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The Inpatient Process:

Ways to be a Better Inpatient Provider, Avoid Harming Patients, and Stay out of the Courtroom.

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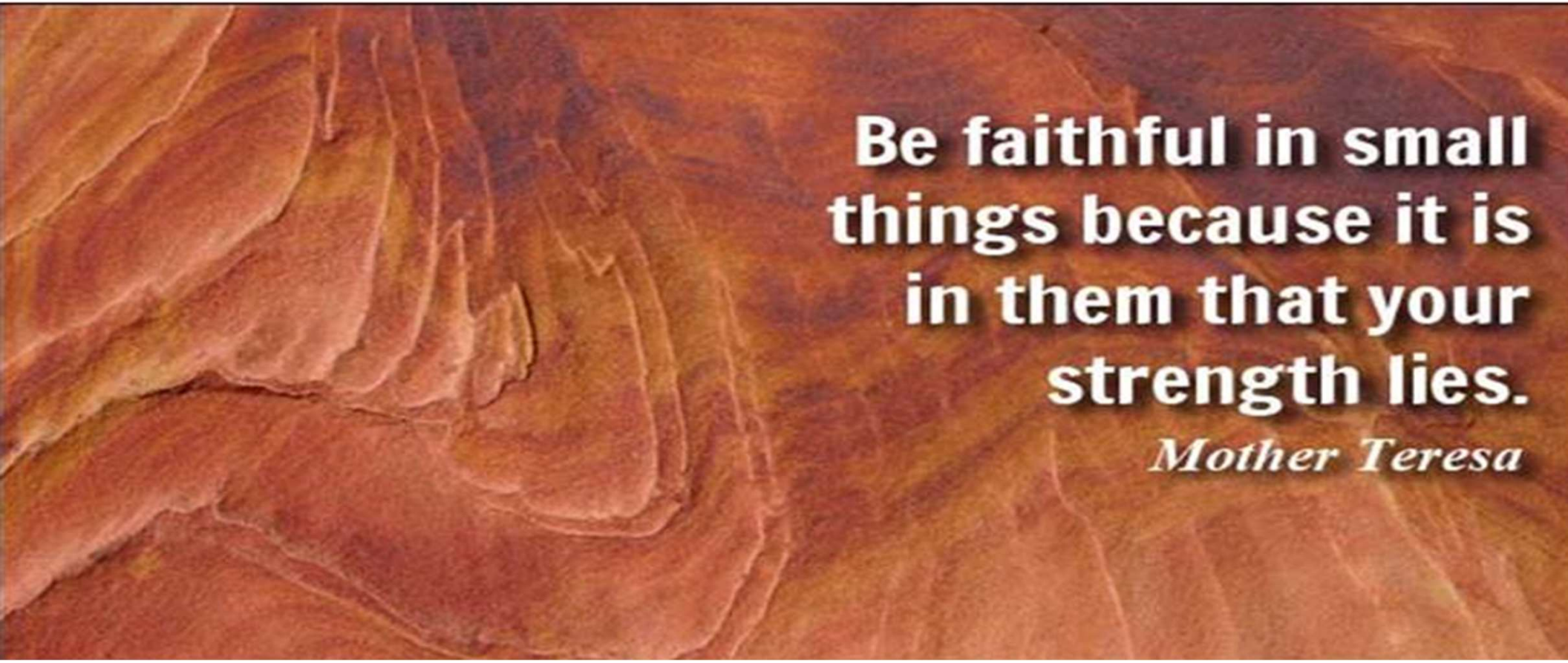
DISCLOSURES

- I’m the guy that gets called when things aren’t going well with a patient or family
- I’m also getting old
- Huge Alabama Football fan!
- *Non-Declaration Statement: I have no relevant relationships with ineligible companies to disclose within the past 24 months*

Austin, Texas

QUOTE OF THE TALK



Question of the Talk

How do you see Patients?

THREE ATTRIBUTES OF INPATIENT PROVIDERS WHO GIVE EXCELLENT PATIENT CARE

1. COMPREHENSIVE
2. COMMUNICATIVE
3. CARING

Educational Objectives

- Review a case where medical errors occurred and how to avoid those errors in the future.
- Identify side effects of IV blood pressure medications that could lead to patient harm
- Detailed breakdown of key interactions with patients in the hospital that will help you be successful (“The Process”).

