

HELPFUL CONTACTS FOR NIGHTFLOAT
---------------------------------

SPPO:	x8455
House Supervisor:	x8455, or pager 6000
Transfer Center:	x2222
Admission pager:	pager 1763
Cross Cover Pagers:	pager 6575
Team H Consult Pager:	pager 6555
On Call Hospitalist Attending:	pager 2112
On Call Chief Resident:	pager 6666
On Call Nocturnist:	pager 1010
Nurses Stations:	
3 Tower	x5712/5963
4 Tower	x7168
5 Tower	x6995
ER	x5705
Main Lab	x5121
Microbiology	x5439/5298
Chemistry	x5507
Hematology	x5090/5030
Blood Gas	x5486
Blood Bank	x5716
Cytology	x5021
ECG Tech	x6802
Radiology:	
MRI	x7404/7413
US	x5450/5246
CT	x6581/7503
ER Radiology Pager	pager 6473

## UCI Night Float Orientation

1. Objectives
  - a. Educational Rationale
  - b. Learning Objectives
  - c. Recommended Readings
2. Responsibilities
  - a. Admitting Residents
  - b. Cross-Cover Resident
3. Admission Guidelines/Policies
  - a. Family Medicine Admission Guidelines
  - b. Family Medicine Overflow Policy
  - c. Orthopedic Admission Guidelines
  - d. Intrathecal Pump/Spinal Cord Stimulator Issues
  - e. Heart Failure Patients
4. Medicine Night Float
  - a. Back Up Assistance
  - b. MICU transfers
  - c. Heme/Onc Patients
  - d. Dialysis/Transplant Patients
  - e. Role of the House Supervisor
5. Team H/Hospitalist Consults
6. Outside Transfers
7. Role of the Nocturnist
8. When to Call the Primary Attending
9. Logistics
  - a. Schedule/Assignments
  - b. Duty Hours
  - c. Food
  - d. Sleep Rooms
  - e. Days Off
10. Culture and Professionalism
11. References
  - a. Tele vs. Med Surg
  - b. Insulin Management

## 1. OBJECTIVES:

### Educational rationale for this rotation:

- This is a core rotation for internal medicine residency training.
- Learn to diagnose, treat, and manage various medical problems in patients who are admitted to internal medicine services.
- Elements of effective transfer of care of patients will also be covered.

### Learning Objectives:

- Efficient and comprehensive history and physical exams
- Problem-based assessments, accurate diagnosis and initiation of appropriate plans of care
- Providing urgent consultation services for other departments
- Effective Transfer of Care
- Medication Reconciliation
- Common Acute Medical Issues/Emergencies

### Recommended Core Readings:

- MKSAP
- UpToDate
- Common Medical Issues that Arise on Night Float: (<http://www.medicine.uci.edu/noc/PDF/Syllabus.pdf>)

## 2. RESPONSIBILITIES:

### Admitting Residents:

- **Two residents** assigned to admit every evening; assignments can be found on the medicine website: [Schedule and Team Assignments](#)
- Shift starts at **6:30PM**. If a long call team's census is at 18 or greater at 6:30 PM, their long-call ends. If their census is less than 18 at 6:30 PM, call continues until 7:30 PM.
- Each admitting resident must carry **two pagers** at all times:
  1. Admission pager (714-506-1763); there are two clones of this pager– one for each admission resident
  2. Personal pager
- SPPO will page you for new admissions. You must call the ED in <15 minutes of the page to receive signout. Ask questions professionally (what interventions have been done in the ED, what consultants have seen the patient, inquire about stability/vitals, etc.)
- Admitting residents will alternate admissions as SPPO calls them in. If in need of assistance with admissions, see Section 4: Backup Assistance.
- **Remember to check NOW if it is a Family Medicine patient should be cared for on a different service.** (See Section 3: Policies for details)
- **The patient is under your care as soon as you receive ED signout, even if still in the ED.**
- **Do not call SPPO to re-assign patients**, the night float residents can re-assign patients based on bounceback policy, family medicine admissions etc.
- **The admitting residents should call SPPO at the end of the shift** to let them know who should get the first

daytime admission.

