Actionable Patient Safety Solution APSS #6:
HAND-OFF COMMUNICATIONS

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Executive Summary Checklist

Accurate and complete hand-off communications (HOC) are vital to patient safety. When HOC information is incomplete or erroneous, serious patient harm often occurs. The establishment of accurate, complete, effective HOC requires an implementation plan that includes the following actionable steps:

☐ Hospital governance must become aware of this major performance gap as it exists in their own organization, and must participate in and support the following actions.

☐ Establish an HOC core team that includes a strong sponsor (senior clinical leadership is recommended for this role), physician champion, nursing champion and project leader. Other members will include practicing physicians, nurses, therapists, technicians and information technology experts.

☐ Define the exact roles of the sender and receiver in each category of HOC in order to make them effective and reliable.

☐ Educate all hospital staff on the following principles and requirements for effective HOC:
   ☐ HOC's occur whenever patient care is transferred to a different caregiver, care team, hospital unit, or patient care site. Each HOC involves a "sender" and a "receiver."
   ☐ HOC failures occurs when (1) the "sender" omits vital patient information from his/her report, or (2) the "receiver" fails to understand or properly record vital information given by the sender.
   ☐ A systematic, complete HOC process is similar in many ways to the pre-takeoff and pre-landing procedures used by aircraft crew. Aviation has made great progress in Quality Improvement in these procedures through the use of checklists. We will use a similar approach here.
   ☐ We have identified seventeen different categories of HOC that commonly occur in hospitals or other care units. Each of these categories requires a specific HOC checklist. We have developed the first 6, ready to be implemented:
      ▪ 1b – Emergency Department to Operating Room (**Appendix A**);
      ▪ 2f – Hospital Unit to Home (discharge) (**Appendix B**);
      ▪ 2g – Hospital Unit Shift Change (**Appendix C**);
      ▪ 3b – Operating Room to Hospital Unit (**Appendix D**);
      ▪ 3c – Operating Room to Home (**Appendix E**);
      ▪ 4c– Hospital to Outside Care Unit (**Appendix F**).

☐ Measure the effectiveness of current hand-off communication processes and build in to performance goals

The Performance Gap

A successful patient hand-off between caregivers is defined as a transfer and acceptance of responsibility for care that is achieved through effective communication. It is a real-time process of transmitting patient-specific information from one caregiver or team to another, to ensure the continuity and safety of care. The hand-off process involves "senders" – the caregivers transmitting information and transitioning care to the next caregiver, and "receivers" – the caregivers who accept patient information and care of that patient.

Risk to the patient is introduced when clinicians fail to properly communicate patient's condition, therapies and treatment plans, and/or any special considerations. Communication is both inherent to and essential to patient care, and yet it is often incomplete, ineffective, or non-existent at the most crucial junctures of care. The Agency for Healthcare Research and Quality (AHRQ) reports that nearly half of hospital staff believes that patient information is lost during transfers across hospital units and during shift changes.[1] Breakdown in communication was the leading root cause of sentinel events reported to The Joint Commission between 1995 and 2006.[2]

Poor communication during hand-offs has caused, and continues to cause, preventable patient injury or death, and increased costs of care. Closing the performance gap will require healthcare organizations to commit to specific actions.

Leadership Plan

- Hospital governance and senior administrative leadership must commit to become aware of this major performance gap in their own organization.
- Hospital governance, senior administrative leadership, and clinical/safety leadership must close this performance gap by implementing a comprehensive approach to addressing hand-off communication.
- Healthcare leadership must reinforce their commitment by taking an active role in championing process improvement, giving their time and attention, removing barriers, and providing necessary resources.
- Leadership must demonstrate their commitment and support by shaping a vision of the future, clearly defining goals, supporting staff as they work through improvement initiatives, measuring results, and communicating progress towards goals. Actions speak louder than words. As role models, leadership must 'walk the walk' when it comes to supporting process improvement across an organization.
- There are many types of leaders within a healthcare organization and in order for process improvement to be successful, leadership commitment and action are required at all levels. The Board, the C-Suite, senior leadership, physicians, directors, managers, and unit leaders all have important roles and must be engaged.

Change management is a critical element that must be included to sustain improvements. Recognizing the needs and ideas of the people who are part of the process—and who are charged with implementing and sustaining a new solution—is critical in building acceptance and accountability for change. A technical solution without acceptance of the proposed changes will not succeed. Building a strategy for acceptance and accountability of a change initiative increases the opportunity for success and sustainability of improvements.

