NIGHT FLOAT

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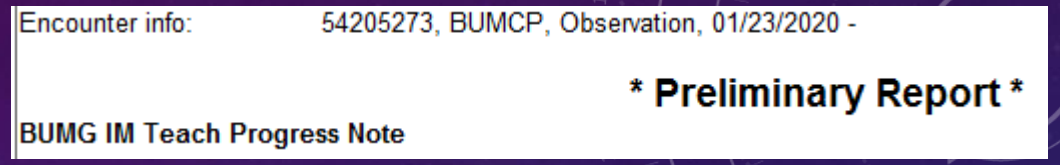
DOCUMENTATION

- Every H&P/Consult must have thorough review of systems (no longer has to be 10 organ ROS), PMH, PSH, FHx, Soc hx and physical exam
- ICU downgrades require an accept progress note (not H&P), DO NOT addended ICU teams note as attending teams covering are different
- Use Banner approved verbiage when cosigning medical student notes (because it specifies the conditions which must be met according to medicare)
- Any patient you see at bedside should have a cross cover note. Be sure to title " cross cover note" (see upcoming slides for more detail)
- Send all notes (H&P and cross cover) for REVIEW to the NF attending
- Med Recs need to be done on **every patient, every time** for new admissions and transfers from other services.

MISC MANDATORY DOCUMENTATION


Encounter info: 54205273, BUMCP, Observation, 01/23/2020 -

*** Preliminary Report ***

BUMG IM Teach Progress Note

- Make sure you are charting under the right encounter and have the correct note type (H&P, consult, etc)—obs or inpatient, don't select outpatient visits…if the wrong encounter type appears on the top of your document, please fix asap
- All notes must have patient name, MRN and DOB below 'preliminary/final report' (example on this page is missing this info)
- Include signature block at the bottom of ALL your notes: name, position (MS, intern, resident), service, and page number
- Translator use must be documented, use a translator if the patient wants one.
- Use of chaperones must be documented!

YOUR ATTENDINGS SAID THIS ABOUT H&PS

- Notes should reflect patient's baseline
  - function
  - thought/mentation
  - Resources/to include family or other support
  - Existing health problems: eg CAD (what causes angina, use of SL nitro, exercise tolerance)..DM (no endo ROS in template: hypo or hyperglycemia, BS monitoring, adherence to therapy), sz (last sz, frequency, description, etc)
- Should capture all the information you got—teams often get way more information than they document
- Thought process should be clear (clinical reasoning)—we can look up vitals and what you ordered but we can't see inside your head (and you are sleeping)

WHEN SHOULD I SEE PATIENTS ON CROSS COVER

- At the beginning of the shift when patient's condition seems tenuous/concerning
- Lab/imaging/study results are significantly abnormal
- Change in status: confusion, shortness of breath, increased pain
- If you are going to request a consult—you shouldn't be requesting a consult if you haven't seen the patient
- When asked to do so by nursing—sometimes we all have problems putting into words exactly what we are seeing and what concerns us, so even though you think a bedside assessment isn't needed, please see the patient

CROSS COVER NOTES-USE SOAP FORMAT TO ORGANIZE INFORMATION

- CC: why you were called
- Identify patient, list pertinent PMH and reason for admission (gives context to note and shows reader that you knew something about pt) and what the patient is being treated for
- TARGETED history and physical, please list vitals
- PERTINENT DATA relevant laboratory/imaging studies and interpretation included or noted as ordered
- TARGETED Assessment and plan—should reflect your differential diagnosis for the problem at hand and what your working diagnosis is and why

CROSS COVER NOTE TIPS

- Write notes as you go along and addend if necessary—you may get really busy, if you put off writing it, you may never write the note
- Let go of perfectionism→ some documentation better than none
- ****most important part of note, your clinical reasoning—what is going on and why
- Notes are critical so all participating in the care of the patient can read (your consultants want to know what happened overnight too)
- NOTE SHOULD BE ABLE TO STAND ON ITS OWN—need enough detail in the note about why pt is hospitalized and what they are being treated for to give good picture of what is going on
- DO NOT write an addendum to the day team's note to serve as your cross cover note

