ANTICipate for Written Sign-out *(Vidyarthi, et al. 2006)*

✓   Administrative Data

☐	Patient name, age, gender
☐	Medical record number
☐	Room number
☐	Admission date
☐	Primary inpatient medical team, primary care physician
☐	Family contact information

✓   New Information (Clinical Update)

☐	Chief complaint, brief HPI, and diagnosis (or differential diagnosis)
☐	Updated list of medications with doses, updated allergies
☐	Updated, brief assessment by system/problem, with dates
☐	Current "baseline" status (e.g., mental status, cardiopulmonary, vital signs, especially if abnormal but stable)
☐	Recent procedures and significant events

✓   Tasks (What needs to be done)

☐	Prepare cross-coverage (e.g., patient consent for blood transfusion)
☐	Warn of incoming information (e.g., study results, consultant recommendations), and what action, if any, needs to be taken that night

✓   Illness

☐	Is the patient sick?

✓   Contingency Planning / Code Status

☐	What may go wrong and what to do about it
☐	Using if/then statements
☐	What has or hasn't worked before (e.g., responds to 40mg IV furosemide)
☐	Difficult family or psychosocial situations
☐	Code status, especially recent changes or family discussions

Checklist for Anesthesia Resident to PACU Nurse Handoff at University of Chicago: "PACU To-Do" at University of Chicago

✓ **P**atient one-liner

- □ Identifying information (age, sex)
- □ Surgical procedure & surgeon
- □ Anesthetic used (i.e. MAC, epidural anesthetic, peripheral nerve block, general, etc.)
- □ Reason for surgery
- □ Example "Mr. Smith is a 65 yo M who just had a X procedure with Dr. Y b/c he had cancer."
- □ Pertinent past medical history with focus on major comorbidities (i.e. "pt also has DM, HTN, ESRD, HIV..."etc)

✓ **A**llergies, Weight, Vitals

- □ Allergies (specific statement if no allergies)
- □ Weight in kg
- □ Vitals if unstable

✓ **C**linical record in OR (routine)

- □ Medications given [esp narcotics, vasoactive substances (i.e. Labetolol); antibiotics, antiemetics (i.e. Zofran)]
- □ I/O's (UOP)
- □ What labs were done (i.e. ABG, pO2, Hgb, etc.)

✓ **U**nstable or unexpected (departures from routine) findings from OR

- □ Lability in blood pressure, glucose, other vitals, etc. and what was done ("labile BP requiring 4 sticks of labetolol")
- □ Inadequate anesthetic (i.e. "I don't think the epidural is working well")
- □ Unstable intubation/invasive devices or monitoring (i.e. "Difficult intubation with possible tooth chipped" or "the Arterial line is tenuous/positional")
- □ Patient communication barriers (deaf/blind/Spanish speaking, etc.)

✓ **To-do**

- □ Any labs or tests to order or follow-up on (i.e. CXR, ABG, etc.)
- □ Any orders that the resident is ordering
- □ Plan for post-op pain control, i.e. epidural, PCA, IV prns, po meds, etc)

Figure 4. *The checklist for anesthesia resident to the postanesthesia care unit (PACU) nurse handoff at the University of Chicago is shown. MAC, Monitored anesthesia care; M, male; DM, diabetes mellitus; HTN, hypertension; ESRD, end-stage renal disease; HIV, human immunodeficiency virus; OR, operating room; I/Os, inputs/outputs; UOP, Urine output; ABG, Arterial blood gas; pO2, partial pressure of oxygen; HgB, hemoglobin; BP, blood pressure; CXR, chest x-ray. Used with permission.*

Standardized Content Checklist for Pediatric Handoff

✓ **P**roblem List
- ▢ Any pertinent past medical history (e.g., cerebral palsy, seizure disorder)
- ▢ Systems-based list of current problems
- ▢ Focus on any invasive tubes/devices (e.g., GI-has g tube or Pulm-trach)

✓ **E**xpected tasks to be done
- ▢ Any labs to check on and what to do about them
- ▢ Tests to order or follow-up on (e.g., CT scans)