"Facilitating Change," the change management model developed by The Joint Commission developed, contains four key elements to consider while working through a change initiative for hand-off communications.

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[1] Agency for Healthcare Research and Quality. Hospital survey on patient safety culture: 2009 comparative database report. Rockville, MD: 2009. Mar, AHRQ Publication No. 09-0030.

[2] The Joint Commission Sentinel Event Data Unit.

- Plan the Project:
  - Build a strong foundation for change by assessing the culture for change, defining the change, building a strategy, engaging the right people, and painting a vision of the future. This should be done at the outset of the project.
- Inspire People:
  - Solicit support and active involvement in the plan to improve hand-off communication, obtain buy-in and build accountability for the outcomes.
  - Identify a leader for the hand-off communication initiative. This is critical to the success of the project.
  - Understand where resistance may come from.
  - Develop an action plan or strategy to work through any resistance.
- Launch the Initiative:
  - Align operations and ensure the organization has the capacity to change, not just the ability to change.
  - Launch the hand-off communication initiative with a clear champion and a clearly communicated vision by leadership.
- Support the Change:
  - Support change, the capacity to do this is critical; therefore all leaders within the organization must be a visible part of the hand-off communication initiative.
  - Communicate frequently regarding all aspects of the hand-off communication initiative   in order to enhance the initiative.
  - Celebrate success as it relates to hand-off communication.
  - Identify resistance to the hand-off communication initiative as soon as it occurs.

Practice Plan

There is not a "one size fits all" approach to addressing hand-off communication; it requires a data driven approach to determine the contributing factors unique to the specific transition of care and the appropriate targeted solutions to implement. We have identified at least 17 distinct types of HOC's in the hospital, as described below. The Joint Commission Center for Transforming Healthcare Targeted Solutions Tool (TST)® provides healthcare organizations a comprehensive step by-step systematic approach that improves hand-off communication. The TST helps organizations accurately measure their actual performance, identify their barriers to excellent performance, and direct them to proven solutions that are customized to address their particular barriers related to hand-off communication. The TST can be accessed at:
http://www.centerfortransforminghealthcare.org/tst_hoc.aspx.

Healthcare organizations that have used this approach and the TST have reported an increase in patient and family satisfaction, staff satisfaction, and successful transfers of patients. One healthcare organization reduced their readmissions by 50% and another one reduced the time it takes to move a patient from the emergency department to an inpatient unit by 33%. Healthcare organizations are able to complete a hand-off communications project in approximately four months, using minimal resources. By using targeted solutions for your organization's specific root causes, you can begin to see results within 16 to 21 weeks.

The TST recommends the following setps to improve HOCs:
- Establish effective hand-off communication as an organizational priority and performance expectation.
- Establish a core team. The team should include a strong sponsor (senior leadership is recommended for this role), physician champion, nursing champion and project leader. The project leader will facilitate meetings and help gain buy-in from stakeholders. We recommend that the project leader has operational understanding of the project's areas.

- Identify and consider the project stakeholders. A stakeholder analysis can help your core team identify the roles or individuals that are key to the success of your project.
- Define effective hand-off communication and the roles of the sender and receiver.
    - Hand-off: The transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care.
    - Sender: Responsible for sending or transmitting the patient information and releasing care of the patient to another caregiver (the receiver).
    - Receiver: Responsible for receiving the patient information and accepting care of the patient.
- Measure the effectiveness of current hand-off communication processes.
    - Identify a group of hand-off communication data collectors (senders and receivers of the hand-off communication process that is being measured).
    - Create a sender or receiver data collection form for the data collector to complete after the hand-off communication and physical transfer of the patient has occurred.
    - Collect data for analysis.
    - Assess whether the hand-off met their (sender or receiver) needs to care for the patient (defect rate), and if not, what contributing factors caused the failure.
- Review the analysis of the entered data to identify the top contributing factors.
    - Share the baseline data results.
        - Post the data in staff areas and schedule frequent meetings with all staff to review the data and opportunities to improve, as well as perform training.
- Implement solutions targeting the top contributing factors identified at your organization.
    - Describe each solution with actions to implement, identify who will lead each action, and define when the actions will be completed.
- Examples of specific contributing factors and targeted solutions that could be identified in your project include:
    - Contributing factor: Receiver unable to focus. Solution: Create environment for successful hand-off communications.
    - Contributing factor: Unable to contact Receiver. Solution: Formalize how to establish contact.
- Measure progress and the effectiveness of change.
    - Progress and effectiveness can be measured by utilizing the same data collection and analysis tools utilized to calculate baseline performance.
- Share the results of the project.
    - Implement a plan with the process owner to ensure that process and gains are sustainable.

