Medicine Cross-Cover and Admitting Night Float – Policies and Orientation

Inova Fairfax Department of Medicine
http://www.inova.org/imrp
Chief residents – Pager: #61100 (24/7/365)
MedicineChiefs@inova.org
IM Residency Program Director: Zehra Gaudiano, MD, Zehra.Gaudiano@inova.org
(cell # 703-304-0461)

GOLDEN RULE #1

- The chief residents and Dr. Gaudiano are always available to you for **any** problems or concerns. Please contact us at any time! We are all genuinely interested in you having a worthwhile and productive experience on this rotation. The chief residents will review this information with you, but you are responsible for being aware of all these policies. Refer to this sheet if you have any questions or if uncertainty arises.

SCHEDULE

- You should visit www.amion.com to view the schedule, the login is "ffxmed". The attending schedule is on Qgenda https://app.qgenda.com/landingpage/inovahospitalmed"

DRESS CODE

- Scrubs are allowed when on overnight shifts. A matching scrub top should be worn with scrub pants. Open toed shoes are not allowed and are an OSHA violation.
- Sweatshirts and fleece jackets cannot be worn in patient care areas unless monogram with inova logo and name.

SUPERVISION

- The crosscover intern should always work closely with the admitting and overnight residents and discuss with them all assessments and orders.
- Real-time communication via pager/phone or Epic Secure Chat with the senior resident or attending of record, or if unavailable the on-call hospitalist, is required for all of the following events or circumstances:
  - The patient needs emergent surgery that night or early the next morning
  - An MSET or a significant rapid response is called
  - The patient is upgraded to intermediate or critical care
  - The patient wants to or does leave AMA, or other unexpected or questionable discharge
  - The patient dies (even if it was expected)
  - The patient requests a change in code status

BACKUP

- There is always backup available to you and you should never feel reluctant to ask for help.
- You will use your resident as backup on night-float and discuss anything aside from the most basic order with them. If you aren't absolutely sure about something, call and ask the resident.
- Attending physicians are in-house 24/7 both hospitalists and intensivists. The resident may decide to escalate to the attending, but the crosscover intern should contact the resident rather than the attending.
- On nights (7:00pm – 8:00am) and weekends (24hrs), there is a House MD on call that is either a senior resident, fellow, or attending who responds to all RRT pages. There are also always ICU/CCU residents or moonlighters in-house. If you have too much going on at once, please call either the RRT or the ICU or CCU resident to come evaluate the patient as appropriate.
- The chief medical residents can be contacted at any time if you have any questions about how and when to utilize this backup system. Our pager, spectra, and cell phone numbers are listed above. If you are too tired, stressed, confused, or just unsure of yourself, please reach out to one of us at any time.

IN-HOUSE OPTIONS FOR BACK-UP

- Always communicate all events under the "Supervision" header with the resident who should relay to the attending of record ASAP.
- Always call backup to the bedside if you feel that a patient situation is, or could soon become, beyond your comfort level.
- The chief residents are available to discuss which back-up option you should use if you have a question.
  - Medicine Admitting Resident (Spectra- 63950 pager- 63950)
  - Cross-Cover (65751, pager-65751)

- Hospitalist on call (Epic Group Fx ED Hospitalist or pager #84677)
- House-MD (63903, pager #63903) on nights and weekends (have RN call for Rapid Response Team "RRT")
- ICU resident (63953)
- CCU resident/APP at night (67580)
- In-house intensivist (68927 night 7-7, 65497 day 7-7 or pager #88927)

ESCALATION OF CARE

- At any time if any patient care provider (RN, intern, resident, midlevel, or student) feel that an acute change in a patient's condition has occurred, they should quickly communicate these changes to the appropriate senior or advanced care provider with the authority to take actions necessary to ensure the patient receives immediate and appropriate intervention and care.
- The crosscover intern should always work closely with the admitting and overnight residents, and discuss with them all assessments and orders
- SBAR (Situation, Background, Assessment, and Recommendation) format should be used to communicate the concern to the appropriate provider.

