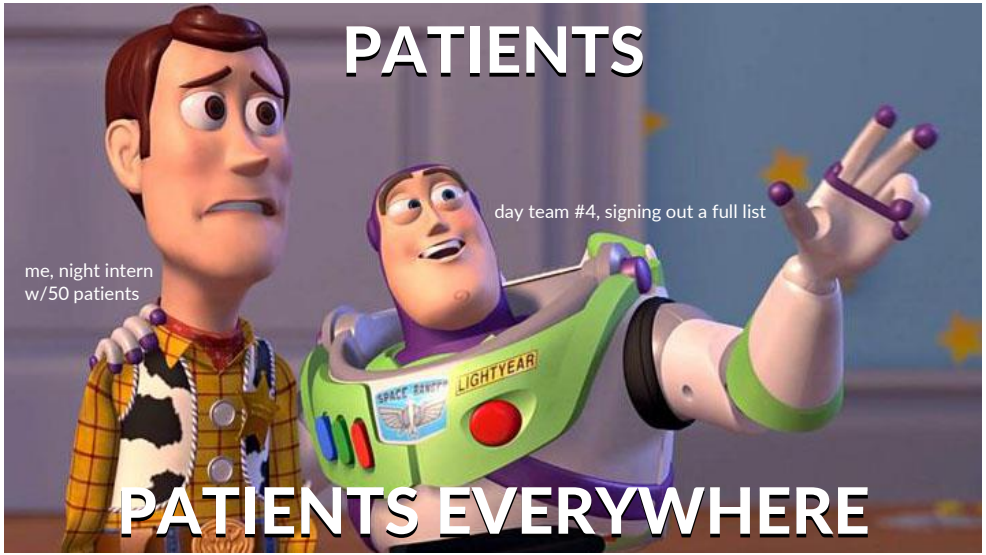
Transitions of Care: Day to Night Handoff

Adapted from Rebecca J. Ye, MD

Handoffs… the witching hour



Effective Handoffs Have the Following:

Minimal Distractions

Sufficient Time

Updated

Standardized Format - IPASS

A Dialogue (Face-to-Face with interactive questioning and **readback)**

Clear, specific **If/Then** (anticipatory guidance) and **To Do** statements

Culture of shared responsibility/ownership, prioritization of handoffs

What goes into an effective handoff?

How sick is this person?

Who they are

What we think they have

What we're doing/how it's working

To-do items

Contingency plans

The Nitty-Gritty

Use the Handoff patient list

Enter the IPASS info using **.IMIPASS** in Summary field

Illness Severity (and some extra)

- Illness severity
  - Discharged/ALC/Stable/Watcher/**HOTSPOT**
- Code Status
- DVT ppx/therapeutic AC
  - Why are they on it?
- Antibiotics

Patient Summary

This should be updated daily!

Major PMHx

Reason for admission

Major events this hospitalization

24h events

Action Items

Night To-Do

Day To-Dos

Discharge checklist

Situational & Contingency Plans

Anticipatory guidance (if/then)

Contact information

Synthesis by Receiver

Ask questions!

Seriously, ask questions.

Handoff Responsibilities

Sender

- Face to face
- Prioritize and call attention to the most sick; include current clinical condition
- Make sure you achieve a shared mental model for each patient (confirm understanding with read-back)

Receiver

- Active listening (stay focused, limit interruptions, take notes, ask questions for clarification)
- Use a system to keep track of To Do items
- Read-back the anticipatory guidance and To Do's to make sure you're on the same page
- Receiver needs to make sure they are satisfied with the handoff (they are responsible overnight!)

“Admitted for further management”

“Consider”

Illness Severity

Stable
Full Code

Patient Summary

78F with AF, HFrEF, T2DM, COPD, glaucoma, CVA, admitted for AMS after falling at home. Has UTI and volume overload. Downgraded from CCU yesterday.

24h: stroke code called for facial droop

Action Items

NF:
[ ] round for neuro exam
[ ] replete lytes

Day:
[ ] family meeting

Dispo:
[ ] PT recs

Situational/Contingency Plan

FYI: if hypotensive, has HF - discuss careful fluids with TR
FYI: On 2L O2, has room to go if hypoxic
FYI: If febrile, infectious workup; consider broadening abx

Illness Severity

Stable
Full Code

Anticoagulation or DVT ppx?
Antibiotics?

Patient Summary

78F with AF, HFrEF, T2DM, COPD, glaucoma, CVA, admitted for AMS after falling at home. Has UTI and volume overload. Downgraded from CCU yesterday.

24h: stroke code called for facial droop

Action Items

NF:
[ ] round for neuro exam
[ ] replete lytes

Day:
[ ] family meeting

Dispo:
[ ] PT recs

Situational/Contingency Plan

FYI: if hypotensive, has HF - discuss careful fluids with TR
FYI: On 2L O2, has room to go if hypoxic
FYI: If febrile, infectious workup; consider broadening abx

Illness Severity

HOTSPOT
Full Code

Apixaban for AF
Cefepime for MDRO UTI (ends 10/17)

Patient Summary

78F with AF on apixaban, HFrEF (EF 15% 8/2020), DM2 (A1c 9% c/b retinopathy), COPD, prior CVA x2 with L sided deficits p/w unwitnessed fall at SAR found to be grossly volume overloaded with MDRO E. coli UTI. Admitted to CCU for mixed septic/cardiogenic shock now s/p inotrope-assisted diuresis. Downgraded to floor 10/14 but still overloaded. Stroke code called today 10/15 for transient facial droop but no infarct.

24h: stroke code above, CTH negative, CTA negative

Action Items

NF:
[ ] round x1 for neuro exam - if changes stroke code, stat CTH
[ ] f/u 6 PM lytes, replete for K/Mg 4/2

Day Team:
[ ] call daughter for family meeting
[ ] f/u final cards recs for d/c meds

Discharge:
[ ] request cards, geri
[ ] f/u PT eval

Situational/Contingency Plan

FYI: BPs soft since downgrade but repeat lactates negative; if drops further think septic vs cardiogenic - get VBG, infectious w/u, add vanc + stat amikacin; TR + cards for CCU uptriage
FYI: neuro exam = AOx2-3 (self, location, sometimes date but knows year). PERRL, 3.5-4/5 strength throughout L, 4.5-5/5 R side; SILT throughout
FYI: volume exam - +2 BLE edema to mid-shin, crackles at b/l lung bases, no O2 requirement
FYI: If hypoxic, gas + CXR - think COPD (nebs) vs worsening pulmonary edema (stat dose 80 IV lasix)
FYI: hard of hearing, L ear works best

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