- The order of admissions should follow alphabetically.
  - For example, after reassigning patients overnight, if Team C is the last team to receive a patient, then Team D is the next team up for an admission. Call SPPO and tell them that Team D is up next.
  - As an FYI, SPPO does not follow our short call/long call admission system; they assign patients to teams in an alphabetical order
- **Bouncebacks** from the ED will follow the senior resident for the current block EXCEPT if the senior is absent, no call, the team is capped OR if it is the first or last day of the senior's block.
    - If the team receiving the bounce back is admitting and not capped the patient should go back to the original team to preserve continuity and the team doing the H&P should get credit for the admission
    - If the senior is not present or not admitting the patient from the ED should go to another team who should get credit and then transferred the next morning with no credit.
    - If the senior is there and a MICU patient is being transferred, the original team should accept the bounce back even on a no call day (write an accept note)
    - In summary, ED bounce backs only go to the original team if they are admitting, MICU transfers can come to the team on non-admitting days if the senior is there. Credit only goes to one team (who ever does the H&P or note on admission/transfer)
- **Call SPPO at x8455 as soon as a team caps or uncaps at night**
    - 18 patients takes a team out of the admission drip.
    - Once a team has fewer than 18 (death, discharge, etc.) they are back in the drip.
    - Once a team has been assigned **5 admissions overnight**, then they are taken out of the drip
      - For example, if Team G has a census of 6 patients, then Team G can only be assigned 5 patients overnight, to a total of 11 patients.
      - Even if all the other teams are capped at 18, then Team G will still only be assigned 5 patients overnight and the other teams will uncap and start to admit.
- **Do not argue with the ED about admissions.** If you feel the patient would be better served in a different level of care (e.g., observation, ICU), discuss it professionally with the ED, MICU and/or the Nocturnist. Review the Section 4: Policies for more about triage/service assignments.
- **For each patient admitted** to the medicine wards, you must:
    1. Write a complete H&P
      - On busy nights, a brief but thoughtful assessment, followed by a “problem-list style” plan is acceptable.
      - Do not assign an attending as a cosigner to the H&P, as attendings may vary from day to day.
    2. Hospital Status Order Cosigned by Attending (**if not already done by the ED, you must complete it**).
      - Go to Order Entry Worksheet in Quest. In top left corner, click the radio button titled Requested By; on the window that appears, select “Other”, and enter the Attending's name for the assigned team.
      - While in that window, click “Source” -> and select *Attending CoSignature Required*, then click OK
      - In the Order search bar, enter “Hospital Status Order Set”; complete and sign
      - **Once you have signed the hospital status order, go back to top left corner and change the “Requested By” back to YOU— otherwise the attending will have to cosign the remainder of your orders!**

3. Admission Orders
  - Use: "Internal Medicine General Medicine Admit" Order set in QUEST
  - The ED resident/attending decides assignment to level of care, **not** SPPO. If on your assessment the patient needs a different level of care (ex. Tele vs Med Surg, ICU, etc.), place a "Transfer To" order in Quest and call SPPO, and they will make the arrangements.
  - **If you think a patient needs to be in the ICU, page the ICU resident before placing the Transfer order.**
  - *See Section 11 on indications for Telemetry placement.*
4. Medication Reconciliation
  - Complete accurate medications using "Order Reconciliation" tab on admission.
5. VTE Prophylaxis
  - Assess every patients VTE risk and order appropriate prophylaxis using the VTE prophylaxis order set. **Do NOT use the emergency bypass.** If there are contraindications to starting chemical prophylaxis, please select that option instead of bypassing it and document in H&P.