✓ **D**iagnostic one-liner
- ▢ Includes age, sex, relevant past history related to current problem and current chief complaint/reason for hospitalization (4 yo F with history of chronic severe asthma here with status asthmaticus)

✓ **I**f/Then
- ▢ Frequent issues to be expected with a plan to resolve using if/then format (e.g., "if HTN, please give Hydralazine")

✓ **A**dministrative data/Advanced directives
- ▢ Patient name, medical record number
- ▢ Room number
- ▢ Admission date
- ▢ Primary inpatient team, attending
- ▢ Family contact information
- ▢ Weight/BSA (body surface area)
- ▢ Code status

✓ **T**herapeutics
- ▢ Medications (updated list of medications with doses (esp dates that any antibiotics were started and duration)
- ▢ Diet with any weaning orders—Is the patient NPO?
- ▢ IVF
- ▢ Oxygen with weaning instructions

✓ **R**esults and other important facts
- ▢ Labs (e.g., recent Hgb/Hct)
- ▢ Cultures (esp any outside hospital cultures that were obtained)
- ▢ Radiology test results
- ▢ Consults

✓ **I**v Access/Invasive devices
- ▢ IV access and what to do if it comes out overnight (e.g., "Has PIV, must be replaced if it falls out")
- ▢ Any invasive devices listed in problem list

✓ **C**ustody and Consent Issues
- ▢ Is the patient DCFS (Department of Child and Family Services)?—if yes, need to get consents from them. Is child protective services involved?
- ▢ Parental custody or any issues related to parental custody

Figure 5. *The standardized content checklist for the pediatrics hand-off protocol is shown. GI, gastrointestinal; Pulm, pulmonary; g, gastrostomy ; trach, tracheotomy; CT, computerized tomography; HTN, hypertension; NPO, nothing by mouth; IVF, intravenous fluid; Hgb, hemoglobin; Hct, hematocrit; PIV, peripheral intravenous.*

Patient Care Profile, University of Chicago

University of Chicago Hospitals Patient Care Profile

Room: _____
Name: _____
Service: _____ Attending: _____

Date of Admission: _____ Age: _____ Date/Time of Arrival on the Unit: _____
Sex: F/M
Resident: _____ Pager: _____

S
Situation

Allergy(ies): Drug _____ Food: _____

Height: _____ Weight: _____ Code Status: _____
Diagnosis: _____

Surgical Procedure(s): _____

Mental Status: _____
Precautions: Isolation   Fall   Seizure   Aspiration   Restraints : Y/N   Sitter: Y/N

B
Background

Past Medical History: _____

Past Surgical History & Year: _____

| Parameters: T:> | HR:> | < | RR:> | < | UOP:< | SBP:> | < |
| DBP:> | < | O2 Sat< | Pain goal: | | | |

Vitals: (frequency) _____

IV Fluids: Blood Sugar monitoring:(frequency) _____ / SSI starts at: _____
.... : _____   site: _____ date: _____
.... : _____   site: _____ date: _____
.... : _____   site: _____ date: _____
    site: _____ date: _____

Dialysis access : _____   Tube feeding: _____   Type of tube: _____
Diet: _____

Calorie count: Y/N   Daily Weight: Y/N   Neuro Checks: Y/N   Activity: _____

Wound/Incision: _____   Dressing Change/ Frequency: _____
Wound/Incision: _____   Dressing Change/ Frequency: _____
Wound/Incision: _____   Dressing Change/ Frequency: _____
Wound/Incision: _____   Dressing Change/ Frequency: _____

Patient Care Profile, University of Chicago, *continued*

B
Background – cont

Respiratory: (CPT/NEBS & Frequency) _____ Trach/Size _____
Oxygen support: _____ Tubes: _____
Is/Os: Drains: _____
Foley: _____ Others: _____ Last BM: _____

Pertinent Labs Results: _____
Routine labs to be drawn: _____

A
Assessment

Significant events/Date: _____
(Information in this section should answer some of the following questions: What do you think is going on with this patient?
Do you have concern? If so, what are they? How severe? Is there a problem that could be life threatening? Did you start anything
that could not be finished on this shift?)

