# LBVA NIGHT FLOAT GUIDE FOR INTERNS

# NIGHTFLOAT

	Basic Principles	1
	Common Crosscover Pages	1
	Running a Rapid Response or Code Blue	4
	Nightly Schedule	4
	Passcodes	4
	Basic Pain Management Guide	5
	Electrolyte Repletion Guide	5
QUICK	GUIDE TO LBVA	
	The Essentials	6
	Admission Orders	7
	Discharging/Discharging AMA	8
	Locations	9
	Man	10

#### LBVA NIGHT FLOAT GUIDE FOR INTERNS

#### **BASIC PRINCIPLES**

- 1. For any patient who is unstable or in any scenario where you're not sure what to do, call your senior/resident (even if they are busy).
- 2. When in doubt, see and evaluate the patient.
- 3. Triage constantly.
- 4. If a significant event occurred, ie: you assessed a patient for acute hypoxia, write an event note detailing the event, your assessment, and plan.

#### **COMMON CROSSCOVER PAGES**

#### Pain

- Before ordering pain medication, ask for location, severity, and time of onset. Determine if the pain is new or old. For new pain, determine the underlying cause.
- For old pain with known cause, check sign out to see if primary team has any specific recommendations.
  - o If sign out does not have specific recs, see Pain Management section below (page 5)

#### **Agitation**

- Examine patient to rule out secondary cases of delirium: (ie: pain, medications, withdrawal, hypoxia, infection, etc)
- Always try to reorient patient first: Frequent touch, reassurance, orientation lessens disruptive behavior (NEJM 1995;332:1338)
- Consider 1:1 sitter.
- Check Q-T interval prior to IV/IM antipsychotics. Avoid benzos in elderly patients and non-alcohol withdrawal patients (Cochrane Rev 2009)
- Restraints should be last resort (J Am Ger 2011;59:S269)

#### Insomnia

- Ensure distractions are minimized in patient room: lights off, TV off, hallway quiet
- Ask if any med has worked in past. Check home medication list to see if pt on sleep med at home.
- If ordering new sleep med, use lowest effective dose.
- Commonly prescribed sleep meds: trazodone, zolpidem, melatonin

#### **Constipation**

- Before giving laxative, ensure patient is not impact or obstructed with history/physical. Does pt have abdominal pain? When was the last time pt passed gas? KUB and DRE may assist in evaluation.
- General step-wise approach to constipation:
  - o Step 1: Milk of Magnesia PO, or Miralax PO, or Lactulose PO
  - Step 2: Bisacodyl suppository
  - O Step 3: Tap water enema +/- soap suds or lactulose enema
- Avoid Milk of Magnesia and fleet enemas in renal insufficient pts. Avoid psyllium in pts taking opioids. Avoid fleet enemas in CHF pts.

#### **Fever**

- Differential for fever is broad. As a cross cover physician your job is to triage and initiate a basic work-up and to evaluate for life-threatening conditions
- First, check sign out. Primary team may have recommendations. If not:
- Triage: full vitals, notify senior resident if pt is hemodynamically unstable
- Consider: blood cultures x 2 (should always be drawn before antibiotics), U/A with reflex culture, consider CXR
- If patient is stable, generally no need to broaden/start antibiotic coverage. If patient unstable, should be covered broadly, with narrowing of antibiotics once a source/bug is identified

#### Hypertension

- When paged about hypertension, evaluate whether:
  - o This represents hypertensive emergency (assess for end organ damage of eyes, heart, brain, kidneys)
  - o This reflects a more serious underlying process (withdrawal, drug overdose, severe pain, increased ICP, renal failure, etc)
- First, ensure this is an accurate reading: Ensure correct cuff size, re-take BP on BOTH arms
- Chart review: Did this develop suddenly? Does pt have history of HTN, cardiac disease or renal failure?
- Hypertensive Urgency: Elevated BP ≥180/120 without end-organ damage. Should be lowered in 24-48 hrs with PO meds. (Crit Care 2003;7(5):374)
- Hypertensive Emergency: evidence of end-organ damage in setting of hypertension. Goal is to reduce BP by 10% in first hour, then another 10-15% in first 6 hours. (Prog Cardiovasc Dis 2006; 48:316)

#### **Hypotension**

- While tx for hypotension is individualized, treat all episodes of hypotension seriously. Notify senior resident immediately.
- Immediately evaluate patient. First priority is to stabilize: Ensure IV access present, supplemental O2, trendelenberg position. Determine if IV fluids needed. Consider checking BP again to ensure accuracy.
- Perform history and physical with note to urine output, mental status, and work of breathing. Order stat labs as appropriate. Determine cause of hypotension and if patient is in shock.
- Call rapid response (or code as appropriate) if need to mobilize support faster