Technology Plan

The recommendations of specific technologies or products herein are those of Patient Safety Movement Foundation and do not necessarily represent the opinions of the Joint Commission Center for Transforming Healthcare or its affiliates. The Joint Commission Center for Transforming Healthcare was not consulted on, nor did it participate in the decision or choice of any specific product or technology, and as a matter of policy the Joint Commission Center for Transforming Healthcare does not endorse any specific technologies, equipment, or other products.

The technologies utilized should focus on ensuring that at the point of hand-off, all items critical to the care of the patient are communicated by the sender, and both captured and synthesized by the receiver.

- Implement technologies that support the efficient utilization and data capture of the checklist methods.

- o   Such as CareInSync Carebook™ or iPatient SignOut by Fluent Medical.
- Implement technologies that support clinician communication
  - o   Such as Vocera Hand-Off Communications, Vocera Care Transitions, and Doctella.
- Implement technologies that support the ability for clinicians to detail specific information regarding emergent or new-onset conditions that may have occurred during the previous shift or in the previous care environment.

The Checklist Solution

The most common failure of hand-off communications are that the sender omits vital data from his presentation, or the receiver fails to understand or record it. This has been a very common source of errors in aviation, and their approach is to use a system of checklists for each major task, such as preflight, takeoff, emergency management, and landing. The checklist is not a fixed recipe for flying the airplane – it is not intended to prevent creative problem solving. Its purpose is to prevent an overloaded and stressed flight crew from forgetting things. The same logic applies to the use of checklists in the field of medicine. This has been recognized by Dr. Atul Gawande, among others, in his creation of a "Checklist Manifesto" for use by surgeons in the operating room. *(Reference: "The Checklist Manifesto")*

Three issues that make checklists mandatory in aviation are: (1) workload stress, (2) distractors, and (3) increasing levels of complexity. These three problems are abundant in the clinical settings in which handoff communications must occur. For example:

- Workload stress
    - Patient is very ill; may even be an emergency situation.
    - Fatigue is very common. "I was up all night on-call."
    - Multiple priorities. "This is not my only patient!"
- Distractors
    - Noise and hallway traffic during rounds.
    - Pagers going off during hand-off communication.
    - Emergency arises on a different patient.
- Increased level of complexity
    - Electronic Medical Record (EMR) requirements.
    - Compliance documentation.
    - More complex monitors and other devices.

All of these factors have increased significantly in recent years, making the use of checklists obligatory in clinical medicine today. HOC is a key application for medical checklists, because the most common errors in HOC are omissions of vital facts or data.

There are many different types of HOC in the hospital setting: we have identified at least 17, as listed below. Each of these will require its own specific checklist.

Table 1: List of HOC Checklists

SENDER	RECEIVER
1. Emergency Dept.	a. Hospital ward team
	b. Operating room
	(1) anesthesiology team
	(2) surgery team
	d. Critical care unit.
	e. Testing unit (radiology, etc.)
2. Hospital unit (ward or ICU)	a. Hospital unit (different unit or new team)
	b. Operating room.
	c. Outpatient clinic
	d. Long-term care unit
	e. Testing unit (radiology, etc.)
	f. Home (D/C instructions)
	g. Change of shift in same unit.
3. Operating room	a. PACU.
	b. Hospital unit (ward or ICU)
	c. Home (Amb. surg.)
4. Paramedics	a. Emergency Dept.
	b. Hospital unit (ward, ICU)
	c. Long-term care unit.

In 2016, we developed preliminary versions of six of these HOC checklists. We will then obtain feedback from informal clinical evaluations before making refinements and developing the remaining checklists. The initial six checklists are:

- 1b – Emergency Department to Operating Room (**Appendix A**);
- 2f – Hospital Unit to Home (discharge) (**Appendix B**);
- 2g – Hospital Unit Shift Change (**Appendix C**);
- 3b – Operating Room to Hospital Unit (**Appendix D**);
- 3c – Operating Room to Home (**Appendix E**);
- 4c– Hospital to Outside Care Unit (**Appendix F**).