- **If you feel that accepting an admission would jeopardize patient care**, discuss with the Nocturnist or on-call chief resident.
- **You are responsible for the admitted patient's care all night until morning signout.**
- **Give succinct, accurate, face-to-face handoffs** to the primary team at 6:30AM. Notify them of any significant events, pending imaging/labs that need followed up, etc. You must comply with program policy for the handoff process.
- **Ensure at sign-out the day team notifies the primary care physicians** at Gottschalk and Pavilion III when their patients are admitted, either via UCI HS email or secure health message in Quest.
- **Respond to Code Blue/Rapid Responses *if able*.**
- **Do not violate duty hours.** Day teams must accept late admissions if they can finish the admission without violating hours themselves

Cross-Cover Resident:

- **One resident** assigned to cross-cover every evening; assignments can be found on the medicine website: [Schedule and Team Assignments](#)
- **Shift starts at 5:00 PM:**
  - Pick up Night Float Binder and pagers from the Team C room.
  - Non-admitting and short call teams can sign out at 5PM
  - Hold the admitting pager p1763 and triage the first 6 admissions to the long call teams starting with the first one listed on the Ward Schedule. You must triage all assignments, even outside hospital transfers.
  - If more than 6 patients are admitted, you must eyeball the patients until 6:30PM when admitting residents arrive.
  - Team H signs out after 5:00PM and returns at 6:30AM
- **7:30 PM:** long call teams may sign out.

- **Do not accept a poor signout!**
  - Ask questions to clarify plans of care
  - Insist the primary team anticipates problems and plan for different outcomes
  - *Don't stop asking questions until you feel comfortable assuming care of the patient.*
- **Obtain a census of each medicine team** and record it in the binder at the start of the night.
- **Team L is NOT your responsibility.** MICU resident covers Team L.
- **Carry three pagers at all times** and respond professionally and promptly (<15 minutes):
  1. Cross-cover pager (714-506-6575)
  2. Team H/medicine consult pager (714-506-6555)
  3. Your personal pager
- **Document all significant events or changes in a patient's clinical status as an "Event Note."**
  - Document ALL rapid responses/codes/airways
  - Consider documenting when patient is placed in restraints, any significant discussion with patient or family, changes in medications/antibiotics, etc.
- **Follow up on all cross-cover "to-do's".**
- **Help the admitting residents with admissions when necessary.**
- **Evaluate and staff Team H consults** (see Section 5: Team H Consults, below).
- **Give succinct, accurate, face-to-face handoffs** to the primary team at 6:30AM. Notify them of any significant events, transfers to MICU, or pending labs that you ordered and need followed up. You must comply with program policy for the handoff process.
- **Collect the binder and all pagers at the end of the shift:** In total, there are 4 night float pagers that must be accounted for: 2 admitting, 1 cross-cover, 1 team H. Put the binder and pagers the team C team room for the next night.
- **Respond to ALL Code Blue/Rapid Responses immediately.**
- **Do not violate duty hours.** Day teams must arrive on time to accept signout. If it becomes an issue with particular teams, please inform the chiefs immediately.

### 3. ADMISSION GUIDELINES/POLICIES:

#### a. [Family Medicine Admission Guidelines:](#)

- A family medicine patient is a patient who identifies a UCI family medicine or UCI geriatrics provider as their primary provider, and with whom the patient intends on following up with upon hospital discharge.
- A family medicine patient is a patient who has been seen on 2 visits during the previous 2 years by any family medicine resident or family medicine or geriatrics attending at our outpatient family medicine/geriatric sites (FHC Santa Ana, Anaheim, Orange or Irvine). These 2 visits are to be continuity visits and not just urgent care visits.

b. Overflow Policy between Family and Internal Medicine

- o If a patient admitted by the IM day team turns out to be a continuity FM/Senior Center patient, the IM team will keep the patient on their service to avoid further hand-offs and to provide best continuity of care with for the patient. Vice versa is true.
- o If a patient admitted by the IM nightfloat turns out to be a continuity FM/SHC patient and FM is not capped, the IM float resident should hand-off the patient to the FM team (pager 9001) ASAP in the AM. If the patient is handed-off to the IM day team, the IM day team will keep the patient to avoid further hand-offs.
- o FM team cap is 15 (including peds and OB). Once the cap is reached for the FM service, the next patient with a senior health center PCP goes to IM and the next patient with a PCP at PQHC goes to FM. Once the FM team hits 15 adult patients then the rest will go to IM until the FM team uncaps. If all teams are capped above 15 then everyone will share the distribution.
- o Family Medicine Bouncebacks:
  - Patients who were last discharged from the family medicine service should be readmitted to family medicine regardless of their last visit to the outpatient clinic. This applies only if the same FM team is on service and they are not capped.
- o MICU/CCU transfers are subject to the same policies.