#### Hypoxia

- Treat all cases of hypoxia seriously. Notify senior resident immediately.
- Immediately evaluate patient. First priority is to stabilize.
- Examples of O2 supplementation: Nasal Cannula → Simple face mask → VentiMask → Non-Rebreather Mask → BIPAP → Endotracheal Intubation (Thorax 2008;63viI)
- Evaluate patient: take history, review recent meds given, lung disease history, thrombotic risk, on exam note lung sounds and mental status. Order appropriate labs/imaging (ie: ABG, CXR)
- Call rapid response (or code as appropriate) if need to mobilize support faster

#### Hypoglycemia

- If hypoglycemia mild and pt stable, give oral glucose (ie: juice)
- If more serious hypoglycemia, give 50g (1 amp) of D50. Consider starting D5 or D10 maintenance IV fluids.

#### **Leaving Against Medical Advice**

- See the patient. Ensure patient understands the risk of leaving without standard treatment.
- Use a harm reduction approach: follow up appointments if possible, prescription for essential discharge medications (like antibiotics).
- Ask pt to sign an AMA form under Tools>iMedConsent
- Write a brief discharge note documenting what occurred. See "Discharge AMA" on pg 8 for further details.

#### Hyperkalemia

- If suspicious for hemolysis, redraw BMP
- Common treatments: Insulin/glucose, calcium, bicarb, B-agonist, kayexalate, dialysis

#### **Patient Loses IV Access and Nurse Cannot Regain Access**

- Patients who lose IV's overnight often have poor venous access (ie: ESRD or IV drug user)
- Ascertain that more than one nurse has tried. Some nurses are more experienced with difficult access

- pts.
- Determine if IV access is necessary., and if IV meds can be given PO overnight.
- If a patient can wait safely until morning, more experienced staff can place peripherals, mid-line, or PICC
- If patient needs IV access overnight, consider placing an IV w/ ultrasound. Ask for help if not comfortable.

#### Clarifying Orders Entered by Day Team

- The goal of the night float physician is to fix serious problems, but leave overall, big picture patient management to primary team.
- If any orders are unclear and will not change patient care overnight, write down the question you were paged about and sign it out to the team in the morning.

#### RUNNING A RAPID RESPONSE OR CODE BLUE

- Review ACLS and BLS prior to night float
- Carry ACLS card with you
- All Rapid Response and Code Blues need an event note, written by the code/rapid response leader

#### NIGHTLY SCHEDULE

#### WEEKDAY

- 4:55pm Pick up Medicine Triage Binder, intern cross cover pager, senior admit pager, and code blue pager from ED (Ask for Melvin in ED)
- 5:00pm Get sign out from no call team. Cross cover begins.
- 6:00pm Get sign out from the 2 short call teams.
- 7:00pm Get sign out from long call team
- 7:00pm 6:30am Continue cross cover, admit patients with senior, rapid responses, code blues
- 6:30am Sign out to day teams. Return Medicine Triage Binder and pagers to Emergency Department

#### WEEKEND

- 11:55am Pick up Medicine Triage Binder, intern cross cover pager, senior admit pager, and code blue pager from ED (Ask for Melvin)
- 12:00pm Get sign out from 2 short call teams. Cross cover begins.
- 6:00pm Get sign out from long call teams
- 6:00pm-12:00am Continue cross cover, admit patients with senior, rapid responses, code blues
- 12:00am Sign out crosscover patients to overnight senior, hand over crosscover pager

# Basics (WHO Analgesia Ladder, 1996)

- Mild Pain: Tylenol, ibuprofen

- Moderate Pain: Norco, tramadol, codeine +/- adjuvant

- Severe Pain: IV opiates +/- adjuvant

# Renal Insufficiency/Failure

- Avoid morphine

- Preferred: Dilaudid, fentanyl, (methadone- w/ palliative consult)

#### **Liver Disease**

- Preferred: Fentanyl, (methadone- w/ palliative consult)

