff;"> <p><b>Ongoing Assessment by Problems/Diagnoses</b></p> <ul style="list-style-type: none"> <li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li> <li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li> </ul> </div>	<p><b>Plan by Problems/Diagnoses</b></p> <ul style="list-style-type: none"> <li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li> <li>• Lorem ipsum dolor sit amet, consectetur adipiscing elit</li> </ul>
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The ongoing assessment section reflects the critical thinking, diagnostic reasoning and thought process related to current problems or diagnoses.

For example: For a patient admitted with presumed LLL pneumonia who was not improving, what elements might be captured in an ongoing assessment?

Answer – Patient with presumed LLL pneumonia who has not been improving, we are concerned that there may be antibiotic resistance or a developing empyema, we may need to consider imaging and changing antibiotics.



## Problem vs. Systems List

- Choose problems or systems based on
  - Patient complexity
  - Patient settings
  - Institutional culture
- Use caution for systems-based approach
  - Don't lose sight of active, high-priority issues by including all systems
- Use caution for problem-based approach
  - Don't forget to monitor all systems

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We favor Problems/Diagnoses, but understand that some patients may be better served by a systems approach

**Add in discussion of thought process/how arrived at assessment**

If you are doing an assessment, you will arrive at a diagnosis – “diagnostic assessment”  
Systems might be used more in ICUs , problems on general ward teams

## Plan Section

- Develops specific plan for each problem or diagnosis
- Uses appropriate organizational framework
- Reflects global plan for entire hospital stay
  - Avoid “to-do” items for next shift
- Specifies “None” if no plan is required

### Patient Summary

**Summary Statement**  
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**Ongoing Assessment by Problems/Diagnoses**  
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**Plan by Problems/Diagnoses**  
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Plans are listed by problem or diagnosis and document current treatments and monitoring. Not all problems require a plan, so listing, “None” is acceptable.

## Action List

- To do list
- Includes specific elements
  - Timeline
  - Level of priority
  - Clearly-assigned responsibility (if not receiver)
  - Indication of completion
- Needs to be up-to-date
  - If no action items anticipated,  
clearly specify “nothing to do”

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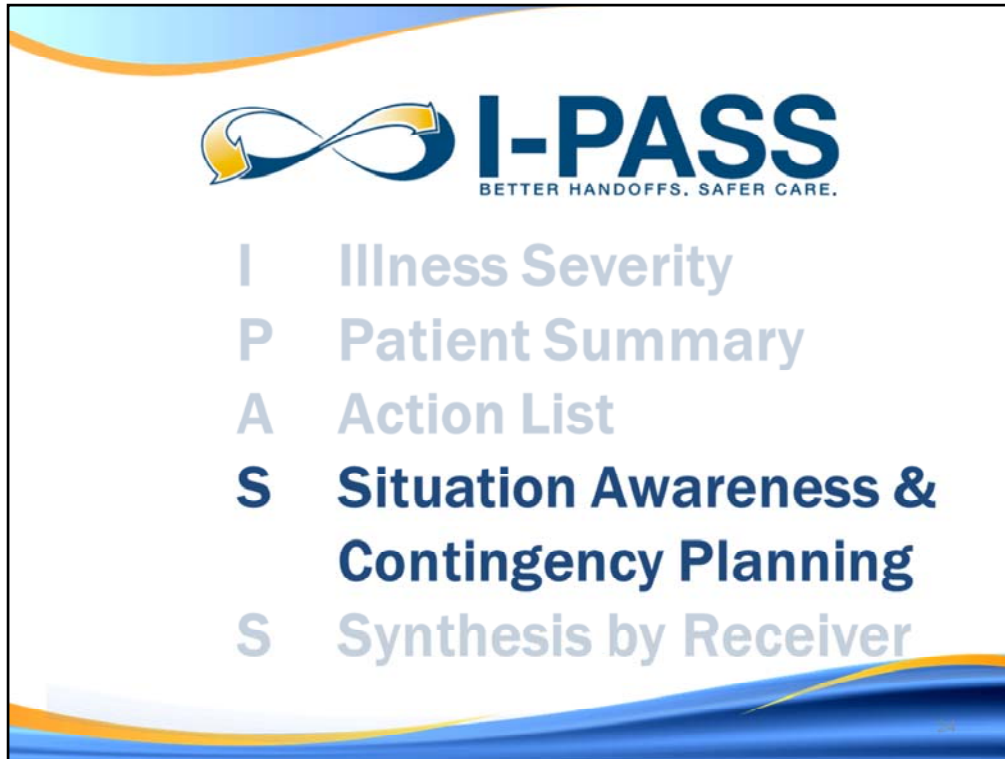
Action List is a “To Do List” with attention to timelines, level of priority, assigned responsibility, and updating

## Action List

To Do:	
<input type="checkbox"/>	Check respiratory exam now
<input type="checkbox"/>	Monitor respiratory exam Q2h overnight
<input type="checkbox"/>	Check pain scores Q4h
<input type="checkbox"/>	Check ins and outs at midnight
<input type="checkbox"/>	Follow up 6PM electrolytes
<input type="checkbox"/>	Follow up blood culture results

This is the action list from our sickle cell patient. Why is this a good action list?