CROSS COVER NOTE TIPS CONT

- You do not need to use the progress note template!
- Longer ≠ better
- More serious/complex problems warrant longer notes
- MS 4 students are expected to participate in cross cover and should write cross cover notes
- Send to NF attending for review

MEDICAL STUDENTS ON NIGHTS

- Typically no MS 3 on nights—schedule dictated by Dr. Bergin
- MS 4 should work 4 nights (required) minimum
- MS 4 typically off Monday nights. If they have simulations/lecture on Tuesday they should leave the hospital by 11:45 pm
- MS 4 should write up no more than 2 H&P per night but can and should see cross cover in addition to that AND write the cross cover notes
- Interns must also present some patients-divide the H&Ps among the interns and MS 4
- Be sure to complete MS 4 call log (particularly for UACOMP and UACOMT)—if you sign that means they completed the night at the level of a beginning intern
- MS 4 usually have Friday nights off
- Should be encouraged to CONCISELY present patients on rounds, please prepare them
  - Focus on pertinent positives, negatives, highlight important labs/radiographic findings, differential diagnosis, why working diagnosis was selected and assessment and plan by problem

BANNER APPROVED VERBIAGE FOR STUDENT NOTES

Med student H&P/consult note/cross cover/progress note must be signed before rounds

I, the resident, was present with the medical student during the visit. I personally performed an exam, made the assessment and developed the care plan (e.g. medical decision making, as documented above. I have verified the student's documentation and agree with the student's findings.

Make sure your signature block is below this AND you should have an addendum particularly about the assessment and plan.

OBSERVATION PATIENTS

- AMS does follow observation patients: BOUNCE BACK AND OUR CLINIC PATIENTS and special requests
- If is better to admit a patient under OBS and convert them to inpatient than the other way around
- OBS admitting goal is discharge within 18 hours of admission (average).
- If we accept a patient and then they are determined to be OBS, we keep them—don't worry too much about this
- If our census is really low (any team in single digits-even orange team), take the OBS patient

WHAT DIAGNOSES ARE OBS?

- Almost anything can be OBS
- Short stay surgeries (even intraabdominal eg cholecystectomy) can be OBS
- You can get IV abx, blood, IV diuretics, IV pain medications and be OBS
- If you expect a short stay, 1-2 days, they are probably OBS.
- When your outreach patient arrives and things seem really easy and you expect dc in 1-2 days, make them OBS
- Write order “place in observation”—yes, you can do this even if they have been in the hospital for a day or two

OUTREACH PART 1

- You are responsible for triaging and accepting outreach patients.
- Ensure patient is stable for transfer
- Ensure that there is a need for transfer-recognize many smaller our outlying facilities don’t have a lot of resources
- Doc to doc communication is important, even if BUMCP specialist has already talked to hospitalist.
- We take almost all patients. Exception: unstable patients requiring ICU care

OUTREACH PART 2

- Assume the worst if they are coming from outside Banner—what information would you need if parts of the transfer packet were missing? GET THAT INFO DURING YOUR DOC TO DOC
- If you really think a patient doesn't need to be admitted or shouldn't come to BUMCP, call your attending for guidance
- Residents cannot refuse a patient from outreach, only attendings can refuse a patient, saying pt is ICU is not refusing
- Patients accepted from outreach sometimes become OBS and that is OK

SENIORS SAID…MOST IMPORTANT INFORMATION TO GET FROM OUTREACH

- HPI, comorbidities, and as much objective data as you can get
- Why can’t the transferring facility handle this type of patient? What do we have to offer the patient at our facility? Is the patient stable enough for transfer (to the floor)?
- If the consulting service for which the patient is coming for has been identified, reached and made aware of patient transfer

PATIENTS THAT GO TO DIRECT CARE

- Private neurosurg group prefers direct care
- Nakaji neurosurg group is OK with teach
- LVADs tend to go to direct care but teach can take these
- Covid and covid rule out—if patient is admitted for other reason and happens to have covid, that is ok to have on teach