- Dilaudid with caution, decrease dose and frequency

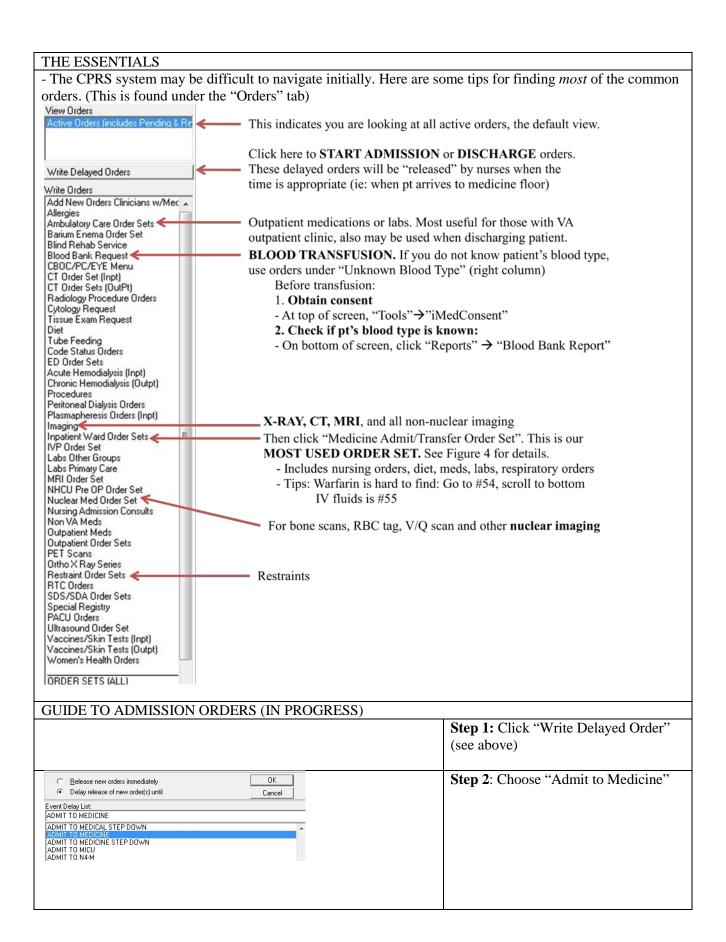
# **Opioid Analgesic Equivalences**

Opioid Agents	IV/Subcut/IM	PO/Rectal	Duration of	
	(mg)	(mg)	effect	
Morphine	10	30	4 hours	
HYDROcodone	-	30	4 hours	
OXYcodone	-	20	4 hours	
HYDROmorphone (Dilaudid)	1.5	7.5	4 hours	
Fentanyl	0.2	-	0.5 - 1 hours	
Codeine	130	200	4 hours	

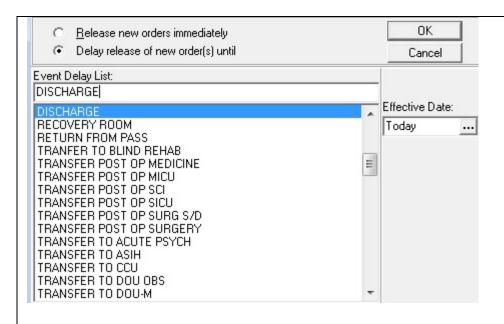
### ELECTROLYTE REPLETION GUIDE

	Preferred Route*	Preferred Formulation	Response	
Potassium	*Oral	Potassium Chloride	.1 increase serum K for 10meq given	
Magnesium	Oral – causes diarrhea	Magnesium Oxide	.5 increase for 2g (50meq) IV	
	*IV	Magnesium Sulfate		
Calcium (correct for hypoalbumin)	*IV- acute	Ca Gluc (peripheral) CaCl (central line)	.5mg/dL increase serum Ca for 1g given (1amp = 1g)	
	Oral- maintenance	Calcium Carbonate		
Phosphate	*Oral	Sodium Phosphate (neutra-phos, Phos-Nak)	(varies by patient) ~1.2mg/dL increase serum PO4	