Case Discussion

"Lost time is never found again"

MEDICAL ERRORS

- It's difficult to make a decision that leads to a patient's mortality, while in the hospital.
  - Pharmacy support
  - Nursing support
  - Multiple support services cross-checking your work
  - What we often see is harm to a patient **by not identifying a potential issue**

Frellick, Marcia (3 May 2016). "Medical Error Is Third Leading Cause of Death in US Marcia Frellick". Medscape. Retrieved 7 May 2016.

Framing

- Framing effect: a different conclusion drawn from the same set of facts, depending on how the facts are presented
- “Frames” provide people a quick way to process information

Framing

- The ED doc calls you with an admission:

"*80-year-old anxious female with hypertension and diabetes brought to the ED with a blood pressure a little elevated (200/95)….*"

VS

"80-year-old female with dysarthria, left arm numbness and elevated blood pressure who is being ruled out for stroke…"

Swiss Cheese Hole #1

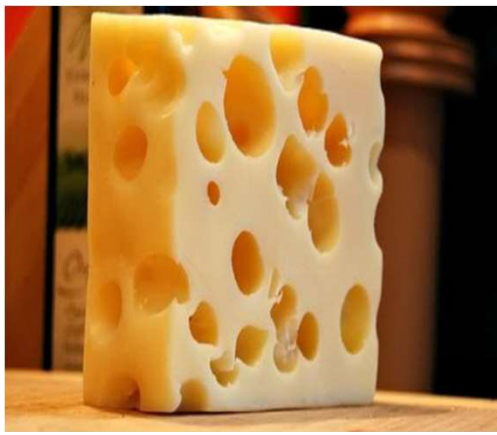
- **The ED doctor calls you with an admission.**

"*80-year-old female with hypertension and diabetes brought to the ED with anxiety whose blood pressure is a little elevated (220/95). IV Labetalol is bringing it down. Might be a good idea to watch her overnight. "*

You have patients still to see and 2 other admissions.

You tell the ED doctor: "Send her up."

ED puts in some initial admit orders.



Yes or No?

- Is the ED doctor always correct?
- What happens if you always put your license and your reputation on the line based on another provider's opinion?
- If you send the patient to the floor, should you put your eyes on the patient as soon as you can?

Yes or No?

- Is the ED doctor always correct? My reply is no.
- What happens if you always put your license and your reputation on the line based on another provider's opinion?
- If you send the patient to the floor, should you put your eyes on the patient as soon as you can?

Yes or No?

- Is the ED doctor always correct? My reply is no.
- What happens if you always put your license and your reputation on the line based on another provider's opinion? Outlook not so good.
- If you send the patient to the floor, should you put your eyes on the patient as soon as you can?

Yes or No?

- Is the ED doctor always correct? My reply is no.
- What happens if you always put your license and your reputation on the line based on another provider's opinion? Outlook not so good.
- If you send the patient to the floor, should you put your eyes on the patient as soon as you can? Signs point to yes.

Swiss Cheese Hole #2

- **Patient is placed in the ICU and nurse calls you.**

"*Patient's blood pressure is 218/107 and she is maxed out on IV Labetalol. The patient is anxious and has a headache*"

It's 5:30 pm and your shift ends at 7. You still have 2 admissions left. You finished seeing 20 patients and did 3 admissions today.

You review the vital signs in the computer and everything looks good except the blood pressure.

What should be your first thought at this moment?

Answer: I need to go see this patient

Case Discussion

- Evaluating a patient is more than just going to the computer and looking at numbers.

- History
- Physical
- Labs, Vital Signs, Radiologic studies
- Notes in the chart

Breakdown of the “Process”

“Listening and asking pertinent questions followed by a thorough examination works.”

“Imaging and complex testing should support or refute your hypothesis or differential diagnosis. Testing should not be used to replace listening , a thorough history session and physical examination.”

Rutecki, GW, Is the history and physical examination worth performing anymore. Medpage Today; February 2013

History is The Key

- 7 decades ago: the correct diagnosis can be made after history-taking alone in 74% of patients
  (Platt R. Manchester University Medical School Gazette 1947; 27:139-145)

- Comparing the relative value of history, exam, and labs in making medical diagnoses: correct diagnosis determined after only history in 82% of patients
  (Hampton JR, Br Med J 1975;2:486-489)

- In 1992, Petersen reproduced the above study: found that the history led to the correct diagnosis 76% of the time
  (Peterson MC, West J Med 1992;156:163-165)

Swiss Cheese Hole #3

You give an order over the phone.