c. Orthopedic Admission Guidelines for Elderly Patients with Fractures (Effective 5/2013)

- o For all elderly patients ( $\geq 60$  years old) who present to the emergency department with an orthopedic injury requiring admission:
- o Patients with multiple trauma including orthopedic injury will be admitted to Trauma with Orthopedic consult. Medicine is happy to consult on medical issues as needed.
- o Patients with fractures without other traumatic injuries will be admitted to the Internal Medicine service with Orthopedic consult.
- o Patients will be evaluated by the Orthopedic team in the emergency department and appropriate evaluation and splinting will be performed.
- o An appropriate medical work up will be performed by the medicine service to “medically optimize” the patient for surgery. Once optimized, the Orthopedic service will perform surgery within 24 hours, including weekends.
- o The Medicine and Orthopedic services will round on each patient every day and leave a daily note in the medical record with an appropriate sign-out between attendings every day. The orthopedics attending will contact the medicine attending to review the case and ensure the most expeditious care. Management of anticoagulation and antibiotics for wound infection should be coordinated with Orthopedic team.
- o Residents from both teams will communicate with each other daily in a respectful, collegial manner that will foster the best overall care for the patients, and allow for mutual education and learning opportunities regarding the patient being cared for.
- o The Orthopedic service will be responsible for arranging orthopedic follow-up for each patient. Follow-up appointments, wound care, and activity restrictions should be noted in the discharge

- instructions and summary by the Orthopedic team.
- o Delays in care will be an attending to attending discussion between both services.
  - o If unresolved after an attending to attending discussion, which presumably would be mainly due to systems issues such as OR access, please inform immediately (1) your case manager, (2) Viviana Rayburn, case management director, and (3) Dr. Lloyd Rucker, UM Physician Advisor.
- d. Intrathecal Pump/Spinal Cord Stimulator Issues (effective 5/23/2013)
- o After hours/Weekends:
    - First call Chronic Pain Management Fellow on-call. The 24/7 Chronic Pain Fellow can be reached at pager 3386, or under the "Acute Pain Service" on paging system.
    - On-call Chronic Pain Fellow to contact UCICPM faculty to staff case and manage issues.
    - The UCICPM team (24/7 on-call pain fellow and attending) will coordinate management of any issues regarding ITP, SCS.
    - If admission is required, Neurosurgery attending on-call will admit these patients to his/her neurosurgery service. UCICPM faculty/fellow on-call (as a consultant) will help manage any non-surgical (pain or spasticity) issues with these patients while the patient is admitted to UCIMC. There should be a direct discussion between pain attending and neurosurgery/other attending regarding plan for admission and plan of care.
- e. Admission Criteria for Patients with Heart Failure
- All heart failure admissions require a formal cardiology consult.



#### 4. MEDICINE NIGHT FLOAT:

##### a. Backup Assistance

- **If you are the admitting resident and are overwhelmed, do the following:**
  1. Breathe! The ED often boluses admissions early in the shift, and it is not uncommon to have several patients in the ED waiting to be seen. Triage them based on acuity and see the sickest patients first. The admissions usually will taper later in the shift and you will have time to catch up. If not:
  2. Ask for assistance from the cross-cover resident. If they are too busy with cross cover/consults, then:
  3. Ask for assistance from the MICU resident/intern. If they are too busy with their own responsibilities, then:
  4. Ask for assistance from the nocturnist. If they are unavailable, then:
  5. Page the chief resident (pgr 6666) at any time you feel the number of patients exceeds your ability to comply with duty hours or if patient care is compromised, so that they can provide further guidance/call in backup.
  - **This is a team effort, and the expectation is that all night patients will be cared for and all admissions completed. All persons in-house at night are expected to help each other accomplish these goals as safely as possible.**

