How to Cover for a Colleague's Patients

Last updated June 2024

Introduction

Covering other clinicians' patients is a fact of life on the inpatient unit. Sometimes such coverage will be arranged well in advance due to a scheduled vacation, but other times your colleague gets sick and can't come in. Suddenly, you and the other clinicians have to split a patient caseload and you may have several extra patients to see. Don't panic—just come up with a procedure for efficiently getting to know these new patients quickly via focused interviews and write concise notes. Here are some tips.

Preparation

1. Ask your colleague for a sign-out sheet for their patients, which should include:
    a. Basic demographics (gender, age, marital status, what they came in for…essentially the one-liner we expect in the Identifying information section of the H and P).
    b. A one-liner recapping the hospital course thus far, including what meds have been started and what the response has been.
    c. The current plan for both medications and for disposition.
2. Ask the provider to inform their patient that they will be seen by a different provider.
3. Ask nursing and social work for any useful information (see list of questions below under "Rounding").
4. When you round, bring the printed sign out sheet with you, leaving extra space for you to jot notes during your interviews.
5. If possible, round with one of the social workers, who can introduce you and ask relevant questions that you may not know to ask.

Rounding

1. Introduce yourself to patients and explain that you are covering for their regular provider (hopefully the regular provider will have laid the groundwork)
2. Your goal in these visits is to ensure that you address any concerns with a focus on medication response and side effects. Depending on how much time you have, you can also see these visits as an opportunity for you to bring a set of fresh eyes to the patient and to provide a second opinion.
3. Information you are hoping to learn during this visit (some of this info may have already been obtained during team meeting with nursing)
    a. How are they feeling in general?
    b. How have they been sleeping/eating?
    c. Have they been taking meds?
    d. Have they noticed any side effects?
    e. Have they been going to groups?
    f. Have they taken a shower and attended to hygiene?
    g. Do they feel they've made progress during the hospitalization so far?
    h. Do they understand the treatment plan and do they agree with it?
    i. Do they understand the disposition plan and do they agree with it?
    j. Are they experiencing any new symptoms (either psychological, psychiatric, or medical) that they have not yet brought up with the primary provider?
    k. Do they have any other questions or concerns?
4. Thank them for talking and assure them that you will pass on all this information to their primary provider.

Documenting

1. Add a note indicating that you are a covering provider, eg, the first line of the note can be “(Dr. X covering for Dr. Y”). This is helpful for the primary provider when they are reviewing notes before writing a discharge summary, as well as for other disciplines who may be curious what your thoughts were as another opinion.
2. Whenever possible, complete a full note on each patient, following the usual format for a progress note (see “How to write a progress note”).
3. If you’re pressed for time:
    a. Under interval history, write a focused note documenting the basics, such as whether there are any new issues and whether the patient is taking meds.
    b. For MSE, briefly summarize the patient’s current MSE based on your observation and interactions.
    c. For assessment, evaluate the patient using the latest clinical data and your professional judgment. If your findings align with the primary team’s assessment, state, “no change from primary team assessment based on today’s interview.” Otherwise, note any differences.
    d. For plan, if there are no changes, outline the primary team’s treatment plan and precede with “Continue treatment and disposition plan of primary treatment team below.” If adjustments are necessary, provide a clear justification for any changes.

Billing

1. If you have written full notes, bill as you would normally bill, based on the time you spent with face to face interviewing and care coordination.
2. If you have written abbreviated notes, bill for brief 15-minute visits.