

# Welcome to Presby!

## Internship 101: Crosscover

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Chief Residents

# How to make cross cover list

- × Click on “Sign Out Rpt” for each under your patient list
- × Enter any pertinent information, things that need to be done or followed, important information for the night float and on call team to know, etc & click “Accept” or “Close”
- × When finished updating all of your patients, click “Print”
- × Most recent sign out note for each patient will print
- × Write 1) your name and 2) time you will check back in the next day on the back of your list & give to your cross cover person for that day (see bottom of call calendar)
- × Let them know about any tenuous patients or things that need to be done (eg: waiting for CT results)
- × Call page operator at 5PM (no earlier) and say, “This is Dr. \_\_\_\_\_. I need to check out my pager to Dr. \_\_\_\_\_ until 7AM/8AM.” **DO NOT CALL THE PAGE OPERATOR AT 3PM TO SET A FUTURE CHECK OUT TIME.**
- × You are responsible for all pages and evaluating patients until you are checked out at 5pm

Hyperspace - MEDICINE\_PHD - Production Database Server - STEPHANIE SBONG

Epic In Basket Patient Station Patient Lists References Service Desk ED Track Board

Transcriptions Cosign Notes Overdue Results Staff Message EpicCare

Patient Lists Actions

Edit List Properties Remove Add Patient Copy Paste Open Chart Sign Out Rpt Reports Navigators Tx Team Assign Me UnAssign Me

My Lists Current Rotation (21 Patients) Last refreshed: 2305 Search All My Lists

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Patient Lists

Edit List Properties Remove Add Patient

My Lists

- Apr Wards 2013
- Apr Wards 2014
- Aug Wards 2013
- Code Blue
- Conference Potentials
- CPC Possibilities
- \*Current Rotation**
- Dec Census 2012
- Dec ICU 2013
- Endo Jan 2014
- Fax DC SUMM

Available Lists

- Recent Searches
- System Lists
- Discharges
- Outpatient Service Areas

### Sign Out Report for Current Rotation

**[REDACTED] M 72 y.o. DOB: 06/09/1942**

Room/Bed: H201/H20101  
 Hospital Service: Medical  
 Attending Provider: Khouri, Georges Ibrahim, MD  
 Admission Dx: DYSPNEA, CHF CONGESTIVE HEART FAILURE), UNSPECIFIED FAILURE  
 Principal Dx:

Prey Patient Next Patient Print

**My Report** Priority: ⚠

Arial 11 B A + Insert SmartText

Dictation Accept

**Previous Reports** Filter

Report Information	Priority	Action
[06/19/14 1620 Patel, Roma, MD - Resident] This is a 65 y.o. male with hx of CAD post CABG and PCI, CHF, recently diagnosed SCC of lung awaiting radiation therapy, Barrett's oesophagus, chronic back pain post multiple surgery, chronic staph infection of back hardware on suppressive therapy who presents with SOB. Treating as per CHF exacerbation with EF 35% however	None	<a href="#">Remove</a> <a href="#">Edit</a> <a href="#">Copy to Chart</a>

Close

Search All My Lists

IP Cert Needs Completion	IP Cert Signed
Yes	
	✓
Yes	

Report: Sign Out Notes

H2NO

radiation therapy, Barrett's  
 ve therapy who presents with  
 eresis and now have reinitiated  
 on but if symptomatic may consider

fluids. No PE or COPD exac. Has frequent PVC/NSVT and started on sotalol. Please review tele if any concerns. Dr. Joshi following from EP and Dr. Kawalsky for cards. Haem/onc following for radiation therapy given yesterday.