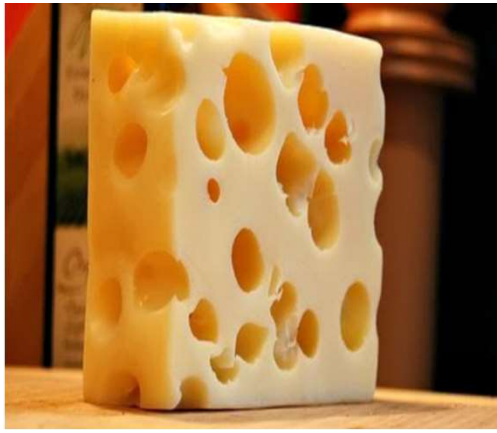
"*How about Nitroprusside? Does that sound okay?*"

Nurse replies: "That sounds good. That worked in a patient I took care of last week."

You decide to finish up for the day, and pass off this admission to the night team.

You checkout the patient to the night team ("Hypertensive urgency, needs H&P,Orders") and leave for the day.

Swiss Cheese Hole #3



Nit*roprusside*

- When administered by IV infusion, begins to act within one minute or less.
- Vasodilator (arterioles and veins)
- This drug can produce a sudden and drastic drop in blood in blood pressure.

- Cherney D, Straus S. Management of patients with hypertensive urgencies and emergencies: a systematic review of the literature. J Gen Intern Med 2002; 17: 937
- Jauch EC, Saver JL, Adams HP Jr, et al, “Guidelines for the Early Management of Patients With Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association,” Stroke, 2013, 44(3):870-947.

Result

- **Patient suffers a massive left-sided stroke and is debilitated to this day.**

What Happened?

Result

- **Patient suffers a massive left-sided stroke and is debilitated to this day.**

- Patient presented to ED with dysarthria and left arm numbness that was resolving.

- Neurology was consulted in the ED to evaluate for tPA. Their note stated “Concern for acute ischemic event.”

- ED placed on stroke order set.

- Blood pressure dropped from 218/107 to 105/60 with 2 minutes on IV Nitroprusside.

Question of the Talk

How do you see Patients?

THREE ATTRIBUTES THAT PATIENTS PERCEIVE AS EXCELLENT CARE

1. COMPREHENSIVE
2. COMMUNICATIVE
3. CARING

Nepal,S., et al. What do Patients Want? A Qualitative Analysis of Patient, Provider, and Administrative Perceptions and Expectations about Hospital Stays. J Patient Exp. 2020 Dec: 7 (6): 1760-1770

Comprehensive

- Having or exhibiting wide mental grasp of the subject
- Comprehending or thoroughly understanding all or most details.

COMMON PATIENT COMPLAINT: **“My provider doesn’t know what is going on. Don’t the doctors talk to each other?”**

Develop a Comprehensive PROCESS for Inpatient Care

I start the process before I see the patient.