##### b. MICU transfers:

- The unit is a “closed” ICU: The patient remains the responsibility of the MICU team as long as patient is still physically in the MICU.
- Bouncebacks: The MICU resident is responsible for figuring out which team the patient is bouncing back to (if applicable). The MICU resident will call SPPO and get the patient assigned to the team it came from if the senior is there, AND the team is not capped AND it is not the first or last day of the senior’s block.
- If a patient is assigned a bed & short call ward team before 5 PM, the patient will be cared for by the MICU team until the patient is physically out of the unit. This should occur within 1-2h, but there is no guarantee. However, it is the responsibility of the accepting ward team to assess the patient, write an accept note, and sign the patient out to the ward cross-cover. If the patient is transferred out of the unit between 5 PM and 6 PM, the ward cross-cover is responsible for the care of the patient overnight. If the patient is transferred out of the unit after 6 PM, the ICU cross-cover is responsible for the care of the patient overnight. If this happens, the ICU cross-cover must sign-out overnight events to either the ward day team or ward cross-cover in the morning.
- If a patient is assigned a bed & long-call ward team before 7:30 PM, the patient will be cared for by the MICU team until the patient is physically out of the unit. This should occur within 1-2h, but there is no guarantee. However, it is the responsibility of the accepting ward team to assess the patient, write an accept note, and sign the patient out to the ward cross-cover. If the patient is transferred out of the unit before 7:30 PM, the ward cross-cover is responsible for the care of the patient overnight. If the patient is transferred out of the unit after 7:30 PM, the ICU cross-cover is responsible for the care of the patient overnight. If this happens, the ICU cross-cover must sign-out overnight events to either the ward day team or ward cross-cover.
- The only exception to the above rules is when the MICU census is >17. In this case, the ICU is then “open” and the patient will be assigned a team without having a bed assignment. The ward team is responsible for the care of the patient regardless of where they are physically located. This

includes, then, that the ward cross-cover manages the patient overnight.

c. Heme/Onc Admissions:

- o Team L admissions are the responsibility of the MICU resident.
- o Team S admissions are the responsibility of the Ward Admitting residents.
- o For heme/onc patients admitted to the medicine service, ensure at sign-out that the day team sends a UCI HS email or SHM to the primary UCI oncologist for every admission. Furthermore, the heme/onc fellow must be notified for every admission in the morning (or earlier, if appropriate based on the patient's clinical status).
- o All code status/goals of care discussions regarding heme/onc patients need to be decided upon between attending physicians or fellows and should NOT be initiated by residents. If the patient's clinical status warrants an immediate discussion, call the Heme/Onc fellow on call. It is also advised to contact the on-call nocturnist (see below) for further assistance in this situation.

d. Dialysis/Transplant Admissions:

- o Notify the Renal fellow about every dialysis patient or renal transplant patient being admitted. The renal fellow should be called at the time of admission if the patient needs to be emergently dialyzed or by the day team if they will need dialysis in the morning.
- o Notify the Transplant Surgery service about every transplant patient being admitted. They can typically be contacted in the AM, unless their clinical status warrants being contacted urgent/emergently.

e. Role of the House Supervisor:

- o The House Supervisor can be reached by contacting SPPO (x8455) or pager 6000. They can assist with rearranging beds to meet appropriate levels of care, nursing ratios, getting additional sitters for combative patients, etc.
- o They are a great resource and can assist with logistics regarding many patient-care issues!

5. TEAM H/HOSPITALIST CONSULTS:

1. Team H signs out at 5:00 PM and returns at 6:30 AM. The last consult that they can take for the day is at 5 PM. Consults after 5 PM are completed by the night cross-cover resident or, if non-urgent, the next day by the day residents.
2. Hospitalist consults should be staffed overnight with the on-call hospitalist attending:
  - a. A full consult note should be written and staffed with the on-call hospitalist attending during the night. The on-call hospitalist can be contacted at pager 2112. There is no published schedule of which hospitalist is on call. **If there is no response after two pages, page the service attending, if no answer page Dr. Dangodara.**
3. If another service wants to transfer a patient to Medicine, **please instruct them to call the Medicine Consult Service (team H) at pager 6555 in the morning.** All transfers from other services are done through Team H during the daytime.
4. Preoperative Evaluation Algorithm:

1. Ask when the surgery is planned, if it is emergent, and if it needs to be staffed with the on-call hospitalist that evening or if it can be staffed in the morning.
2. Go to: <http://www.medicine.uci.edu/residency/index.asp> and select the link [Preoperative Evaluation Guidelines & Summary](#)
3. Review the disclaimer on the first page. Use this as a guide while making your preoperative assessment; the Pocket Medicine (“Green book”) also has a preoperative evaluation algorithm on the last page of the first chapter (Cardiology).
4. Complete the evaluation, focusing particular attention on Cardiac, Pulmonary, and Hematologic risk.
5. Write preoperative evaluation note in Quest; mark as INCOMPLETE.
- 6a. Page on-call attending and staff that evening (depending on answer to 1.) and then sign out to Team H resident in morning.  
or...
- 6b. Sign out evaluation to Team H resident and patient will be staffed in morning with team H attending (again, depending on answer to 1.)
7. Do not give recommendations to primary team or deem the patient as medically optimized until the patient has been staffed.
8. NEVER say the patient is ‘cleared’ (‘medically optimized’ is the appropriate designation).

Reference for Pre-Op:

<http://circ.ahajournals.org/content/early/2014/07/31/CIR.000000000000106.full.pdf>

#### 6. OUTSIDE TRANSFERS:

- a. All pending admits coming from outside hospital or clinic will be entered into the medicine sharepoint and assigned to the drip immediately through SPPO. This may mean that the patient is assigned a team even before arrival, which may be that evening or even the next day. No matter the case, the patient will be assigned to the team it was scheduled during the day (even if the senior is off the day of arrival). Call SPPO x8455 if you are unsure which team the patient was assigned.
- b. Even if the patient does not arrive during your night shift, still give credit to the team originally assigned by SPPO. They will most likely come during the day.**
- c. The Transfer center often has records from the outside hospital; they can be called at x2222 and they will email you the records that they have before the patient arrives (very useful!)
- d. If the patient is coming for a procedure (ex. ERCP for GI), admit the patient as you would any other and instruct the primary team at signout in the AM to consult the corresponding specialty service. If the patient’s clinical status is unstable or needs urgent intervention, you can call the on-call fellow or consider transfer to MICU.

#### 7. ROLE OF THE NOCTURNIST:

Revised: 1/31/2017

- The MICU has a nocturnist from 6:00PM-6:00AM. (pager 714-506-1010).
- Focus is on safety and quality of care for ALL medicine patients (emphasis on ICU), but also has responsibilities to the general medicine night float, including:
  - **Directly supervise MICU/CCU residents.**
  - **Personally evaluate each new admission to the CCU and MICU.**
  - **Supervise all of the following procedures:** central line insertion, arterial line insertion, thoracentesis, paracentesis, lumbar puncture **for both ICU AND Medicine ward patients.**
  - **Speak with the medicine ward night float resident 2-3 times per night** at convenient times to determine if assistance is needed and to briefly discuss complicated cases.
  - **Assistance may include anything the Nocturnist feels is appropriate-** even taking over some of the work for the resident if the Nocturnist feels that is needed to avoid problems with quality of care or safety.
  - **Directly supervise medicine ward residents when necessary.** If the Medicine Night Float resident calls for help for any reason, the Nocturnist is to provide assistance. (see below).
- The nocturnist is NOT:
  - **The Nocturnist is NOT the leader of the Code Blue Team.** This remains the role of the MICU senior resident. In many situations, the Nocturnist should attend a Code Blue, but is not required to do so.
  - **The Nocturnist is NOT the admitting attending** for general medicine ward patients or for ICU patients, and should not be listed as the cosigner on H&P's.
  - **The Nocturnist is NOT the on-call medicine consult attending.** However, Nocturnists with faculty appointments have discretion to get involved with urgent medicine consults, if appropriate.
  - **The Nocturnist is NOT the in-house resident backup for completing work on stable patients.** If the floor medicine residents call for assistance, the Nocturnist should make a sincere effort to investigate and determine if/how the Nocturnist's involvement can best help the situation, being professional in all interactions. This may include assistance with triage, helping residents prioritize their work, stabilizing situations, helping with admissions, calling in resident backup, or whatever assistance the Nocturnist feels is most appropriate to prevent safety or quality problems. Helping residents complete non-urgent work must never compromise the Core Responsibilities and Expectations.
- Full description of the role of the nocturnist can be found on the medicine website: [http://www.medicine.uci.edu/noc/PDF/JobDescription\\_13.pdf](http://www.medicine.uci.edu/noc/PDF/JobDescription_13.pdf)
- Any issues that cannot be addressed directly with the nocturnist, should be directed to Dr. Cliff Fornwalt ([cliff.fornwalt@uci.edu](mailto:cliff.fornwalt@uci.edu), UCI pager 6400).