QUICK GUIDE TO LBVA

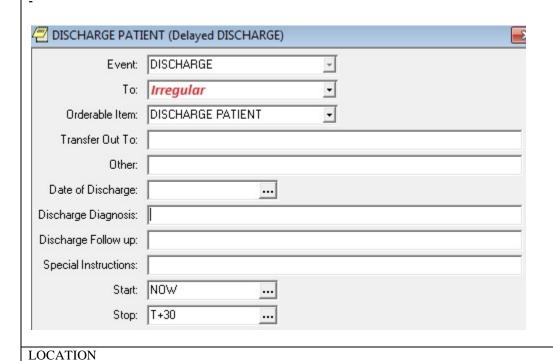


Admit Patient: (Delay	ved ADMIT TO MEDICINE)			Step 3: Fill out Admission
Event	ADMIT TO MEDICINE			information:
Urderable Item:	ADMIT TU MEDICINE			information.
Treating Specialty:	GENERAL MEDICINE			
Expected Location:				
Attending:				
Primary:				
PGY 1:				
Admitted for SC Condition?				
Diagnosis:				
Condition:				
Instructions:	<u>'</u>			
70000	NOW			
	T+30			
MRSA MEDICINE ADI				<b>Step 4:</b> Complete pop-up order set.
MRSA PCR TEST A				Hint:
✓ MRSA NARES CUL ✓ MRSA SURVL NAR				
	on in hospitalized medical pts	NTC		- Ask about code status in every
☑ ENOXAPARIN 40M	'VENTION IN HOSPITALIZED MEDICAL PATIE G SC Q24H	CINI		initial interview
☑ ANTICIPATED DISC	CHARGE DATE	ATMENT		- VTE prophylaxis: Avoid lovenox
■ ATTENDING WARP	GO CPR AND OTHER LIFE SUSTAINING TRE VING FOR DNR ORDER	MIMEN!		
CODE STATUS OR				in CKD/AKI pts
<ul> <li>□ PN WARNING FOR</li> <li>□ MEDICINE ADMISS</li> </ul>	IONH ION/TRANSFER ORDER SETS			
	Stop Order Set			
CLICK HERE FOR	MRSA NARES SCREENING	MED		<b>Step 5:</b> Complete your orders
ISOLATION		50 51	MOM 30ml po qhs prn Acetaminophen 650mg po q4h prn	
Isolation Precautio	ons	52	Maalox Plus 30ml po q4h pm	(isolation, diet, nursing orders, meds,
				IV fluids, labs)
DX RELATED ORDER Acute Coronary Sy		54 54a	Medication Quick Orders PRN QUICK ORDERS	
Community Acquir		54b	VACCINES/SKIN TESTS	
Heart Failure	B	541	CUENCTUEDARA PROTOCOL	
Hospital Acquired	Pneumonia	54d	CHEMOTHERAPY PROTOCOL	
Order #2 if pt has Ne		VTE	PROPHYLAXIS	
or no "A" in the postii 2 Allergy Enter/Edit	ng box		Pharmacologic Agent Intermittent pneumatic compression	
2 Allergy Eriter/Euit			memicent prieumatic compression	
₹3 Regular Diet		IV'S	MUSIUM ONION OPPERO	
■ 3a NPO  3b Diet Orders		55 57	IV FLUID QUICK ORDERS IV DRIPS/ELECTROLYTE REPLACEMENT	
3c Common Diets				
		PCA	Orders  Morphine Sulfate PCA Orders	
NURSING ORDERS			Hydromorphone PCA Orders (Restricted to Surgery	
3a Notify MD upon a	rival to ward			
3b Nasogastric 4 Activity		58	Insert Saline Lock & Flush Q Shift	
✓ Vitals: Routine		59	Convert IV to Saline Lock	
5a Weight		60	D/C Saline Lock	
6 I & O: Q Shift	Insulin Quick Order for SS)	ANT	BIOTICS	
7a Insulin Sliding Sca			IV Antibiotic Quick Orders	
8 Turn patient 9 Precautions			Hospital Acquired Pneumonia	
9 Precautions 10 Limitations:		LAB	3	
11 GU Care				
12 Bowel Care		₽ 70 ₽ 71	Sodium Retaccium	
<ul><li>13 Wound Care</li><li>14 Peak and Trough</li></ul>		₩ 72	Potassium Chloride	
		₩ 73	BUN	
FREE TEXT ORDERS	CAN NOT BE USED FOR	<b>-</b> 274 <b>-</b> 275	CO2 Creatinine	
15 Free Text Orders t		₽ 76	Glucose	
16 Free Text Orders t	o Clerk	₽ 77	Albumin	
Select this item for ot	her	<b>⊷</b> 78 <b>⊷</b> 79	Calcium Magnesium	
16 Patient Care Orders			P04	
RESPIRATORY ORDERS			CBC w/Diff	
17 Respiratory Care	-nə		Legionella Ur Ag & SPUTUM Culture AFB Culture & Smear X3 (sputum) TB	
18 Suction			fiva & Parasites (stool x3 days)	
DISCHARGI	NG AND AGAINST ME	EDIC	AL ADVICE DISCHAR	GES
Discharge				
	- D-110 1 "/	L _ `	411:-1 (475:-1	??
- Click "Write	e Delayed Orders" (see al	oove)	, tnen click on "Discharg	ge



# **Discharge Against Medical Advice**

- In pop-up after clicking on "Discharge," choose "Irregular" under "To" (see below)
- Discharge AMA require, at minimum:
  - o Discharge order
  - o Brief discharge note
  - o Signed AMA form by patient, if possible. Go to Tools>iMedConsent



8

## MAIN BUILDING (Building 126), by floors:

- 1 Radiology, Outpatient clinics
- 2 Labs: Chemistry, Heme, Microbiology, Pathology, Cytology labs
- 3 ICU/CCU
- 4 "4 North", "DOU" (Direct Observation Unit)
- 5 OR
- 6 Surgery offices
- 7 Surgery offices
- 8 CONFERENCE ROOM FOR SIGN OUT, Resident Call Room, "8 South", fellow work rooms
- 9 GI Procedures
- 10 "10 South", Neurology, Outpatient EKG, Outpatient echo,
- 11 Sleep Clinic

X-POD/Y-POD: Spinal Cord Injury patients, CLC (SNF) patients

M-POD: Inpatient Psychiatry patients