EMERGENT SITUATIONS

- Specific in-house emergencies have protocols in place for when they occur regardless of who is responding to the situation.
  - **STEMI** – if a STEMI is diagnosed on the floor: Call x65905 AND Call an RRT. Call 65905 for cardiac access which will mobilize the cardiac cath team, contact the interventionalist on call, and get the STEMI response RN to the bedside.
  - **Suspected Stroke** – If an acute stroke is suspected on the floor: Call x65440 AND Call an RRT. Call 65440 for the stroke response nurse who can help facilitate imaging and coordination with neurologist on call and IR.
  - **Acute PE** - The PE response team should be notified by activating them at 65905 (cardiac access) if the patient has *hemodynamic instability* OR *positive biomarkers* (trop/BNP/lactate) OR a *high clot burden* on imaging – Radiology is trained now to use that terminology on their reports. The PE response team consists of pulmonary + MCCS + IR. See algorithm (last page).
  - **Fall in the Hospital** - See algorithm (last page). You need to know when to call for an RRT and for C-spine stabilization.
  - **Rapid Response** – The House MD responds to all rapid responses in all buildings and is the primary medical provider for the patient until it is appropriate to transfer responsibility back to the primary team or to MCCS staff.
  - **MSET (Medical Surgical Emergency Team)** – This is the equivalent of a "code blue" elsewhere. House MD should go to all MSETs as backup if not actively providing care elsewhere, however it is the MICU or CCU team's responsibility to respond and provide emergency care.
  - **OB Rapid Response** – This should only be paged to appropriate OB staff, it refers to urgent need for surgical evaluation and medicine/House MD does not respond to this (*House MD should not be paged for this specific issue, alert us if you are*).
  - **Safe Team Alert**- Only moonlighting House MD physicians will respond to this code. If it is a resident covered patient please attend the alert if called overhead.

NIGHT RESIDENT RESPONSIBILITIES

NIGHT FLOAT MEDICAL ADMITTING RESIDENT (PAGER 63950/ SPECTRA 63950)

- The night float MAR will serve as the supervising resident for any questions the intern may have on cross-cover intern
- Should also carry personal pager in addition to spectra 63950.
- The late admitting resident(s) will sign-out all of the day's newly-admitted patients to the night cross-cover intern (5:30pm – 6:30am shift) when they leave. Cross-cover will be responsible for signing-out these patients to rounding teams in AM with updates from overnight events.
- Night MAR will be assigned new admissions from 10:00pm through 5:00am.
  - Night MAR is responsible for admissions assigned via secure chat before 5:00am even if they do not read the message until after 5:00am cut off (example: nocturnist sends message at 4:55am but not read by resident until 5:05am)
  - Night MAR should not be assigned more than one admission after 4:00am even if cap has not been reached
- Night MAR is expected to staff all admissions with nocturnist team in a timely fashion.
- Night MAR will sign-out their newly admitted patients to rounding teams by 6:00am. Night MAR may NOT signout their patients to the cross-cover resident.
  - If interns arrive before resident and ask about new patients assigned to their lists, the night MAR should provide sign-out to the interns. They still, however, need to verbally sign-out to rounding residents as well at 6:00am.

- In the event that night MAR is still working on new admits at time of sign-out, patients should still be placed on appropriate resident teams and verbally sign-out the patient/relay pertinent information to the receiving team by 6:00am.
  - In this scenario, when the patient will be assigned to an uncovered hospitalist rounder, appropriate information should be signed-out/relayed at 7:00am when the day provider assumes care
- Night MAR is expected to wrap up any pending issues and complete all H&Ps before leaving the hospital. It can be helpful to have your note completed (or at least shared) when you are staffing new admissions to allow for real-time feedback on your documentation. You have until 9:00 am before you must leave the hospital.
- Night MAR must touch base with distro hospitalist (Nocturnist 1) by 5:00am each day to discuss final distribution including whether or not there are additional spots on teams to be filled with uncovered patients, additional resident patients need to be uncovered etc. The distro hospitalist schedule can be found on Qgenda
  - Night MAR should obtain/be able to provide basic signout for any uncovered patients that are assigned to resident teams. Signout to MAR can be from admitting nocturnist or through brief chart review if the patient was admitted on an earlier shift.
- Night MAR rotations start on Monday in keeping with other PGY-2 and 3 rotations. Sunday will be day off. Exceptions to this schedule may occur on:
  - July 1st
  - Holiday Block
  - Disaster situations