PATIENT DISTRIBUTION

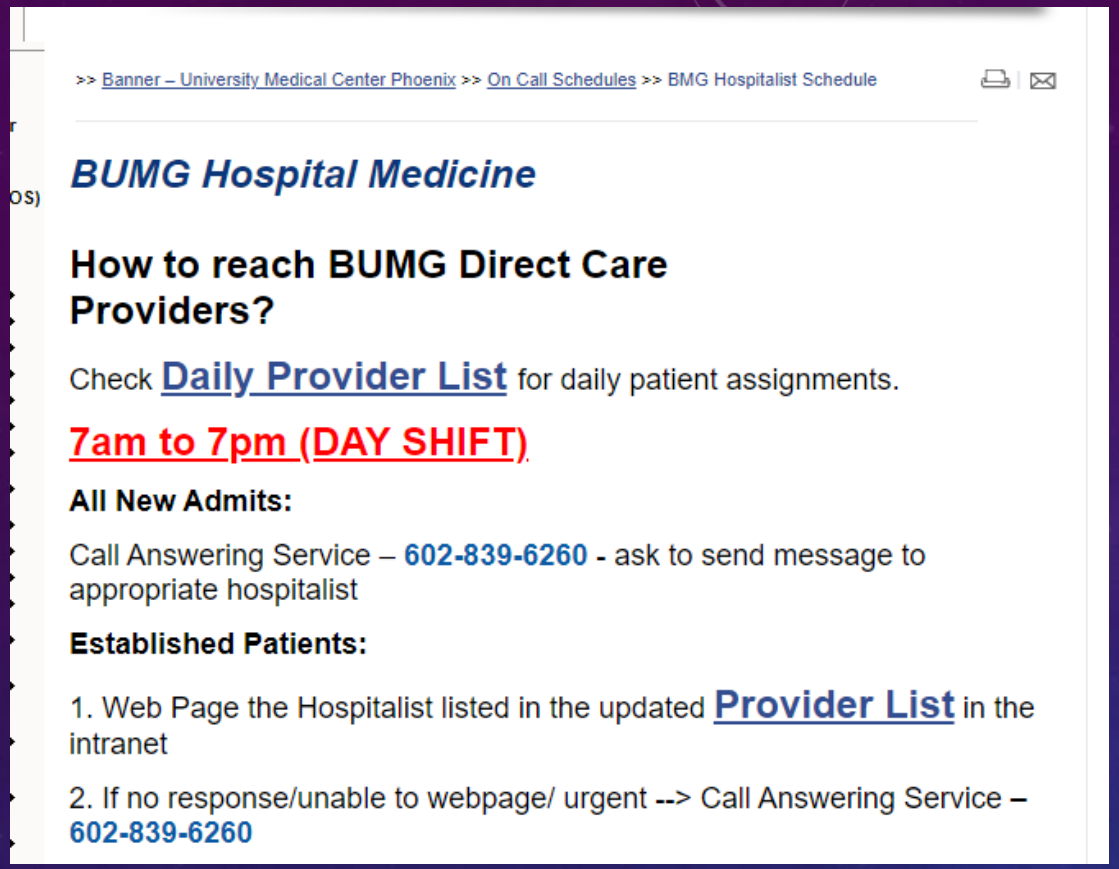
- Spread the wealth among teams: CF, translator requiring, liver, etc. note that liver patients can go to ANY team
- No team should ever be <10, give non liver patients to orange if needed
- Try to keep teams even
- Make sure teach orders in by 0559 so count is right for ‘wheel’ and for the provider list (what nurses use to call you—different that amion but dependent on the teach order info) AND have patients on the correct team list by then
- Try to have the long call team start the day a little lighter than the other teams, particularly important on Saturday and Sunday
- Distribute patients Sunday am if your census is >=2 higher than the next highest census (NF is at 17, next highest census is 13, distribute 2 patients)