#### 8. WHEN TO CALL THE PRIMARY DAYTIME ATTENDING:

- You should contact the primary team hospitalist attending in the following situations:
  - o Patient transfers to higher-level care, including into the ICU
  - o Patient code event or change in code status
  - o Patient mortality
  - o Any unusual incident involving patients, family members or visitors of patients, or staff
  - o Any AMA (Against Medical Advice) discharge
  - o Anytime the 2112 on-call hospitalist is unavailable

9. LOGISTICS:

- Schedule/Assignments
  - You will rotate nightly between cross cover and admission duties. Review the [Schedule and Team Assignments](#) ([http://www.medicine.uci.edu/residency/call\\_service\\_schedules.asp](http://www.medicine.uci.edu/residency/call_service_schedules.asp))
- Duty Hours
  - Record your duty hours daily using the New Innovations website (<https://www.new-innov.com/login>) or smartphone application. Institution = uci. Username = first initial and last name. First time you login, your password will be your username and the system will prompt you to change your password.
- Food
  - Cafeteria. Open until 12:30 AM on weekdays. Holidays and weekend hours vary.
  - Vending machines are available in the basement connecting Douglas and Tower, as well as the ER waiting room.
  - Microwaves & refrigerators are available in the Tower nursing break room, across from beds 7/8 on each floor.
- Sleep rooms

Sleep Room Assignments	Resident	Telephone Extension
DH3834 (3 <sup>rd</sup> Floor East Side)	Ward Night Float	1115
DH4838 (4th Floor East Side, in Mother/Baby Unit)	Ward Night Float	1158
Sleep Trailer (Bldg. 58) Room 113-Keys located in a box at the 4T nurses station.	Ward Cross Cover Resident	n/a

- Days off
  - Days off for night float ward residents are pre-assigned (see [Ward Call schedule](#) link above)
  - **Leave an out of office message** at the end of your shift on your pager with the appropriate contact information of the covering resident.
  - All team members must get at least 3 days off per block.

10. CULTURE AND PROFESSIONALISM:

- Night float is challenging, but it can be a great rotation with the right mindset. **One negative resident can bring down morale for the entire night float team.** Be sure to come in with enough sleep, bring something to snack on, and bring a good attitude!
- If the day team is called for a late admission and feel they can admit this patient without violating duty hours, they should do so. Similarly, if you are night float and see that the daytime residents are overwhelmed, please assist in admissions.
- You cannot refuse the admission when called by the ED. Do not argue with the emergency department, other services, or your colleagues. Any issues should be brought to the attention of your chief resident in the morning, and/or discussed with the Nocturnist.
- Respond to your pages in a timely manner, ideally within 15 minutes. Please act professionally with the nurses and ancillary staff.

- [Anonymous Feedback](#)
  - If you have concerns that you would like to express anonymously, please go to the resident website [www.medicine.uci.edu/residency](http://www.medicine.uci.edu/residency) .
    - a. Click on “Resident Resources” in the left-hand column.
    - b. At the top of the next page right under words [Residency Portal](#), you will see the link to “[Anonymous Feedback](#)”. Click on that link.
    - c. The system removes your identity and you can post your concerns anonymously. If you want a response, provide your actual name (obviously not anonymous) or an outside, non-uci email address which does not identify you (and therefore is anonymous).
  - There is also an anonymous GME hotline and [other grievance resources for housestaff](#) if you feel your grievance should be handled outside the department: 714-456-3535