# Who do you check out to?

20 C HEMANI GILL NGO  <i>Off: CHAKRAVORTY DICKSON JONES</i> <i>NF: THOMPSON</i>	21 D PAN DICKSON JONES  <i>NF: THOMPSON</i>	22 A CHAKRAVORTY WUNDERLICH  <i>Off: HEMANI STIDGER KLIMAS</i> <i>NF: THOMPSON</i>	23 B SBONG STIDGER KLIMAS  <i>MU: HEMANI</i> <i>NF: THOMPSON</i>	24 C HEMANI GILL NGO  <i>Off: CHAKRAVORTY DICKSON JONES</i> <i>NF: GOLDMAN</i>	25 D PAN DICKSON JONES  <i>NF: GOLDMAN</i>	26 A CHAKRAVORTY WUNDERLICH  <i>Off: HEMANI STIDGER KLIMAS</i> <i>NF: GOLDMAN</i>
27 B SBONG STIDGER KLIMAS  <i>Off: PAN GILL NGO</i> <i>NF: GOLDMAN</i>	28 C PATEL GILL NGO  <i>MU: CHAKRAVORTY</i> <i>NF: THOMPSON</i>	29 D MITTRA DICKSON JONES  <i>Off: ABID WUNDERLICH</i> <i>NF: THOMPSON</i>	30 A LE WUNDERLICH  <i>NF: THOMPSON</i>	31 B SBONG STIDGER KLIMAS  <i>Off: MITTRA GILL NGO</i> <i>NF: THOMPSON</i>		

CALL TEAMS ATTENDING	RESIDENT	INTERNS	CROSS COVERAGE GROUPS
A	CHAKRAVORTY	WUNDERLICH	I. CHAKRAVORTY, STIDGER, GILL, DICKSON
B	SBONG	STIDGER, KLIMAS	II. WUNDERLICH, KLIMAS, NGO, JONES
C	HEMANI	GILL, NGO	
D	PAN	DICKSON, JONES	

**10 PM – Night Float takes all the crosscover and must check out all pagers to himself/herself via page operator x8480.**

# Taking cross cover

- ✗ Document any calls, events, meds given, etc in Sign Out Report (you may also want to write it down on the paper copy)
- ✗ Sign Out Report does not become part of the chart (unless you click “Copy to Chart”)
- ✗ If something important happens or you went to examine the patient, put a quick note in the chart
- ✗ Let night float and/or primary team know about any events

# When you get called...

- × Ask for **current vital signs & medications** patient was given
- × Review patient's **labs & I/Os**
- × Why was patient admitted? Is this a new or worsening problem?
- × Is the patient **stable or unstable**?
- × Do you need to go & **examine the patient**? YES!
  - × It is recommended that you go see most, if not all patients during the first few months of intern year.
- × Review information on Up-to-Date, MD Consult, etc.
- × Call resident if you are unsure
- × **Let resident know if a major event occurred with their patient**

# PICC Lines

- × Night RNs are notorious for calling the night float intern and asking if the patient can have a central line knowing you just want to go back to sleep.
- × Before giving in...
  - × Ask how many times have they tried to put in a PIV?
  - × Did the nursing supervisor try?
  - × Did they call the PICC nurse to try a PIV via ultrasound?
  - × When will the patient be discharged? If tomorrow, then definitely not.
  - × Does the patient actually need one in the middle of the night? Can it wait so that the daytime RN can try?
- × If all attempts to avoid a PICC line fails, get a midline first!

# Altered Mental Status

- × **Go to evaluate pt & perform neuro exam**
- × Check bedside glucose, electrolytes +/- ABG, ammonia, UA
- × If stroke-like symptoms: activate stroke team
  - × Order stat non-contrast head CT
- × Consider giving Naloxone 0.4-2 mg IV/IM
  - × May repeat after 2-3 mins
- × Use caution with Flumazenil as this may precipitate a seizure in a patient who is chronically on benzo's
  - × 0.2 mg over 30 seconds
  - × Repeat dose of 0.5 mg after 1 min if needed, max 3 mg



# MOVE STUPID (mnemonic for AMS)

- × Metabolic: Na disturbance, hyperCa, ammonia
- × Oxygen: hypoxia, hypercapnea, carbon monoxide
- × Vascular: stroke, bleed/trauma, acute change in BP
- × Endocrine: glucose, thyroid, cortisol
- × Seizure/post-ictal state
- × Trauma, tumor, TTP
- × Uremia
- × Psychogenic
- × Infection: esp UTI in elderly, CNS, sepsis
- × Drugs: esp narcotics, benzos, sleep aids, also w/d, check level when appropriate