NIGHT FLOAT CROSS COVER RESIDENT (PAGER/SPECTRA 65751)

- Receive sign-out from all rounding teams plus 1pm and 3pm admitters before they leave. The admitters should have assigned to the appropriate teams for the morning.
- The night float cross-cover will sign-out cross-covered patients plus evening admitted patients **face-to-face** with rounding interns and residents at 6:00am.
- Monday is the day off
- On Sunday night when the NF MAR is off, the cross-cover resident must Sunday night, the intern must contact the distro hospitalist (Nocturnist 1) by 5:00am to discuss final distribution including whether or not there are additional spots on teams to be filled with uncovered patients, additional resident patients need to be uncovered etc. The distro hospitalist schedule can be found on Qgenda
  - Cross-cover resident should obtain/be able to provide basic signout for any uncovered patients that are assigned to resident teams. Signout to MAR can be from admitting nocturnist or through brief chart review if the patient was admitted on an earlier shift.

GLOBAL INFORMATION/RESPONSIBILITIES

DUTY HOURS/DAYS OFF

- We comply with ACGME work hours regulations and hours are monitored by the Chief Residents
  - No one may work more than an average of 80 hours a week, averaged over a 4-week period.
  - Every resident must have two days off per two week block of the NF rotation
  - No one may work more than 6 consecutive nights
  - Residents will never work more than 24 consecutive hours with four additional hours allowed for transition of care

SPECIALTY CONSULTS

- Attendings and residents will determine together which consults should be called. Attendings can help with making distinction between method and urgency of consultation. Night MAR and cross-cover interns should discuss whether an urgent consult is needed with attending of record, covering nocturnist or hospitalist, or House MD or MCCS team responding to a situation.
- For urgent/overnight consults, identify yourself, the patient with MRN, attending physician on whose behalf you are calling as well as a brief history
- Obvious, medically necessary non-urgent consults should be placed by the night team when possible. Examples include (but are not limited to) nephrology consult for a patient on dialysis, cardiology consult for patient with NSTEMI who will need a cath, GI consult for a stable GI bleed that will need an endoscopy. You must document clearly whether or not a consult has been called.

- Ask a clear question of the consultant; ***clarify with your attending physician prior to calling the consultant.*** In the event that a consult will be deferred to the rounding team, the clinical question to be asked should be documented in the chart.

INTER-FLOOR TRANSFERS AND CHANGES IN LEVEL OF CARE (I.E. FLOOR → TELE, IMC, ICU)
- Attendings MUST be notified of all changes in patient status (can secure chat them)
- Either the transferring resident or the charge nurse must call the administrative director (AD)

TRANSFERS TO CRITICAL CARE UNITS:
- The attending physician MUST be called about any change in the patient's status.
    - **MCCS needs to be contacted prior to transfer and must accept the patient to ICU level care**
- **Resident is expected to have evaluated the patient in person prior to contacting MCCS and should remain at bedside until critical care team arrives or the transfer is complete**
- **Verbal handoff must be given to the accepting provider team.** Sign-out directly to accepting resident if the patient is going to a teaching service.
- Either the transferring resident or the charge nurse must call the administrative director (AD)

DOCUMENTATION
- Must be signed in order for others to view your note in Epic.
- **Please use Department of Medicine templates for ALL notes.** Use the following smartphrases:
    - **.medffxreshp** [history & physical]
    - **.medffxresprog** [resident Progress note]
    - **.medrapidresponse** [rapid response note]
    - **.medffxsignout1** [sign out]
    - **.medffxdcappt**[d/c appt checklist]
    - **.medffxdcqi** [dc summary + appt]
    - **.medffxdc** [discharge summary]
    - **.death** [death summary]
    - **Please indicate team to <u>contact</u>** with appropriate smartphrase: **.medteam**1-4, A-C in the sticky note and H&P heading
- **All H&Ps must be signed by 9:00AM prior to leaving the hospital.**
- Cross-cover events should be thoroughly documented, and include when family and attendings have been notified where appropriate.
- It is the duty of night float resident to keep the sticky note up to date, with the appropriate team contact information available.
- Likewise it is the duty of the primary team to ensure that the EPIC team list is up to date, with the appropriate team members and attending of record listed.
- Consultant communication must be documented in the admission note and relayed to the receiving team.