While each of these checklists will be distinctly different, they must all contain the vital information needed by the receiving caregiver/team to provide the best care of the patient. That information will include, but not be limited to, the following:

- Chief complaint: *Why is he/she in the hospital?*
- Problem list: *All medical problems, even if not relevant to this admission.*
- History and Physical. *Including relevant parts of review of systems.*
- Labs and other test results.
- Medications and treatments – current and planned.
- I and O's; catheters (IV, urine, etc.)
- Hospital course; complications; progress.
- Discharge plan: *How do we get this patient home? (Final hand-off?)*
- Recommendations: *Here is what I think and suggest.*

Workgroup

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Revision History

Version	Primary Author(s)	Description of Version	Date Completed
Version 1	Paul Jansen	Initial Release	January 2014
Version 2	Steven Barker, Victoria Baskett, Michael Becker, Jim Bialick, Hisham El-Bayer, Leila Entezam, Drew Fuller, Ernest Kestone, Ariana Longley, David Lubarsky, Michael Ramsay, Patricia Roth, Annamarie Saarinen, Rochelle Sandell, Laura Batz Townsend	Workgroup Review	January 2016
Version 3	Steven Barker, Michael Ramsay, Joe Kiani, Ariana Longley	Executive Review	April 2016

Appendix A: Emergency Department to Operating Room Checklist

1. Chief Complaint: Why is patient coming to OR? What made it an emergency?
   a. If a chronic disease, what are its history, treatments, complications, prognosis?

2. Surgical Plan: Exactly what surgery will occur? Major known surgical risks?

3. Special anesthesia needs: Patient position, paralysis or lack thereof, anticipated blood loss, etc.

4. Cervical spine status: "Cleared"? If so, how? History of neck disease or injury?

5. Other acute disease or injury:
   a. Other known acute disease, other than the reason for emergency surgery?
   b. If trauma, other injuries not related to surgery?

6. Medical/Surgical history: To extent known, and as time allows. Review of systems if available.

7. Physical exam findings: Positive findings only. Include ABC's:
   a. Airway: Patent? Assistance required?
   b. Breathing: Status of ventilation and oxygenation.
   c. Circulation: Vital signs, including BP and other findings re circulation.

8. Blood loss & fluid status:
   a. Estimated blood loss from current injury or disease.
   b. IV fluids given: type, amount, route.
   c. Other I and O: recent oral intake, urine output, vomiting, drainage.

9. Patient lines & access: All intravenous lines – size and location. All other patient cannulas, including central line, chest tube, Foley catheter, arterial cannula, etc.

10. Labs and Studies:
    a. Current lab results.
    b. Relevant older lab results.
    c. Results of X-rays, CT, MRI, other studies.

11. Drugs:
    a. Analgesia given by any route, past 24 h. Opiates?
    b. All other meds usually taken by patient.
    c. Any other meds given since current problem began. Dose, frequency, response?

12. Special instructions or findings: Anything unusual or remarkable, not covered by above? Any special instructions or restrictions? (For example: patient refuses blood products for religious reasons.)

Appendix B: Hospital Unit to Home (Discharge) Checklist[3]

Initial Transitional Care Contact

Patient name: _____

Date of contact: _____/_____/_____

Sources of information:
- ☐ Patient, family member, or caregiver
(Name: _____)
- ☐ Hospital discharge summary
- ☐ Hospital fax
- ☐ List of recent hospitalizations or ED visits
- ☐ Other _____

Discharged from: _____
on _____/_____/_____

Diagnosis/problem:

_____
_____

Medication changes:	☐ Yes	☐ No
Medication list updated:	☐ Yes	☐ No
Needs referral:	☐ Yes	☐ No
Needs lab:	☐ Yes	☐ No

Needs follow-up appointment:
- ☐ Within seven days of discharge (highly complex visit).
- ☐ Within 14 days of discharge (moderately complex visit).

Appointment made for _____/_____/_____
with _____

Additional information needed and requested:
- ☐ No
- ☐ Yes: _____

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[3] Alder K, Bloink J, and Arizona Community Physicians. AAFP. 2013. www.aafp.com/fpm/2013/0500/p12.html.

Face-to-Face Transitional Care Visit Documentation

For use in plan section of visit note.