# Agitation/Combative Behavior

- × If patient is not a threat to him/herself or staff, try talking to him/her, re-orienting first, having family stay at bedside.
  - × Try environmental modification first - dim lights, fewer people in the room, calm tones, etc
  - × Activity apron
- × If pulling at lines, trying to get out of bed (and is fall risk), or attempting to harm staff, may need meds
  - × Lorazepam (use with caution in elderly) 0.5-2 mg IV/IM
    - × Higher doses for DTs
  - × Haloperidol 2-5 mg IV/IM
    - × Avoid DA antagonists in patients with Parkinson's
  - × Quetiapine 25 mg PO if recurrent
- × Restraints if needed (wrist vs. ankles vs. 4-point vs. posey vest)
  - × Caution if about to be discharged. Must be restraints-free for 24-48 hours prior to going to SNU/LTAC.
  - × Use as last resort

# Seizure

- × ABC's first: **aspiration** risk
  - × Place in left lateral decubitus position & place bite block
  - × Administer O<sub>2</sub>, suction & intubate if needed
- × Give Lorazepam 4 mg IV over 2 mins (or IM)
  - × May repeat after 10-15 mins
- × Check labs (esp glucose), drug levels if indicated
- × Cooling blankets as needed
- × If persists: call neurology
  - × Give Fosphenytoin 15-20 PE/kg @ 100-150/min
- × If still seizing, transfer to ICU for drip

# Delirium Tremens

- × Give Lorazepam 1-4 mg IV (or IM)
  - × Repeat at 5-15 min intervals as needed
  - × May give lower doses PO for milder withdraw symptoms
- × Give Thiamine 100 mg IV
- × Check glucose or give 1 amp D50 bolus
- × Check magnesium & replace as needed
- × Avoid Haloperidol as this decreases seizure threshold
- × Refractory cases may require transfer to ICU for drip

# Falls

- × **Go to evaluate pt, perform neuro exam, & look for signs of trauma**
- × Why did patient fall? Mechanical? Pre/syncope? AMS?
- × Did patient lose consciousness?
  - × Before the fall: check telemetry, glucose, labs, vitals
    - × Transfer to telemetry if concern for cardiac etiology
    - × Check glucose, labs, vitals
  - × After the fall: consider getting head CT
- × Do you need imaging? (head or other body part)
- × Place patient on fall precautions
- × Order neuro status checks if indicated

# Shortness of Breath

- × Check O<sub>2</sub> sat, give oxygen as needed
  - × Nasal cannula, Ventimask, Non-rebreather, BiPAP
  - × BiPAP initial settings FiO<sub>2</sub> 100%, PIP 10, PEEP 5
  - × Call resident if you think patient needs to be intubated
- × Check ABG for respiratory distress or AMS
- × Order CXR if indicated
- × Wheezing: give albuterol or duonebs
- × Crackles: check I/O's, stop IVF & consider giving Lasix 40 mg or Bumex 1 mg IV
- × Copious respiratory secretions: suction
- × Call the ICU overnight extender and have them evaluate if the patient needs the ICU

# Shortness of Breath

- × If concern for pulmonary embolism, consider checking CTA, V/Q, lower extremity dopplers, or D-dimer.
- × Think about pneumothorax if recent chest procedure
  - × If tension pneumothorax (unilateral breath sounds, tracheal deviation, distended neck veins) in unstable patient, insert large bore needle along midclavicular line of 2<sup>nd</sup> or 3<sup>rd</sup> rib space
- × Consider aspiration in the elderly, patients who have vomited, or with recent loss of consciousness

# Chest Pain

- × Check EKG, CXR, cardiac enzymes, cardiac exam
- × Anginal: give oxygen, nitroglycerin (if BP OK)
- × New murmur, rub: may need stat echo
- × “Tearing:” consider aortic dissection
- × Pleuritic: consider PE, PTX, pleural effusion
- × Musculoskeletal: reproducible on exam?
- × Gastroesophageal: try Maalox
- × STEMI: activate STEMI team, call cardiology



