General Duties and Guidelines:

- In charge of all Medicine Admissions, Medicine Consults, Heme/Onc Admissions, and PALS transfers from 1900 – 0700.
- Perform MICU transfers when the MICU needs beds urgently overnight.
- Check Amion to see when you are listed for admissions or consults.
- General duties are as follows, but are at your discretion to provide the best patient care:
  - **Admission Resident**
    - Receives calls from ED regarding new admissions to place on The List.
    - Triage and manage The List for the night.
      - **If patient has been on the triage list > or = 6hrs then patient should take priority for admission while keeping patient safety in mind for others on the list.**
    - Will be point of contact for new PALS patients that arrive to the floors.
    - Divides admissions between themselves, the consult resident, and OCD.
    - Track all admission requests on the List.
    - Hand off any pending admits to Silver/DCT in the AM.
    - **WILL call NAT Attending if list is >12 to have them help with triage before speaking with each of the ED Attendings.**
  - **Consult Resident**
    - Receives calls regarding new consults from non-medicine services.
    - Signs out ALL consults from overnight with the Silver attending in the morning.
    - Places all consults on the Medicine Consult List and updates cache.

- You should be out by 9 am the next morning in order to have 10 hours between shifts.
- **When the list for admissions is >8 patients you need to call OCD to help with admissions.**
  - **How to direct OCD Resident/Fellow:**
    - Please designate which team the patient they will be admitting should go to before discussing the patient with OCD (Evaluate for Bounce Backs).
    - Encourage Fellows to use H&P Form (this is to help ensure that all major orders – bed request and medicine admission orders- are completed).
- You will meet with the Night Admit Team at 0700 am in the back of the cafeteria (Jemez Room) to staff the patients with the attendings/teams.
- The Gold attending will meet you in the cafeteria to hear about Gold patients.
- If you admit to other teams, the resident who is not presenting to the Night Admit Team, can present their patients to the other attendings by phone.
- **ALL admits MUST be staffed with an attending. Discussing with only the resident**
is not sufficient.

The List:

- The admission resident should keep detailed information on the The List.
  - Use the document on the Hospitalist Wiki Homepage: “Triage Sheets”
    - Under ED Triage/Admission -> Forms -> Triage Sheets
    - Please MAKE SURE to fill out the sheets with time of Consult by the ED
  - Should be handed off from day call team, but if not, then start a new one for the night.
  - Again, put patient identifiers, time contacted by ED, time patient evaluated, and where patient went.
    - Of note: This is what the ED and Medicine Departments use to see how fast or slow we are at admitting patients (It will help you if there is ever an issue).
  - Hand it off to Silver or the MA in the mornings.

Triaging:

- Appropriate Service:
  1) When consulted for an admission, state “Who is their PCP?”
     - This is part of their triaging responsibility.
     - Don’t evaluate a patient until you know they’re not FP.
       - A patient is FP if they identify their PCP as someone on the FP list (FP admitting criteria is located on Resident and Hospitalist wiki).
       - Prior admissions DO NOT MATTER.
       - Where to locate PCP:
         - Appointments
         - Prior Clinic Notes
         - Top of Powerchart (Sometimes)
         - Have the ED ask the patient
  2) Service Agreements:
     - Be sure to review.
     - Available for FP, CF, Neuro, Cards, MICU, Psych, Heme/Onc, Peds, Ortho, Surgery.
     - When in doubt, check the Hospitalist Wiki.
  3) ED Obs:
     - In general, applies to cards, placement, COPD, pyelonephritis, and cellulitis.
  4) If you have to admit a pregnant patient get the attending involved
     - There is a MFM (Maternal Fetal Medicine) Service through OB

- How to Triage Patients:
  1) PALS
     - Should be seen ASAP, at least within 1 hour of them arriving.
       - Have not been evaluated by a physician.
- If you think they need a higher level of care, call the appropriate ICU.
- Drop skeleton orders to get labs before heading upstairs.

2) MICU – only if the MICU needs beds overnight.
   - If beds are needed by the MICU then these patients should be triaged prior to admissions

3) ED:
   - Sickest patients first except as per below:
     - If patient has been in the ED for \( \geq \) 6hrs then patient should be take priority for admission while keeping patient safety in mind for others on the list.
     - Do a chart review on the patients and see if you see anything alarming, ie, meeting Septic Shock Criteria, Critical Labs or other Critical Vitals/Signs.
     - Make sure that any interventions that you recognize are time sensitive at time of consult, are communicated to the ED team caring for the patient.
     - Should let the ED know how long the list is and how long it probably will take before that patient is actually seen/admitted.

**Overnight Admission Protocol:**

1) NF admits to the oncoming NAT up to cap - \textbf{12}.
2) NF admits \textbf{4 patients or up to 12} (whichever comes first, but no more than 4) to previous DCT.
3) NF admits \textbf{2 patients or up to 10} (whichever comes first, but no more than 2) to the oncoming MOT.
4) NF admits all remaining patients to \textbf{Gold and Copper back and forth up to 16 per team}.
5) admits all remaining patients to \textbf{Nickel}.

When in doubt, check the IMChiefs website or Hospitalist Wiki.

**Overnight Consult Protocol:**

- Please use the ED Triage Template for every patient you are approached about by the ED. This is our way of tracking the work you all are doing on patients before we are even admitting them.
  - In powerchart start Consult Note
  - Type “=imed_triage”
  - Template is as per below:
    Internal Medicine Team consulted by ED Provider _ for admission at _
The patient will be placed on the triage list and will be evaluated by IM for admission. Admission orders will follow or an addendum to this note with requests for additional workup.

