

Handover Cases

Care Transitions – Intern Orientation

Emory Department of Medicine

For this small group exercise, you will make your way through a nightly handover. Below, you will be provided with 3 cases and a pre-populated handover sheet.

During this small group exercise, you will complete the following:

- 1. Review the cases provided.**
- 2. Discuss anticipated overnight events on active patients.**
- 3. Populate the overnight handover form.**
- 4. Practice signing out a sick patient and become familiarized with the mnemonic “SAIF-IR”**

By the end of the small group exercise, you will have a better understanding of how to effectively and efficiently sign out your service.

The TOTAL time allotted for this exercise is 30 minutes.

Case 1:

History of Present Illness

Ms. Josephine Smith is an 82 y F who brought in by her family two weeks ago with acute on chronic systolic HF (EF 30%). She was extremely volume overloaded and required aggressive diuresis. In the past few days, she has been gradually transitioned over to all p.o. meds and is euvolemic. She did experience a brief episode of worsening of her renal failure but her creatinine and BUN are back to baseline.

Her course of treatment was complicated by afib with RVR to the 160s. She has been rate controlled on metoprolol (remains in afib) for the past two days. Her family has declined Coumadin therapy as she has had frequent falls. She does not tolerate a telemetry box.

Her course has also been complicated by a gout flare, for which she is on a slow prednisone taper. Currently, she is not complaining of any pain.

She had a urinary tract infection present on admission that was treated with levofloxacin.

Throughout her admission, sundowning has been a problem. She has now been on Seroquel at night which helps somewhat.

She had previously been living at home with her daughter who can no longer manage her care, so she is currently awaiting placement. There have been some family issues so the only person to be given information is her daughter (who is her POA). She is full code.

Past Medical History

Vascular dementia

CKD III

CHF, EF 30%

DM on insulin

Afib

HTN

History of bladder cancer

Gout

Home Medications

Furosemide 60 mg po bid
ASA 325 mg po qday
Metoprolol 50 mg po bid
Lantus 20 units SQ QHS
Aspart insulin 3 units SQ with meal
Captopril 6.25 mg p.o. t.i.d
BiDil 1 tab po q8 hrs
Lexapro 10 mg p.o. qday
Donepezil 10 mg p.o. qday
Calcium with Vitamin D, one tab daily

Case 2:

History of Present Illness

Mr. Randall Franks is a 75 yo M who was admitted today. He has had 2-3 days of worsening respiratory distress, fevers, and cough productive of white sputum. His family brought him in because of his respiratory distress, in addition to confusion and intermittent complaints of chest pain that was new today. His vital signs upon presentation to the ER were Tmax 38.7, HR 136, RR 36, BP 84/56, and 86% on room air. In the emergency department, he was placed on BiPAP and received Lasix. Blood culture results are pending. He was admitted last month for severe hyperglycemia so was started on vancomycin and zosyn to cover HCAP and a UTI. His labs on admission to the ER were notable for a BUN of 45, a creatinine of 2.4 (BUN/creatinine were 24 and 1.5 at last admission), a BG of 84, and a troponin of 0.15 (last troponin in the system was 0.04). His CBC showed a WC of 24,000, hemoglobin/hematocrit of 10.8/31.2. His CXR shows dense fluffy infiltrates. His UA had 65 WBCs, and was positive for leukocyte esterase and nitrates. His initial EKG showed sinus tachycardia, LVH, and T wave inversions in the lateral leads that are unchanged from his past visit.

His vital signs upon reaching the step-down unit were T of 37.6, HR 96, RR 26, and BP of 108/72. His O2 sat is 92-94% on 6L of O2 by NC.

He is DNR at last hospitalization, which was confirmed by his family again today.

Past medical history

Chronic systolic CHF, EF 25%, s/p AICD, secondary to ischemic cardiomyopathy
CAD, s/p stent 5 years ago to the LAD
DM, type 2
CKD III
GERD
Sulfa allergy

Home medications

Lantus 20 units qhs and Novolog 4 units with meals
ASA 81
Protonix 40
Toprol XL 25mg
Atorvastatin 20 mg daily
Enalapril 10 mg bid

Case 3:

Mr. Harold Jackson is a 57-yo male who was admitted 3 days ago with a COPD exacerbation. He was started on scheduled albuterol and atrovent, as well as daily prednisone and antibiotics. He has been very slow to improve. He is on 2L of oxygen at home; he is currently 92% on 3L of oxygen and feels dyspneic on minimal exertion. His RR is 24. He has a few scattered wheezes on exam but in general doesn't move air well. He is usually seen at the VA where is also seen for his anxiety disorder and chronic pain. He has had a few episodes of anxiety while here. He is DNR.

Past Medical History

COPD, on 2L of oxygen at home
Chronic HCV infection, s/p tx with recurrence
Chronic back and leg pain, secondary to MVA
Anxiety disorder
Depression
Tobacco abuse

Home medications

Albuterol, inhaled q6 hrs prn
Symbicort, 1 inhalation bid
Tiotropium, 1 inhalation daily
Citalopram 60 mg p.o. q.day
Seroquel 150 mg po qhs
Ativan 1 mg p.o. q 6 hrs prn
Nicotine patch
MSContin 30 mg p.o. q 12 hrs