LBVA
NIGHT FLOAT GUIDE FOR INTERNS

NIGHTFLOAT

Basic Principles........................................................................................................ 1
Common Crossover 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
Map .......................................................................................................................... 10
**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.
  - 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:
  - Step 1: Milk of Magnesia PO, or Miralax PO, or Lactulose PO
  - Step 2: Bisacodyl suppository
  - 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;63vi1)
- 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)
- Ascertian that more than one nurse has tried. Some nurses are more experienced with difficult access
- 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 with 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

**PAIN MANAGEMENT GUIDE**
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

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

ELECTROLYTE REPLETION GUIDE

<table>
<thead>
<tr>
<th>Electrolyte</th>
<th>Preferred Route*</th>
<th>Preferred Formulation</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium</td>
<td>*Oral</td>
<td>Potassium Chloride</td>
<td>.1 increase serum K for 10meq given</td>
</tr>
<tr>
<td>Magnesium</td>
<td>Oral – causes diarrhea</td>
<td>Magnesium Oxide</td>
<td>.5 increase for 2g (50meq) IV</td>
</tr>
<tr>
<td></td>
<td>*IV</td>
<td>Magnesium Sulfate</td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td>*IV- acute</td>
<td>Ca Gluc (peripheral)</td>
<td>.5mg/dL increase serum Ca for 1g given (1amp = 1g)</td>
</tr>
<tr>
<td></td>
<td>Oral- maintenance</td>
<td>CaCl (central line)</td>
<td></td>
</tr>
<tr>
<td>Phosphate</td>
<td>*Oral</td>
<td>Sodium Phosphate</td>
<td>(varies by patient) ~1.2mg/dL increase serum PO4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(neutra-phos, Phos-Nak)</td>
<td></td>
</tr>
</tbody>
</table>
- The CPRS system may be difficult to navigate initially. Here are some tips for finding most of the common orders. (This is found under the “Orders” tab)

This indicates you are looking at all active orders, the default view.

Click here to START ADMISSION or DISCHARGE orders.

These delayed orders will be “released” by nurses when the time is appropriate (ie: when pt arrives to medicine floor)

Outpatient medications or labs. Most useful for those with VA outpatient clinic, also may be used when discharging patient.

**BLOOD TRANSFUSION.** If you do not know patient’s blood type, use orders under “Unknown Blood Type” (right column)

Before transfusion:
1. **Obtain consent**
   - At top of screen, “Tools” → “iMedConsent”
2. **Check if pt’s blood type is known:**
   - On bottom of screen, click “Reports” → “Blood Bank Report”

**X-RAY, CT, MRI, and all non-nuclear imaging**

Then click “Medicine Admit/Transfer Order Set”. This is our **MOST USED ORDER SET**. See Figure 4 for details.

   - Includes nursing orders, diet, meds, labs, respiratory orders
   - Tips: Warfarin is hard to find: Go to #54, scroll to bottom IV fluids is #55

For bone scans, RBC tag, V/Q scan and other **nuclear imaging**

**GUIDE TO ADMISSION ORDERS (IN PROGRESS)**

<table>
<thead>
<tr>
<th>Step 1: Click “Write Delayed Order” (see above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2: Choose “Admit to Medicine”</td>
</tr>
</tbody>
</table>
**Step 3:** Fill out Admission information:

**Step 4:** Complete pop-up order set.
- Ask about code status in every initial interview
- VTE prophylaxis: Avoid lovenox in CKD/AKI pts

**Step 5:** Complete your orders (isolation, diet, nursing orders, meds, IV fluids, labs)

**DISCHARGING AND AGAINST MEDICAL ADVICE DISCHARGES**

**Discharge**
- Click “Write Delayed Orders” (see above), then click on “Discharge”
Discharge Against Medical Advice

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