1. Start the progress note and print it.

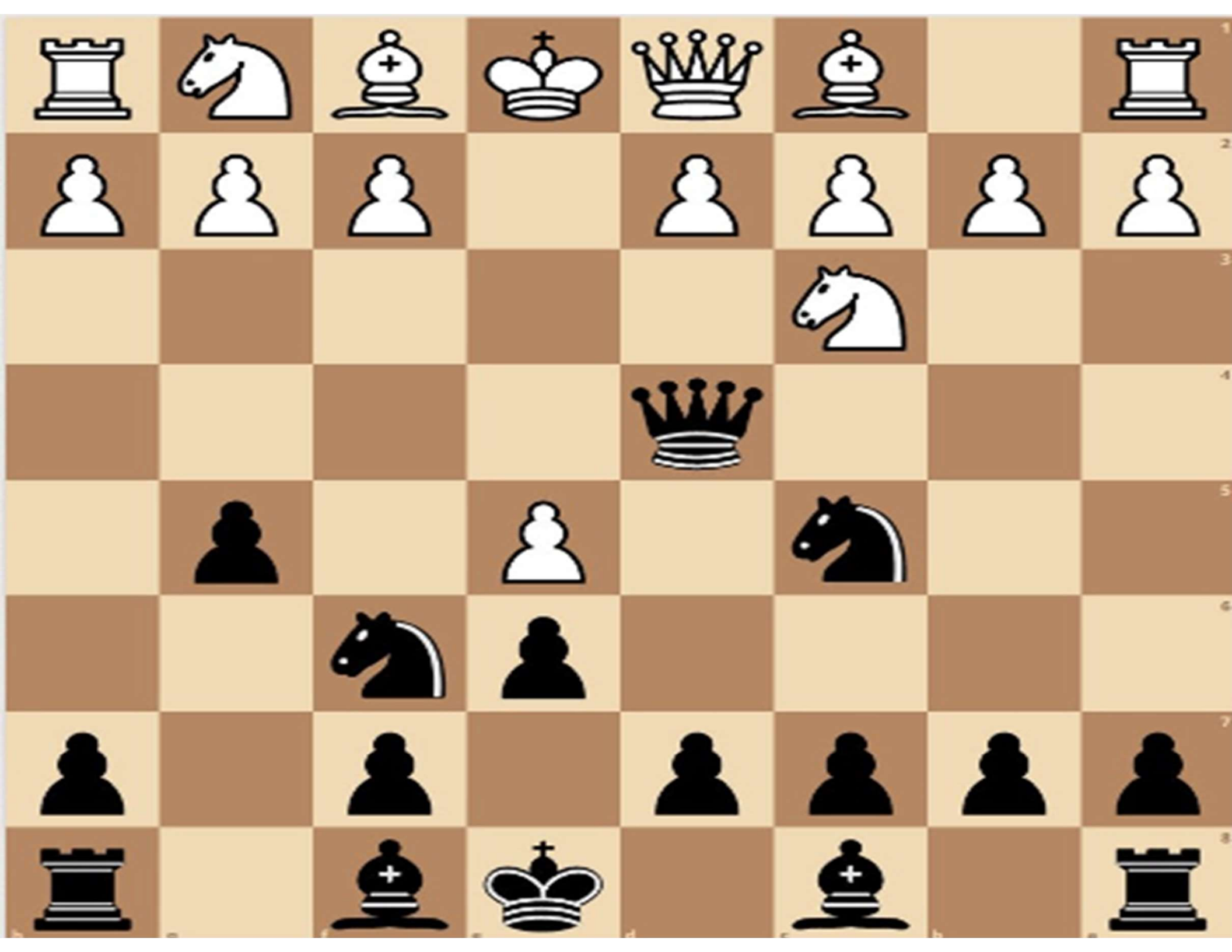
- 24 hour vitals, Key labs, past physical exam
- Read my thought process from the day before
- Subjective pearls

2. Review key notes and tests from prior 24 hours

- Write pertinent points on my progress note

3. Review Medication History including PRN's

4. Talk to the nurse



Entering the Room

Knock on the door, count to 3, and then walk in

The Slide of “Don’ts”

1. Don’t forget to introduce yourself.
2. Don’t forget to ask permission to speak freely if visitors are in the room.
3. Don’t sit on the bed unless you have permission.
4. Don’t use the word “Understand.”
5. Don’t eat, drink or play on your phone in the room.
6. Don’t act like out can’t get out of the room fast enough.
7. Don’t go directly to the computer when you enter the room.


DO NOT TOUCH

Communication

- The imparting or exchanging of information or news.

- A process by which information is exchanged between individuals through a common language or behavior.

COMMON PATIENT COMPLAINT: **“I don’t know what is going on. My provider is saying things I don’t understand. Can someone tell me what is going on?”**

Develop a Communication PROCESS for Inpatient Care

- Your tone almost always sets the mood in the room.

- Nonverbal communication is an essential element of communication that often speaks more powerfully than the words you use.

- I try to come into a room relaxed. My internal thought process is that I have as much time as the patient or family needs.

- **The first 1-2 minutes in the room are critical to connect.**

Develop a Communication PROCESS for Inpatient Care

- Speak the patient's name and then introduce yourself
- Sit if you can
- Eye contact
- Give the patient and family the opportunity to control initially through the subjective.
- LISTEN!!!
- Read the room.
- When you speak, learn how to talk simply, but respectfully


DO NOT TOUCH
DO ASK FOR HELP

Caring

- Displaying kindness and concern for others.

- The work or practice of looking after those unable to care for themselves.

COMMON PATIENT COMPLAINT: **“The provider is arrogant and doesn’t listen to me. All he wants to do is tell me things I need to do. He can’t leave the room fast enough.”**

Nepal,S., et al. What do Patients Want? A Qualitative Analysis of Patient, Provider, and Administrative Perceptions and Expectations about Hospital Stays. J Patient Exp. 2020 Dec: 7 (6): 1760-1770

Caring

- Medicine is “whole-person care.”
- It is not just about sharing medical information.
- It is a caring and service-oriented profession.
- Patients expect responsiveness and attentiveness to needs. They also want to be treated like a human being.