Answer: has timelines, priority levels



Situation Awareness and Contingency Planning is also a high level cognitive skills.

In studies of handoffs, it is surprising to learn that not all handoffs include a contingency plan.

We think this is a very important and mandatory element.

## Contingency Planning

- Problem solving *before* things go wrong



Photo courtesy of Photodisc/Photodisc/Thinkstock

- “If this happens, then...”

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In studies of pediatric residency programs, residents from the daytime team taking call at night were no better at anticipating problems that occurred on call than cross covering residents.

Why was that the case? **They did not include contingency plans in their evening handoff!**

Do you have a personal story about poor contingency planning? (individual reflection)

## Importance of Contingency Planning

- Is critical for patient safety
- Provides the receiver with specific instructions for what might go wrong
- Ensures accepting team is prepared to
  - Anticipate changes in patient status
  - Respond to potential events or changes in status

Contingency planning is essential to alert the receiver of a handoff to what might go wrong and to provide specific instructions for handling these situations.

## Effective Contingency Planning

- Articulate what might go wrong
- Define the plan
  - List interventions that have/have not worked
  - Consider code status
  - Identify resources and chain of command
- Provide details based on receiver' s
  - Level of experience
  - Knowledge of disease process
  - Familiarity with service and/or patient

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Effective Contingency Planning involves essential elements.

### ADDITIONAL INFORMATION AND REFERENCE MATERIAL:

- What should be included in contingency plans
  - Which patients are **worrisome** – Who are the sickest patients, which patients are at risk for decompensation
  - What **may go wrong** and **what to do** – If a patient is at risk for decompensation, provide treatments hints and recommendations if something should occur. Example: If an asthmatic develops worsening respiratory distress, begin continuous albuterol therapy.
  - What **therapies or interventions** will help – Example: racemic epinephrine will help if this child with underlying airway abnormalities develops stridor, if a bronchiolitic develops retractions attempt NP suctioning and start supplemental oxygen therapy.
  - **Resources** for assistance – Call attending, senior or fellow, contact consultant, call MRT/RRT.
  - Difficult **family or psychosocial situations** – Example: Parents who are divorced and social situation is strained, grandmother is guardian and has decision making capacity, child has been removed from parents' custody.
  - Nursing and family **concerns** – Highlight which patients the nurses and families are concerned about, even if the residents are not concerned.
  - **Code status**
- Resources for assistance include contacting the attending or senior resident, calling a consult, or activating an MRT/RRT.
- While contingency planning should be considered on EVERY patient, it is completely permissible for stable patients to mention that one does not anticipate decompensation or for anything to go wrong (that *IS* contingency planning!).
  - “If this happens, then...”
  - If anticipated, patient care **improves**




## Additional Considerations Contingency Planning

- Difficult family or psychosocial situations
- Nursing and family concerns

For stable patients:

“I don’ t anticipate that anything will go wrong.”

Contingency Planning may apply to a variety of other situations related to the patient and patient care.



**I**    **Illness Severity**  
**P**    **Patient Summary**  
**A**    **Action List**  
**S**    **Situation Awareness &  
Contingency Planning**  
**S**    **Synthesis by Receiver**

The final S is critical – synthesis by receiver – a good example is when you order take out from a Chinese restaurant and the person on the other end of the phone reads your order back to you.

## Importance of Synthesis by Receiver

- Provides brief re-statement of essential information in a cogent summary
  - Demonstrates information is received and understood
  - Includes verbal and written elements
- Ensures effective transfer of information and responsibility
- Promotes a shared mental model

This echoes the TeamSTEPPS tool that was introduced earlier that we referred to as “check-back”

Let me emphasize the word *brief*.

## Synthesis by Receiver

- Opportunity for receiver to
  - Clarify elements of handoff
  - Ensure there is a clear understanding
  - Have an active role in handoff process

This synthesis allows the receiver to gain an understanding and verify that understanding with the giver of the handoff

## Elements of Synthesis by Receiver

- Vary in length and content
  - More complex, sicker patients require more detail
  - At times may focus more on action items, contingency planning
- Address priorities for individual patients
- Affirm understanding by receiver

*It is not a re-stating of entire verbal handoff!*

“From what you just told me, my understanding is that this is the sickest patient on this unit and I should be watching the blood pressure tonight. I’ ll make sure we get frequent checks of his vital signs. If we ...