Medication reconciliation:

☐ Medication list updated
☐ New medication list given to patient

Referrals:

☐ None needed
☐ Referrals made to: _____
_____

Community resources identified for patient/family:

☐ None needed
☐ Home health agency
☐ Assisted living
☐ Hospice
☐ Support Group
☐ Education Program: _____

Durable medical equipment ordered:

☐ None needed
☐ DME ordered: _____

Additional communication delivered or planned:

☐ Family/caregiver: _____
☐ Specialists: _____
☐ Other: _____

Patient education:

Topics discussed:
_____
_____
_____

Handouts given:

_____
_____
_____

Initial transitional care contact was made on _____/_____/_____

Appendix C: Shift Change Checklist

The following technique called the Situation, Background, Assessment and Recommendation (SBAR) is the industry's best practice for standardized communication between caregivers.[4] The SBAR technique was developed by the United States Navy for use on nuclear submarines. SBAR was introduced into healthcare in the late-1990's. It is recognized as a simple and effective way to standardize communication between care givers in hospitals across the world.

S (Situation)
>Reason for admission
>Contact information
>Allergies
>Current attending/resident

B (Background)
>Status of advanced directives/code status
>Pertinent medical history
>Labs: abnormals this shift and pending or to do next shift
>Tests/Procedures: current shift and anticipated for next shift
>Current Problems: medical and nursing

A (Assessment)
>VS/pain past 24 hours/shift
>Neuro
>CV
>Respiratory
>GI/GU (include I and O)
>Skin
>Mobility
>Patient safety issues: current and anticipated
>Medication concerns and updates

R (Recommendation)
>Pending/anticipated tests and procedures
>Other concerns
>Current and anticipated family issues
>Status of current shift goals/problems
>Anticipated Goals/problems for next shift
>Other TO Dos/Do you have any questions?
>Patient/Nurse introduction
>Joint review of lines/drips, neuro check, etc.

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[4] Schick, L. & Windle, P. (2016). Discharge Criteria, Education and Postprocedure Care, PeriAnesthesia *Nursing Core Curriculum*. 1281-1282.

Appendix D: Operating Room to Hospital Unit Checklist

Team:

- ☐ Patient Name, Sex & MRN:
- ☐ Attending Anesthesiologist:
- ☐ Anesthesia Resident/Fellow/CRNA:
- ☐ Surgeon:

Pre-Op:

- ☐ Age: _____   ASA: _____   Weight: _____ kg   Height: _____
- ☐ Guardianship, Surrogate, Advance Directives, DNR Status
- ☐ Allergies: _____
- ☐ Pre-Op Vital Signs: BP: _____   HR: _____   SpO2: _____   Temp: _____   RR: _____
- ☐ Current Medications
- ☐ Past Medical History
- ☐ Past Surgical History
- ☐ Past Anesthesia History
- ☐ Pertinent Pre-op labs and studies
- ☐ Pre-op Mental Status and Primary Language
- ☐ NPO Status
- ☐ Blood/Bloodless status

Intra-Op Events:

- ☐ Surgical Procedure Performed
- ☐ Anesthetic Technique & Airway Management
- ☐ IV Sites – Fluid / Location / Difficult Access
- ☐ Fluid Status – Intake / Output / EBL / Blood Products
- ☐ Medications Given (Including Antibiotics)
- ☐ Complications / Interventions

Post-Op:

- ☐ Surgical Procedure Performed
- ☐ Anesthetic Technique & Airway Management
- ☐ Vital Signs
- ☐ Assessment: Respiratory / CV / Neuro / GU / Skin
- ☐ Post-Op Pain Management Plan
- ☐ Recent/Pending Labs / Medications
- ☐ Special Instructions & Concerns
- ☐ Questions from Receiving Provider

Discharge Checklist after Surgery

☐ Responsible Adult to stay with you for 24 hours

☐ Understanding of no driving or major decisions for 24 hours

☐ Understanding of precautions after anesthesia
- o Drowsiness
- o Impaired judgment and slower reaction time
- o Sore throat
- o Muscle aches
- o Sensory block understanding
  - ▪ May not be able to feel sharp pain, hot or cold at the involved site
  - ▪ Understanding to begin pain medication before block wears off

☐ Activity
- o Rest the remainder of the day
- o Move slowly when changing positions (dizziness is normal)
- o Gradually do a little more each day
- o Follow the surgeon's instructions for return to normal activities
- o Do not DRIVE if taking medications for pain like Percocet® or Vicodin®

☐ Best outcomes
- o It is important to walk often, change positions and move legs if resting in a lying or sitting position.
- o Take 10 deep breaths and cough every hour or two while awake.
  - ▪ Remember to hold a small pillow or towel over your abdominal incision while doing your deep breathing and coughing exercises