Nepal,S., et al. What do Patients Want? A Qualitative Analysis of Patient, Provider, and Administrative Perceptions and Expectations about Hospital Stays. J Patient Exp. 2020 Dec: 7 (6): 1760-1770

Note: Pre-COVID Picture

Few Extra Pearls

1. Comprehensive care of the patient

- What do people say about your progress notes?
- Is there a plan that can be followed? What about a discharge plan?

2. Communication

- Smile, even with a mask on
- Can the patient or nurse tell me what the plan is?

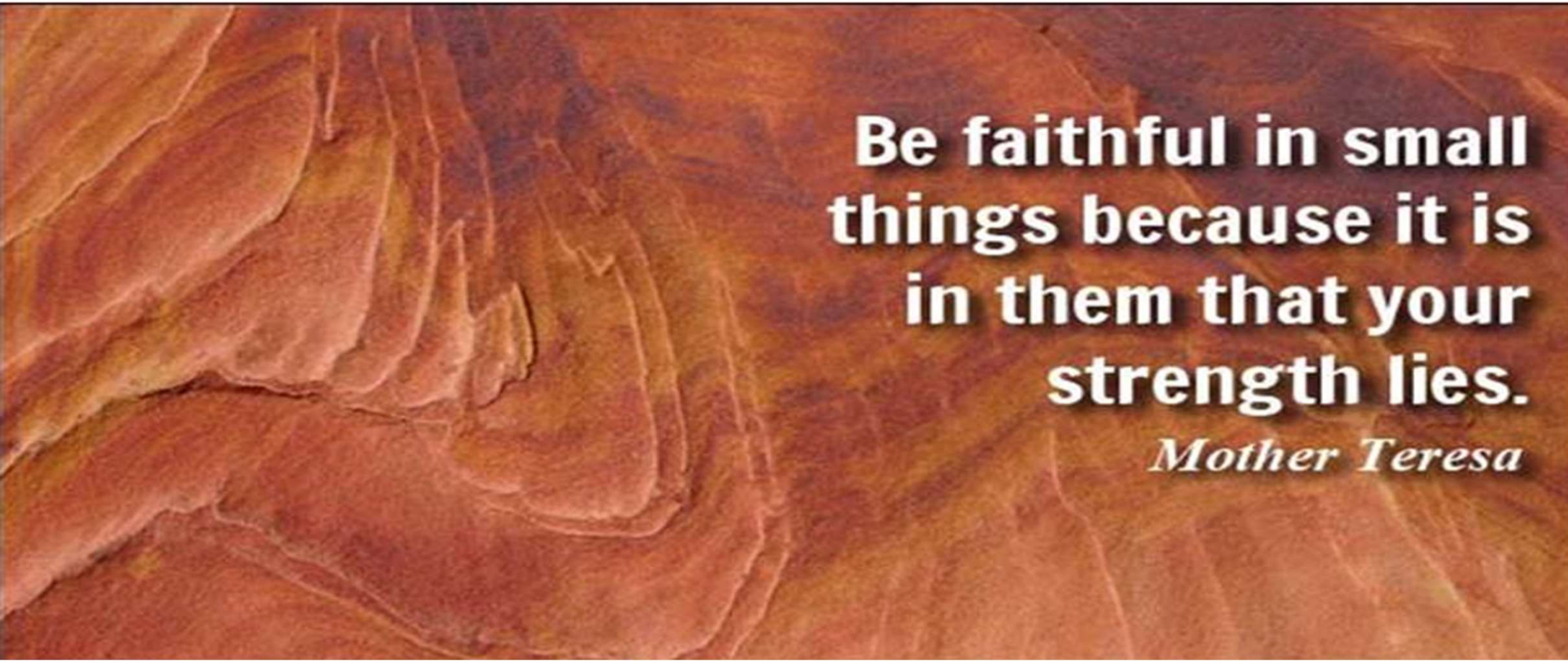
3. Caring

- Touch the patient, if appropriate.
- Call the patient after discharge
- **What is your "sentence" on the floor?**

Take Home Points

1. Trust, but verify
2. Treat staff with respect
3. Put your patient first. Advocate for them.
4. Comprehensive, Communicate, Care
5. Make your “Sentence” a good one.

Questions



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