# Hypotension

- × Is patient tolerating blood pressure?
  - × Yes—repeat BP on other arm, leg
  - × No—fluids, fluids, fluids (cautiously if heart failure)
- × If BP not responding, transfer to ICU for pressors
  - × Norepinephrine: 2-30 mcg/min (watch for bradycardia)
  - × Vasopressin: 0.04-0.08 u/min
  - × Dopamine: 1-2 mcg/kg/min (watch for tachycardia)
- × If concern for sepsis: blood & urine cultures, CXR
  - × Empiric antibiotics (*after getting cultures*): vancomycin or linezolid + piperacillin/tazobactam + levofloxacin
  - × Transfer to ICU for sepsis protocol

# Hypertension

- × If patient has BP meds ordered, may give dose early
- × If patient has been admitted for stroke, may be allowing permissive hypertension
- × If not severely elevated, no need to lower acutely
- × Can use PRN meds:
  - × Clonidine 0.1-0.2 mg PO Q4-6H (may cause sedation, bradycardia)
  - × Enalaprilat 1.25-5 mg IV Q6H (monitor renal function)
  - × Hydralazine 10 mg PO or 10-20 mg IV Q4-6H (watch for tachycardia)

# Hypertensive Emergency

- × If  $> 180/120$ , look for signs of **end-organ damage**
  - × Perform fundoscopic exam
  - × Head CT if neurologic deficits
  - × Check chemistries, UA, cardiac enzymes
- × Decrease MAP by 25%
- × Labetalol 20 mg IV (watch for bradycardia)
  - × May repeat 20-80 mg every 10 mins, max 300 mg
- × Hydralazine 10-20 mg (watch for tachycardia)
- × If unresponsive to boluses, transfer to ICU for drip
  - × Nicardipine 5 mg/hr, increase by 2.5 mg every 5-15 mins

# Arrhythmias

- × ALWAYS LOOK AT THE EKG YOURSELF!
- × Unstable tachyarrhythmia: shock 100 J synchronized
- × Stable w/ narrow complex tachyarrhythmia:
  - × A-fib w/ RVR: rate control w/ nodal blocker
    - × Diltiazem 5-10 mg IV over 2 mins
      - × Repeat after 15 mins if needed
      - × Then start drip if needed @ 5-15 mg/hr, stop if hypotensive
    - × Digoxin if BP low: 0.25-0.5 mg IV
    - × Call cardiology
  - × SVT: try vagal maneuver first, then Adenosine 6 mg IV
    - × Rapid push, may repeat w/ 12 mg
  - × VT: non-sustained
    - × Non-sustained: check Mg and K

# Arrhythmias

- × Stable wide complex tachyarrhythmia:
  - × Adenosine 6-12 mg rapid IV push (have defib on hand)
  - × Then try Amiodarone 150 mg (\*NOT with Torsades)
  - × Torsades: Magnesium 1-2 g over 5-20 mins
- × Unstable bradyarrhythmia:
  - × Atropine 0.5 mg Q3-5 mins, max 3 mg
  - × Start a drip if ineffective:
    - × Dopamine 2-10 mcg/kg/min
    - × Epinephrine 2-10 mcg/min
  - × Prepare for transcutaneous pacing
  - × Call cardiology

# Nausea/Vomiting

- × Medications: narcotics, antibiotics, & many others
- × Obstruction: Check for bowel sounds, KUB.
  - × NPO, NG tube, call surgery
- × Pancreatitis: Check lipase. Consider US or CT scan.
  - × NPO, aggressive IVF, pain control
- × Elevated intracranial pressure: Neuro findings? Check CT.
  - × Call neurosurgery
- × Vestibular disorder: Vertigo? Nystagmus?
- × Metabolic disturbance: Uremia, DKA, para/thyroid, adrenal insufficiency
- × Others: Myocardial infarction, Infection, Migraine, Indigestion
- × Symptomatic relief:
  - × Ondansetron 4-8 mg ODT or IV
  - × Promethazine: 12.5-25 mg PO, PR, IV
  - × Others: Metoclopramide, Prochlorperazine, Lorazepam, Meclizine