NEW TEACH TEAM ORDER MUST BE IN ABSOLUTELY NO LATER THAN 0600

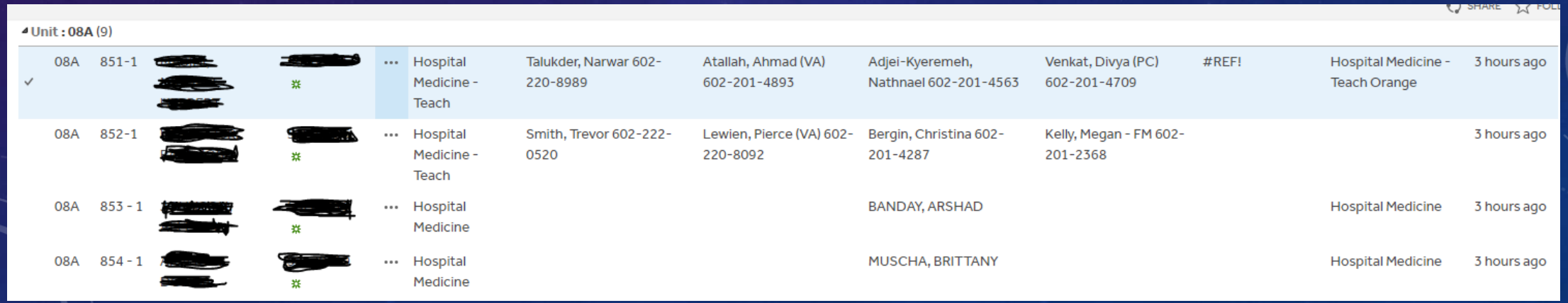
If you don’t do this, the incorrect person will be called for all of your patients.

WHY IS THE TEACH ORDER SO IMPORTANT?

- Data is pulled from the cerner teach order and amion at 0600 every morning and is NOT updated later in the day
- This data is used to create the ‘provider list’
- The provider list for a given day tells the nurse which doctor to call for a given patient



While it says ‘BUMG Direct Care’, this also works for TEACH patients.



Unit : 08A (9)

✓	08A	851-1	[redacted]	[redacted]	...	Hospital Medicine - Teach	Talukder, Narwar 602-220-8989	Atallah, Ahmad (VA) 602-201-4893	Adjei-Kyeremeh, Nathnael 602-201-4563	Venkat, Divya (PC) 602-201-4709	#REF!	Hospital Medicine - Teach Orange	3 hours ago
	08A	852-1	[redacted]	[redacted]	...	Hospital Medicine - Teach	Smith, Trevor 602-222-0520	Lewien, Pierce (VA) 602-220-8092	Bergin, Christina 602-201-4287	Kelly, Megan - FM 602-201-2368			3 hours ago
	08A	853 - 1	[redacted]	[redacted]	...	Hospital Medicine			BANDAY, ARSHAD			Hospital Medicine	3 hours ago
	08A	854 - 1	[redacted]	[redacted]	...	Hospital Medicine			MUSCHA, BRITTANY			Hospital Medicine	3 hours ago

CLOSING TO THE WHEEL 602-839-6260

- If you are overwhlelmed (e.g. all the outreach arrive at once, ER gives you 4 patients in a row, cross cover is a disaster because of unstable patients)
- Typically we close for a specific time frame –say 2 hours, or ask to be skipped once
- We are at ‘goal capacity ‘(15 for regular teams, 12 for orange)—remember that the hard (ACGME) cap is 20
- We will go over goal capacity for clinic patients, CF, special requests (eg dermatology)
- Discuss with long call attending at the beginning of the night if you are near capacity
- If you close, be sure to notify the long call attending (before 10pm), nocturnist (after 10 pm), and the NF attending in the am.

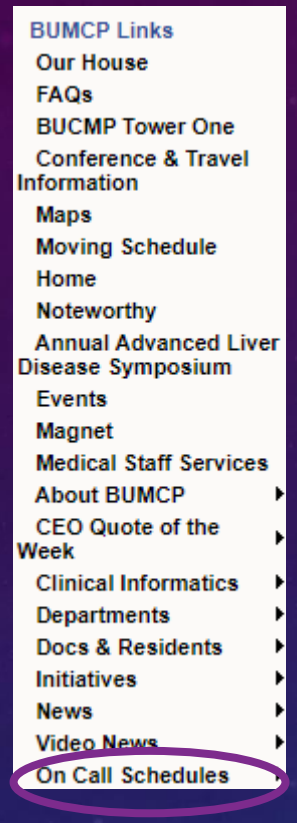
WHEN TO CALL ATTENDING OR NOCTURNIST

- Long call attending nightly around 10 pm; if they don't call you, you call them—you don't need to know who it is, just call the attending pager
- Before calling subspecialty attending unless patient is unstable.
- If you are unsure about patient distribution
- Patient death
- Patient wanting to leave AMA/unsanctioned discharge
- Patient needing to go to the ICU or having a rapid response
- Anyone going to OR first thing in am, nocturnist should staff
- With ANY questions. It's OK to call the long call attending or the nocturnist (if patient needs to be seen)– that's what we're here for!
- If you can't reach the nocturnist because contact on amion is incorrect, talk to long call attending or the wheel as they have contact information for attendings