ORDER WRITING
- All verbal orders must be signed within 24 hours.
- No verbal discharge orders are permitted
- Verbal orders are for urgent/emergent orders only. Verbal orders are not permitted to be given over secure chat
- You can sign off on your co-residents/interns verbal orders so that your patient's chart doesn't become delinquent.
- Nurses should be notified directly of all orders – especially STAT orders
- All orders on resident patients should be placed by the housestaff or have been directly discussed with housestaff team
    - Exceptions include procedure related or specialized orders such as chemotherapy orders or dialysis orders.

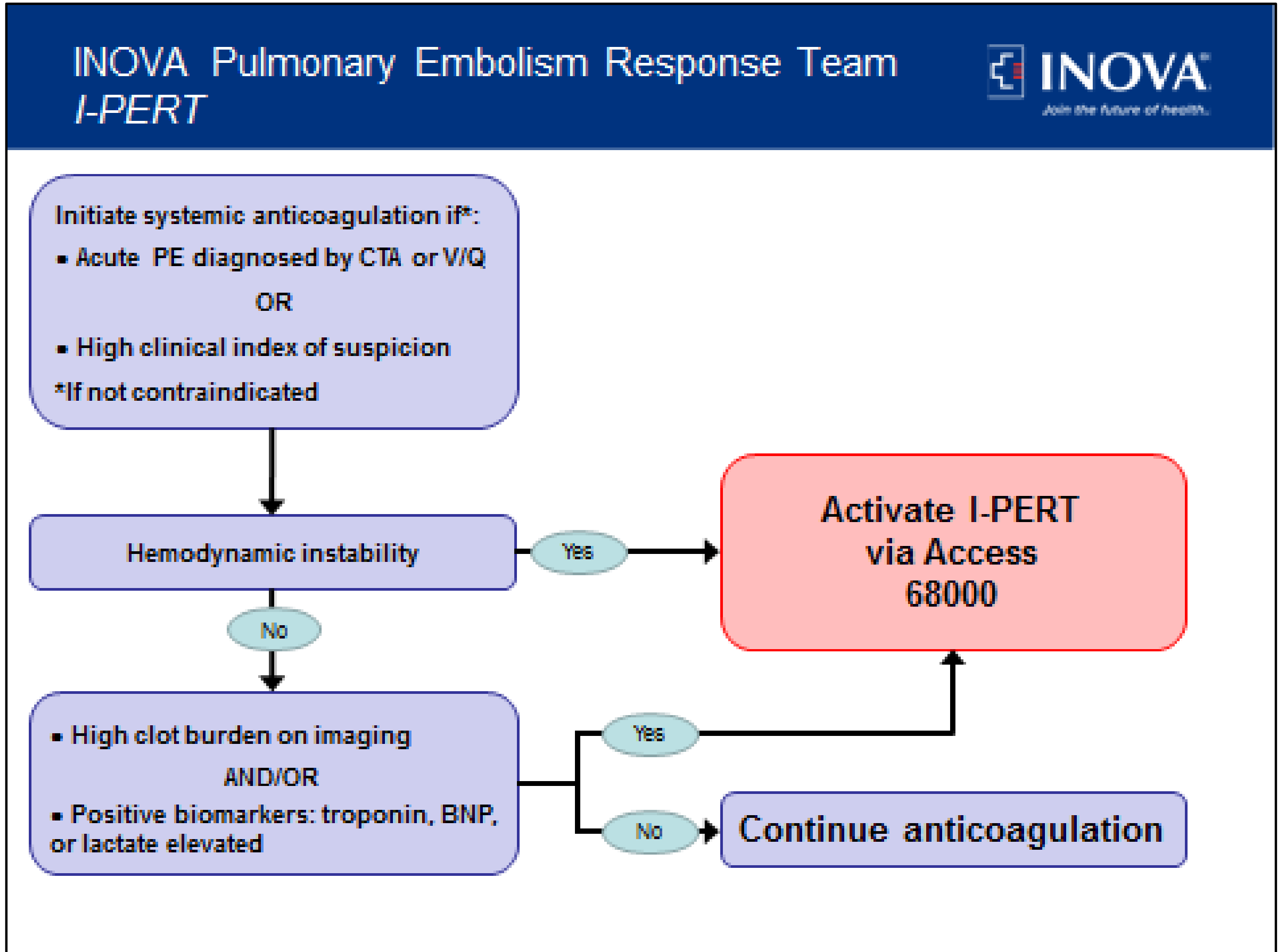
<u>Procedures</u>
ALL RESIDENTS MUST BE DIRECTLY SUPERVISED FOR ALL PROCEDURES by either an attending physician or a credentialed IFMC critical care mid-level provider.
- During the daytime hours, credentialed mid-levels from the MCCS procedure team can be contacted to supervise resident procedures AFTER the attending of record for the patient has deemed the procedure necessary. Residents should take ownership of the procedures and are expected to be at the bedside for the procedures performed with the procedure team.
- During the nighttime hours, credentialed mid-levels from the MCCS service can supervise resident procedures AFTER BOTH the on-call hospitalist and the on-call MCCS attending approve the procedure.
- A moonlighter physician who (may be a resident) is independently credentialed by IFMC med staff office to do procedures may also either supervise or perform the procedure. Outside of MSET or rapid response situation where an urgent central line may be needed, attending physician or MCCS physician must still approve the procedure by phone or in person.