Procedure/s completed/date completed: _____
.. : _____
.. : _____
.. : _____

R
Recommendations

Nursing Interventions
(Information in this section should answer some of the following questions: What would you like the incoming nurse to attend to?
What have the physicians been told? Not yet told? Has anything been left undone? Did you start anything that could not be finished
on this shift?)

Instructions:

Day Shift	Evening Shift	Night Shift	Special
			TEDS/ALPS: _____
			Incentive Spirometer: _____ (Triflo)

Clinical Goal:	Patient Goal:

Figure 5. The Patient Care Profile is divided into the corresponding Situation, Background, Assessment, and Recommendation (SBAR) sections for use during nursing-shift changes. HR, heart rate; RR, respiratory rate; UOP, urine output; SBP, systolic blood pressure; DBP, diastolic blood pressure; O2, oxygen saturation; CPT, chest physiotherapy; NEBS, nebulizers; TEDS, Ted hose; ALPS, silicone lotion (brand name). Used with permission.

Figure 5. Continued.

"SIGNOUT?"		**VERBAL SIGN-OUT** *(Horwitz, et al. 2007)*
S	Sick or DNR?	*OK, this is our sickest patient, and he's full code.*
I	Identifying data (one liner)	*Mr. Jones is a 77-year-old gentleman with a right middle lobe pneumonia.*
G	General hospital course	*He came in a week ago hypoxic and hypotensive but improved rapidly with IV levofloxacin.*
N	New events of day	*Today he spiked to 39.5°C and white count bumped from 8 to 14. Portable chest x-ray was improved from admission, we sent blood and urine cultures. U/A was negative but his IV site looked red so we started vanco.*
O	Overall health status	*Right now he is satting 98% on 2 L NC and is afebrile.*
U	Upcoming possibilities with plan and rationale	*If he becomes persistently febrile or starts to drops his pressures start normal saline at 125 cc/h and have a low threshold for calling the ICU to take a look at him because possible sepsis.*
T	To Do overnight with plan, rationale	*I'd like you to look in on him around midnight and make sure his vitals and exam are unchanged. I don't expect any blood culture results back tonight so there is no need to follow those up.*
?	Any questions?	*Any questions?*

Checklist for Safe and Effective Sign out for OB/GYN at University of Chicago: "The List"

✓ **T**o-do

o Labs to check and what to do with them
o Tests to order
o Dispo (e.g. what to do to get the patient home)

✓ **H**istorical data

o Includes age, sex, relevant past history related to current problem and current chief complaint/reason for hospitalization (25 yo G3p2 F here with EGA 28 weeks IUP with PROM)
o Pregnancy or cancer history
o Any pertinent past medical history (i.e. HTN, DM, etc.)
o Systems-based list of current problems

✓ **E**xpected or anticipated Issues overnight

o Frequent issues to be expected with a plan to resolve using IF/then format (i.e. "if BP > x/y, please give Hydralazine," "CIS" etc.)
o For pregnancies with contractions, plan for tocolytics or delivery?

✓ **L**abs and other results

□ Labs (i.e. recent Hgb/Hct, etc.)
□ Cultures
□ Radiology test results
□ Consults

✓ **I**dentifying and other administrative data

□ Patient name, medical record number
□ Room number
□ Admission date
□ Primary inpatient team, attending
□ Family contact information

✓ **S**ickness

□ Code status
□ Is the patient going to get ill tonight?

✓ **T**herapeutics

□ Medications (updated list of medications with doses (esp dates that any antibiotics were started and duration)
□ Diet—Is the patient NPO?
□ IVF
□ Oxygen with weaning instructions

Figure 2. *The checklist for safe and effective sign out for obstetrics/gynecology (OB/GYN) at the University of Chicago is shown. Yo, years old; G3p2, Gravida 3 Para 2; EGA, estimated gestational age; IUP, Intrauterine pregnancy; PROM, Premature rupture of membranes; HTN, hypertension; DM, diabetes mellitus; BP, blood pressure; CIS, Culture if spikes; Hgb, hemoglobin; Hct, hematocrit; NPO, nothing by mouth; IVF, intravenous fluid. Used with permission.*