

The Art of Writing Effective Sign-outs: The Do's and Don'ts

DO:

1. Place patient's name, MR#, Room number, attending, and code status in a prominent place. Also include any allergies and the patient's reaction.
2. Concisely state the reason for admission, management plan, and how patient is currently doing.
3. Concisely list any other active medical issues and the management plan.
4. List major medical issues that could become active.
5. List medications.
6. If you have a "To do" list, make sure you provide very specific instructions on how to manage any abnormalities.
7. Anticipate problems that may occur and note them.

DON'T

1. Provide so many details that it is difficult for a busy cross-cover intern to see the big picture.
2. Check things out without an action plan.
3. Assume a busy cross-cover will notice details of your patient's history.
4. Use a small font that is difficult to read.

Pearl: Use a specific date rather than "today" or "yesterday" so that as you update your sign-out sheet, it won't leave an error if you forget to change it. (i.e. chest tube was removed on 10/5 rather than "yesterday")

Sample #1

Bond MR# 007 Rm5555 Dr. Q Full Code NKDA

45 yo wm admitted 1/2 w/ CP and dehydration following fight and prolonged exposure. CP from pneumothorax, responded to CT that was removed today. Creatinine improving w/ hydration (2.8 → 1.9 today). Mental status normal (had head trauma but head CT neg). Also broken leg followed by ortho on DVT prophylaxis

- If develops respiratory distress, check stat CXR to look for PTx, if present will need CT reinserted.
- Avoid NSAIDS as renal failure
- If called for high BP or HR, consider ETOH w/d as heavy drinker (if looks like DTs, give ativan start w/ 1mg IV) also make sure pain controlled and consider PE

Meds: morphine PCA (not using much), stool softeners, SQ heparin

To Do: nothing

Sample #2

Bond (# 007)

45yom in fight stable after CT removal from PTx, has PCA for pain
Check CXR

Sample #3

Bond MR# 007 Rm5555 Dr. Q Full Code

45 yo wm admitted 1/2 after being found unresponsive with many bruises suggesting a major fight. Initially he couldn't give a history do head CT ordered which was negative. He was also hypoxic in ER so CXR ordered which showed pneumothorax so CT surgery placed a CT and sats improved. He was also in renal failure which we think is from dehydration. We were initially concerned about rhabdo as CPK 700 but it never got any higher. (We also r/o MI w/ troponins). His creatinine has been decreasing with hydration and went from 2.8 to 2.4 to 2.1 and today is 1.9. He also had mild hyponatremia which has corrected with fluids. Once he woke up the next day he c/o left leg pain so we got a film which showed a small fracture which ortho has casted but it doesn't need surgery. PT is following. He also has a heavy ETOH history so we've been watching for signs of withdrawal but are not giving prophylactic ativan since he has no history of DTs. (he did have an elevated blood alcohol level when he came in.)

He has no PMH but also smokes heavily so could have CAD

Meds: morphine PCA (he's getting a basal rate but hasn't used the demand), colace 100mg BID, Tylenol 650 mg q6hours prn breakthrough pain, NO NSAIDS!! (renal dysfunction☺), benadryl 25mg po qhs prn insomnia, heparin 5000uniis SQ BID

To Do:

1. Check f/u CXR to look for any recurrence of the pneumothorax (sorry but CT surg wanted it repeated in 8 hours after they removed the CT☺)
2. If fever, panculture
3. If CP, check ECG and CXR (remember the PTx history)
4. If hypoxic consider recurrent pneumothorax and recheck CXR, if negative then consider PE and get CT PE protocol