All procedures
- Require a Time-out and informed consent must be completed
- **YOU <u>MUST</u> USE 2 METHODS TO VERIFY A PATIENTS IDENTITY:**
- Ask the patient what his/her name is and verify with his/her wristband
- Require a mask, cap, sterile gown, gloves, and a full sized sterile drape. This is mandatory.

Please always remember:

1. **YOU WILL USE 2 METHODS TO VERIFY A PATIENTS IDENTITY:** Ask the patient what his/her name is and verify with his/her wristband before taking care/doing a procedure on any patient.
2. **ALWAYS VERIFY WHICH SIDE YOU WILL BE DOING A PROCEDURE ON AND DO A TIME-OUT WHEN DOING A PROCEDURE**

I-PERT Protocol



Patient Fall

Patient has pulse and is conscious

Yes

Alert, but complains of C-spine pain, and/or has AMS

Yes

Do not allow patient to move or be moved – support neck in current position

Call RRT

RRT RT to place C-collar – a C-collar should not be placed by untrained personnel

If necessary, RRT calls ED EMT 66837 for assistance with C-collar or scoop stretcher to return patient to bed

RRT MD consults Trauma MD for evaluation of patient

- Notify attending MD
- Conduct post fall huddle
- Document significant clinical findings in EMR
- Submit Safety Always

Unit leader/AD initiates escalation protocol

No

Return patient to position of comfort ***

- Notify attending MD
- Conduct post fall huddle
- Document significant clinical findings in EMR
- Submit Safety Always

***Primary MD should consult Trauma MD and/or order Head CT for the following:

- LOC of any duration
- Scalp laceration or hematoma
- Current full-dose anticoagulation

No

Call MSET

Support neck in current position and place patient on a flat surface

Begin Compressions

All airway management should be with jaw thrust; avoid chin lift/head tilt maneuver

MSET team arrives and will place c-collar

MSET MD consults Trauma MD for C-spine stabilization if resuscitation successful

- Notify attending MD
- Conduct post fall huddle
- Document significant clinical findings in EMR
- Submit Safety Always

Unit leader/AD initiates escalation protocol