#### 11. RESOURCES:

- The [Medicine Resident](#) site (<http://www.medicine.uci.edu/residency/residents.asp>) has a detailed and thorough review of all available resources.
- The [UCI ICU syllabus](#) also has numerous helpful links to minilectures and key articles: <http://www.medicine.uci.edu/noc/PDF/Syllabus.pdf>
- [Where should my patient go, Med Surg or Tele?](#)

#### [Practice Standards for ECG Monitoring Circulation. 2004; 110: 2721-2746](#)

##### **Class I: Cardiac monitoring is indicated for nearly all patients...**

In the early phase of acute coronary syndromes, including “rule-out” myocardial infarction (MI)

In the postoperative period after cardiac surgery

Resuscitated recently from cardiac arrest

With indications for intensive care

During acute management of poisoning with drugs or chemicals at doses known or suspected to have cardiac arrhythmic toxicity

During initiation and loading of type I or type III antiarrhythmic drugs for potentially life-threatening arrhythmias in patients clinically prone to proarrhythmic effects

Immediately after percutaneous transluminal coronary angioplasty for patients with complications of the procedure

With high-risk coronary artery lesions who are candidates for urgent mechanical revascularization

With a temporary pacemaker or transcutaneous pacing pads

Who have undergone implantation of an automatic defibrillator lead or a pacemaker lead and are considered pacemaker-dependent

With Mobitz type II or greater atrioventricular block, advanced second-degree atrioventricular block, complete heart block, or new-onset left bundle branch block in the setting of acute MI

With acute heart failure, pulmonary edema, or receiving intra-aortic balloon counterpulsation

Undergoing diagnostic or therapeutic procedures requiring conscious sedation or anesthesia

With long-QT syndrome and associated ventricular arrhythmias or any other hemodynamically unstable arrhythmia

### **Class II: Cardiac monitoring may be indicated in some patients...**

More than 3 days after an acute myocardial infarction  
With chest pain syndromes  
With a potentially lethal arrhythmia several days after control of the arrhythmia  
At risk of cardiac arrest, respiratory arrest, or development of hypotension  
Who are receiving an antiarrhythmic drug or who require adjustment of drugs for rate control with chronic atrial tachyarrhythmias  
With suspected or proven hemodynamically significant paroxysmal tachyarrhythmia or bradyarrhythmia  
With subacute heart failure or in the acute phase of pericarditis  
With unexplained syncope or other transient neurologic signs or symptoms that might be due to cardiac arrhythmias  
After uncomplicated nonurgent percutaneous transluminal coronary angioplasty or uncomplicated ablation of an arrhythmia  
Who have had a pacemaker implanted within the last 48–72 hours and who are not pacemaker-dependent  
In stable condition after cardiac surgery  
With do-not-resuscitate orders with symptomatic arrhythmia  
Who have undergone routine coronary angiography

### **Class III: Cardiac monitoring is not indicated in patients...**

At low risk after surgery  
Without significant medical conditions during labor and delivery  
With terminal illness who are not candidates for treatment of arrhythmias that might be detected  
With chronic stable atrial fibrillation  
With stable asymptomatic premature ventricular contractions or nonsustained ventricular tachycardia hospitalized for reasons other than cardiac or hemodynamic compromise  
Who have underlying cardiac disease that has been stabilized and who have had no arrhythmias on 3 consecutive days of monitoring

#### o Pearls of Insulin Management:

- If a diabetic patient is made NPO, you may reduce but do not hold basal insulin. Start a carb source, either D5 or D10. The infusion rate will have to take into account the patient's general condition (CHF or Renal Failure).
- In the QUEST NPO Order Set, the number of calories (per liter IVF) is provided for you via a built-in calculator (Note: 1 L of D5W provides fewer calories than a small candy bar!)
- If a patient has a hypoglycemic episode and is on Lantus or other long acting insulin, reduce the dose but do not discontinue the long-acting insulin altogether.
- If premeal insulin needs to be added, rapid acting such as Lipro (Humalog) or Aspart (Novolog) is preferred over Regular Insulin.
- Use the same type of insulin for correctional doses as the patient is receiving for nutritional/premeal. For example, if pt is getting Lispro nutritional insulin tid, then use Lispro SS for correctional; if pt is getting Regular nutritional insulin tid, then use Regular Insulin SS for

correctional.