☐ Medication
- o Medications will be reviewed and when to resume and take them
- o Follow directions on the label
- o Pain medication should be taken before the pain is severe during the initial 2 – 3 days after surgery.
  - ▪ Medications like Percocet and Vicodin contain acetaminophen (Tylenol®); **do not** take plain Tylenol when using these medications.
- o Pain medication cause constipation and nausea
  - ▪ Remember to follow instructions for laxative, if needed
  - ▪ Post-op nausea information sheet can be used for suggestion for this side effect

☐ Diet and Elimination
- o Progress to regular diet as tolerated
- o Begin with comfort foods: soup, crackers, jello, juices
- o Stay away from food that may increase the chance of nausea and vomiting (spicy or greasy foods)
- o If you have trouble voiding (burning or urgency) call your surgeon
- o If you are unable to urinate when you get home have someone bring you to the emergency room.
- o No alcoholic beverages, marijuana, or other drugs for 24 hours or while taking pain medications

☐ Importance of hand washing to prevent infection
  o Keep dressing dry and protect dressing, incisions and casts
  o When you can take a shower or bath depending on the procedure

☐ Special Equipment (based on the procedure)
  o Incision care and when to remove dressing
  o Drain instructions
  o Foley care instruction
  o Crutch walking
  o Incentive spirometer

☐ Reasons to call you surgeon
  o Pain is not relieved with the pain medication
  o Bleeding - _____
  o Call: _____
    ▪ If unable to get physician come to the emergency department
  o Fever over 101ºF – Call you surgeon
  o Continuous nausea and unable to keep fluids down
  o Redness and swelling around the surgical wound or drainage that changes to yellow or green
  o Intravenous site with signs of redness or drainage

☐ **Call 911 if you have breathing problems or chest pain**

☐ **Follow-up with your surgeon at your postoperative appointment**
  Date: _____   Time:_____

Appendix F: Hospital Unit to Outside Care Unit Checklist

This checklist should be used when a patient is being transferred from the hospital to an external facility, such as a Skilled Nursing Facility (SNF), etc.

1. <u>Chief Complaint</u>: Why was patient admitted to hospital?
    a. If the result of a chronic disease, what are its history, treatments, complications, prognosis?
2. <u>Hospital course</u>:
    b. Duration of stay in each hospital unit.
    c. Therapeutic procedures done: indications and results.
    d. Medications while in hospital. Effectiveness? Complications?
    e. General condition at discharge.
3. <u>Diet</u>: Current diet as well as any restrictions and preferences.
4. <u>Allergies</u>: To medications as well as anything else. Include specific type of reaction (skin, pulmonary, anaphylaxis, etc.), severity, type of exposure for trigger (enteric, topical, inhaled).
5. <u>Activity</u>: Amount, type, frequency of exercise. Activity restrictions? Bathroom privileges.
6. <u>Hygiene</u>: Bathing and any other: frequency and assistance/supervision required.
7. <u>Mental status</u>: Ability to communicate and understand instructions. Languages? Sleep habits.
8. <u>Other known diseases or injury</u>:
    f. All diseases requiring continuing treatment or precautions.
    g. Current status of each: chronic, recurrent, cured?
9. <u>Hospital/Surgical history</u>:
    h. Hospitalizations: reasons, treatments, outcomes.
    i. Surgeries: procedures, dates, indications, outcomes.
10. <u>Physical exam findings</u>: Positive findings only.
11. <u>I's & O's</u> (Intakes and Outputs)
    j. Patient lines & access: intravenous lines – size and location. All other patient cannulas, including any drains, Foley catheter.
12. Daily intake/output of each site, including oral, wound drainage, etc.
13. <u>Labs and Studies</u>:
    k. Current lab results, note all abnormal values.
    l. Relevant older lab results.
    m. Results of recent X-rays, CT, MRI, other studies.
14. <u>Drugs</u>:
    n. Daily analgesia required? Opiates? If so, how is respiration being monitored?
    o. All other meds taken by patient: dose, route (oral or other?), frequency.
    p. Any other meds given since current problem began. Dose, frequency, response?
15. <u>Social</u>: Family and/or friends contact information. Visiting needs.
16. <u>Special instructions or findings</u>: Anything unusual or remarkable, not covered by above? Any special instructions or restrictions?