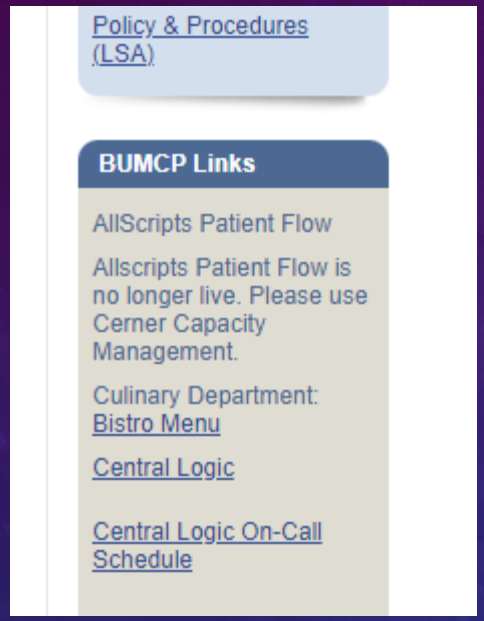
CALLING CONSULTS AT NIGHT

- Consider calling the long call attending or nocturnist first if you are not certain you need an urgent consult
- Ok to call resident or fellow staffed services (surgery, GI, neurology)—they help triage consults and procedures and will do consults at night, particularly urgent ones
- Locums ENT work 12 hour shifts and should be called when the patient arrives (Gujrathi, Tomeeh, Rehl, Hagen late night arrivals should be called into their respective private offices the am unless they instructed you to call on arrival or if urgent questions)
- Call the private groups if you need them
- Most ID consults can wait until the morning except suspicion of prosthetic valve endocarditis, mucor—medicine attending can advise you on initial abx for neutropenic fever.
- HAVE YOUR CLINICAL QUESTION PREPARED BEFORE YOU CALL

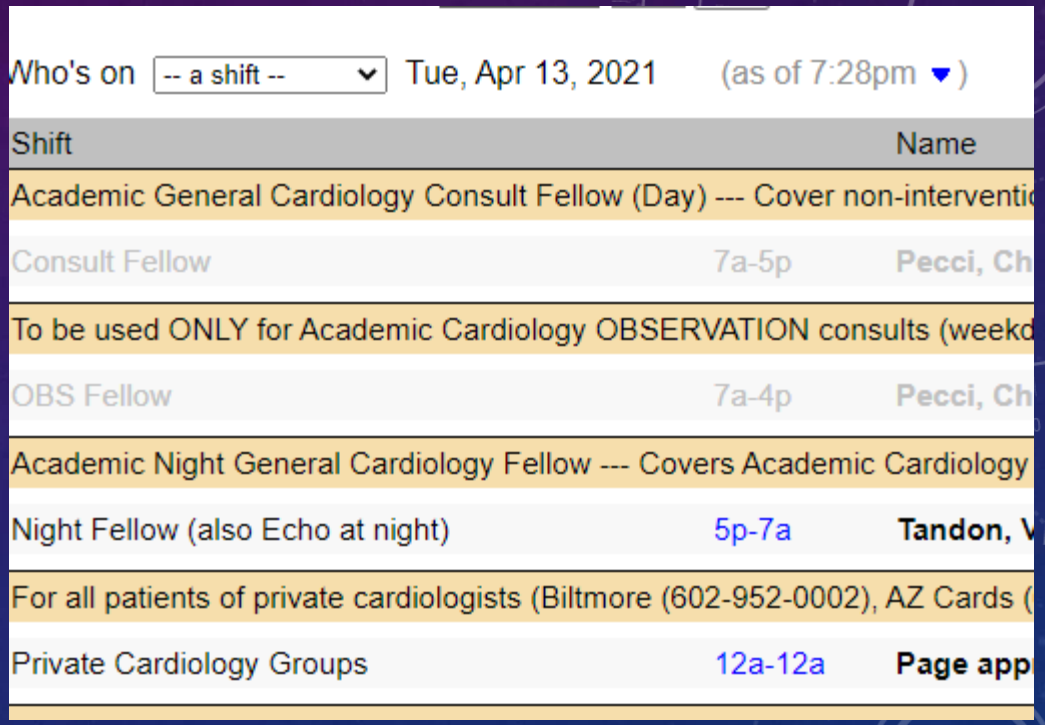
WHO IS ON CALL?