If Patient not placed on triage list:

Additional diagnostic testing to assess need for admission, appropriate service, and/or appropriate level of care prior to further IM evaluation

Please contact medicine for patient to be reevaluated when the following is completed:

After evaluation, we request:

Additional diagnostic testing to assess need for admission, appropriate service, and/or appropriate level of care prior to further IM evaluation

Please contact medicine for patient to be reevaluated when the following is completed:

- You can toggle to the next “_” by pressing F3.

- The blue text are drop menus and you can select what you are going to do (place the patient on the list to be admitted or is there something else to be done and the patient will not be placed on the admission list).

- If the patient is placed on the triage list based on chart biopsy, you can delete the rest of the note and sign it.
  - Signing the note is important because it provides a time stamp.

- If the patient is not placed on the triage list then proceed to the next drop down menu and select which option best fits and make sure to keep the portion of the note that includes “Please contact medicine for patient to be reevaluated when the following is completed:"
  - Please designate what labs/workup you are waiting for so the ED providers know when to contact you again.

- If you have already signed this note above but after seeing the patient you now think that the patient needs further evaluation by another service or further workup you can then open the note again and type “=imed_triage” and delete everything up to

  “After evaluation, we request:
  Additional diagnostic testing to assess need for admission, appropriate service, and/or appropriate level of care prior to further IM evaluation"

  Please contact medicine for patient to be reevaluated when the following is completed:"

  and place your recommendations but be sure to verbally communicate your request to the ED provider as well.
o If you and the ED provider reach an agreement that a patient can go home, document the conversation in this note and this note can count as your consult note. Consult notes for NF patients do not need ROS or PE because they are not staffed by an attending but need clear documentation of the discussion with the ED.

- End this note with “This patient was not staffed by an Internal Medicine Attending Physician.”

- When seeing a regular consult (not for admission request), you will need to place a full consult note (like an H&P) that you will send to the Silver attending.
  - You will staff these consults with the Silver attending in the AM.

**Bounce-backs:**

- Teaching Teams:
  - Within **21 days** after discharge.
    - Follows Residents, Interns, Externs, and Sub-I’s, regardless of if that person was following patient previously.

- Gold Medicine:
  - To enhance continuity, Gold bounce backs will remain at 14 days, but **ONLY** if an advanced practice provider (APP) discharged the patient. To determine if an APP discharged the patient, look at the discharge summary for one of the following names (also see additional important language under this list):
    - Malerie Mock (Noll)
    - Husayn Bln-Bilal
    - Krystle Apodaca
    - Amanda Lechel
    - Radha Denmark
    - Amanda Woodards
    - Karla Enriquez
    - Barbara (Balin) Aronson
    - JoAnne Clinton
    - Lucas Miltenberger
    - Nikolitsa Varvaresou

  **If one of the above APPs discharged the patient, then the patient will bounce back to Gold. If anyone other than those listed discharged the patient, then the patient will fall into the regular flow of admissions.**

- The Bounce Back rules apply to both MICU transfers and admissions from the ER.

- **Sign out to the bounce-back team’s Attending in the morning.**

**Overnight Issues:**

- If you have any concerns regarding a patient, call the on-call attending.
For patients that you believe should be admitted to the MICU instead of medicine, the MICU resident is required to present the patient to the MICU fellow/intensivist before refusing a patient.

If you think the patient is not appropriate for the IM service, you should call the on-call attending.

5-7 admissions per resident per night is the goal at the beginning of the year but should increase as the year progresses.

Heme-Onc Patients:

- Remember that these patients are sick. Do not sit on these patients, review plan with fellow and admit them.

- Call the fellow to discuss **ALL** admissions to their service **prior to flipping** the patient.

- Call the fellow in the morning between 6:45-7AM to discuss any pending admits you did not get to and to present any patients you admitted to heme-onc.

- The fellow should let you know about any clinic admits from the day that are coming in. If you are called by the floor for one that you are unaware of, call the fellow to review the plan.
  - Patients admitted from clinic, normally they have orders that just need to be initiated. The H&P will be dictated from the clinic visit. You just have to initiate the orders and place a code status order and note. (**TALK to the fellow**)  

- Dr. Tarnower has asked any pending overnight admission evaluations not yet completed by NF teams to TigerConnect text to the corresponding heme/onc fellow at 6:00 AM with the Name, MRN and reason for admission.

**My Tips for Surviving Night Float:**

1) **If you keep the ED happy, you will be happy.**
   - At 8PM and midnight, check in with the ED attendings to run **The List** and let them know where you’re at.
   - If you’re having issues with a lot of PALS or MICU transfers, let the ED know things are delayed and why.
   - **Be polite and respectful**
2) **ONE AT A TIME.**
   - Finish everything on your current admit (**H&P, code note, orders, cache**) before even looking at the next one.
   - You want to provide excellent care to the patient you’re seeing, not see as many as you can in one night and overall you do not want to compromise patient care for speed
   - If I had to pick one, admit safer not faster!

3) **You are a Doctor, not a BLOCKER.**
   - It is not your job to block patients at night.
   - No one will fault you for any admits that may seem unreasonable to you.

4) **Three meals a day.**
   - I used to start NF with sign out, and then go to the cafeteria before admitting anyone.
   - 4AM breakfast break

5) **It’s not a sin to hand off patients in the AM.**
   - It is better to provide good care for your patients then to clear The List.

6) **Double-check everything and everybody.**
   - I would stop admitting at 6:00am and make sure all of my admits are doing ok and would update my notes with most recent labs/results.

7) **Enjoy your time off.**
   - Go outside!
   - Spend your time experiencing what it is like to be normal and be awake during the day.

Do not hesitate to contact me (Chih-Wei Chang– 808-675-8892 (cell)) or the Chief Resident-On-Call if you have any questions or concerns.