Coaching Handoff Tips 2018.06.19 v3

-- For new patients or acute clinical changes, include your ddx and clinical reasoning of what is most likely/less likely/can't miss. This helps both day/night teams to have a shared mental model of the patient

-- For physical exams that can potentially evolve over time consider including their most recent physical exam so the day/night team has a baseline.

-- respiratory patients (work of breathing, respiratory score for asthma, etc), -- -- -- patients with focal neurologic findings

-- patients with developmental delay at risk for altered mental status. Without information about baseline mental status, some may **assume** it's "normal" for the patient with delay to be nonverbal

Ex: child with metabolic disorder admitted for hyperammonemia, it can be really helpful to have a baseline of her mental status/developmental delay. Ex: 14 yo girl with arginase deficiency and developmental delay (developmentally ~6-7 years old). Likes taking about her princesses. So if she doesn't answer your questions about Moana, then be concerned for altered mental status.

-- When signing out to the night team, if you anticipate overnight interventions, try to be as **specific** as possible. This is incredibly helpful for the busy night team

-- if I/O balance is +500, give Lasix 10 mg IV x 1

-- if febrile to 38.5, then send blood cultures from both lumens and restart meropenem 1150 mg IV q6 hrs (for *Actinomyces)* and vancomycin 700 mg IV q8 hrs (for *Corynebacterium, Trueperella)*. Order vanco trough before 4th dose. We're using higher doses for CNS penetration with goal vanco trough between 15-20 (closer to 20)

-- followup on ammonia level ~20:00 tonight, goal <80. If above 80 then call genetics. If >150 or any mental status change, call RRT

-- When signing out to the night team (especially on subspecialty service), it can be helpful to say which fellow/attending is on-call and their contact number (pager, phone) and whether they preferred to be paged/called

-- When on night-float, consider identifying your sickest patient, the way they might clinically worsen, and how you would present their SBAR during a rapid response (very different from "signout" format). I've found it helpful to "practice" my SBAR when I'm working nights (especially for the complex stem cell transplant patients)

Situation: Why did you call the RRT?
Ex: Altered mental status, hypotension, tachycardia
"Altered mental status"

Background: One-liner
"14 yo girl with arginase deficiency, multiple recent admits for metabolic crises, remote history of seizures. Admitted for recurrent vomiting and hyperammonemia."

Assessment: What do you think is going on?
"Concerned about acutely elevated ammonia with AMS. May need transfer to PICU for management."

Recommendation: What would you like to do? How can rapid response team help?
"We need a STAT free-flowing ammonia on ice. May need additional IV access and may need to start Ammonul."