Left side of web Page—mostly for Banner ID



Right side of intranet web page-most of the services you need
Cardiology call listed here is for no doc STEMI, all cards groups have physicians on call.
Cardiology groups cath their own STEMIs
Private groups may not be listed here



AMION-cards, pulm
Password: Bumcpcards, bumcppulm

MORNING SCHEDULE

- Send attending a picture of the board at 5 am
- Plan to start rounds after signout approx. 6:15 am
- Attendings may opt to round with students independently either before or after team rounds
- Take care of personal business before rounds (remind students)
- Complete H&P and X cover notes before rounds—student notes must be cosigned with Banner approved verbiage if student note to be used for billing

MORNING PRESENTATIONS

- Focus on pertinent positives and negatives in ROS and PE
- Do **NOT** read through the entire PMH, Soc Hx, etc—bring up the most important things you think attending should know about
- Plan to spend bulk of time discussing assessment and plan
- Discuss cross cover issues—make sure to forward the notes
- Give follow up on selected patients from previous nights

ADVICE FROM SENIOR RESIDENTS

- it is OK to ask the ED/transfer doc to get more information first or ask them to speak to another service (ie ICU) before you accept
- Ensure you know who the direct care attending is and reach out to them to touch base at the beginning of the night. Sometimes amion is wrong. In case something goes wrong later in the night, you'll want to know who to reach out to
- Trust what you are seeing in the chart and from the objective data more than the calling physician if the assessments are different

MORE ADVICE FROM SENIOR RESIDENTS

- All DKA cases need to go to the ICU for insulin drip
- Consider staffing ratios and talk to someone about appropriate placement (ward/PCU)
- Do not hesitate to get labs/test/imaging on patients you do not know well, none one will fault you for wanting more information to make the right decision
- Don’t be a cowboy. Ask for help if you need it. Even if you think it’s obvious or someone will yell at you potentially. You’re there to give the patient the best care possible, so don’t let them possibly suffer if you aren’t sure about something
- Question everything! Trust but verify. Uptodate/pocket medicine will be your best friend. Don’t be afraid to say I don’t know and reach out to the BMG or ICU attending

ATTENDING ADVICE FOR NF TEAM IN GENERAL

- Don’t be afraid to call the attending on call if you need them! We are on call for a reason
- Utilize the BMG nocturnists when you are uncertain or need a second opinion
- Don’t hesitate to page ICU if you are worried about having to upgrade a patient
- If you think patient needs to be upgraded and the academic side won’t take them, call the nocturnist

SELF-CARE ON NIGHTFLOAT

- Prepare for NIGHTS in advance-
  - Do laundry & go to grocery store before the week starts; pay bills, limit other tasks to do while you prioritize sleeping during the day
- DRIVE HOME SAFELY -avoid long commutes if possible that take time away from sleeping. If too tired to drive, take a nap in a call room or call a taxi/uber and email receipt to Arletta
- Keep workplace brightly lighted to promote alertness; being exposed to bright light when you start your "day" can help train your body's internal clock to adjust.
- Limit caffeine. Drinking a cup of coffee at the beginning of your shift will help promote alertness. Avoid caffeine later in the shift- this may impair your sleep when you get home.
- Avoid bright light on the way home from work, which will make it easier for you to fall asleep once you hit the pillow. Wear dark sunglasses going home. Don't stop to run errands, tempting as that may be.
- Ask family/friends to limit phone calls and visitors during your sleep hours.
- Keep your room cool & use blackout blinds or heavy curtains to block sunlight when you sleep during the day