# GI Bleed

- × Upper: ulcers, varices, inflammation, Mallory-Weiss, angiodysplasia, neoplasm, Dieulafoy's lesion
  - × Check GUAIC if melena
  - × NG tube for continued hematemesis
  - × Pantoprazole 80 mg IV bolus, then 8 mg/hr infusion
  - × In cirrhotics/variceal bleeding:
    - × Octreotide 50 mcg IV bolus, then 50 mcg/hr infusion
    - × Prophylactic Ceftriaxone 1 g/day IV
- × Lower: hemorrhoids, diverticula, colitis, angiodysplasia, neoplasm
  - × Check rectal exam
  - × Pain out of proportion: think about ischemic colitis
- × NPO, IVF, transfuse, call GI
- × Check coagulation profile & blood counts

# Decreased Urine Output

- × Check post-void residual
  - × Place Foley if > about 300 ml
- × If unable to place Foley, call urology
- × Check Foley placement/try flushing it
- × May try giving diuretic
- × If dehydrated, try giving fluids
- × With renal failure check US to look for obstruction/hydronephrosis



# Hyperkalemia

- × Most common cause is hemolysis—recheck
- × Check EKG to look for changes
  - × Peaked T waves, flattened P, PR prolonged, QRS wide
- × For life-threatening/severe:
  - × Calcium gluconate 1-2 g IV over 2-5 mins +
  - × D50W 50 ml + Insulin 10 units IV
- × With acidosis: Sodium bicarbonate 50-150 mEq
- × Albuterol 10-20 mg nebulized can also be used
- × Lasix or kayexalate if > about 5.5 and no need for urgent correction
- × If waiting for medications from the pharmacy, can hyperventilate the patient if need IMMEDIATE increase in pH.

# Positive Blood Culture

- × If 1 of 2 is positive with Gram positive cocci, it may be a contaminant
  - × However, if the patient is very sick, running fevers, and/or has a central line/PICC/port, you may want to cover with antibiotics
  - × Consider repeating cultures
- × If 2 of 2 or Gram negative organisms, start patient on empiric antibiotics
  - × Ceftriaxone for Gm neg (Zosyn if risk factors for pseudomonas)
  - × Vancomycin or Linezolid for Gm pos

# Fever

- × May not always be from infection—DVT, transfusion reaction, alcohol withdrawal can also cause fever
  - × Check doppler if concern for DVT
- × Does the patient have signs/symptoms of infection?
  - × Order appropriate studies (CXR, respiratory cultures, UA)
- × Check blood & urine cultures if they have not been done in the last 24 hours
- × Don't need to start antibiotics unless there is a clear source or positive cultures

# Transfusions

- × PRBC indications: 1 unit raises Hgb 1 g/dl
  - × Hgb < 7 for most patients
  - × Hgb < 8 for active bleeding, patients with heart/lung disease or undergoing chemotherapy
  - × May need irradiated and/or leukoreduced for patients with hematologic malignancies/immunosuppression
  - × If history of CHF or CKD, transfuse over 4 hours.

# Transfusions

- × Platelets indications: 1 unit raises Plts by 30K
  - ×  $< 10\text{ K}$  or  $< 50\text{ k}$  if actively bleeding or before procedure
  - × May need single donor platelets for heme malignancies
- × Coagulopathy:
  - × Give FFP for any life-threatening bleeding
  - × Oral vit K 2.5-5 mg for INR  $> 5$  without bleeding

# Transfusion Reaction

- × Stop transfusion & send to blood bank for testing
- × Febrile: check for hemolysis & give antipyretics
- × Hemolytic: monitor hemodynamics
  - × Give saline
  - × Check for antiglobulin, plasma free hemoglobin, repeat type & cross match, & urine hemoglobin

# Radiology

- × CXR: always try to get a 2-view unless patient will have great difficulty moving
  - × Decubitus film to look for layering of effusion
- × Head CT: non-contrast to look for bleeding
  - × MRI usually better to look for other lesions
- × Abdominal CT: IV contrast better for most things
  - × Need PO contrast to look for obstruction
- × Avoid contrasted studies in patient's with renal failure
- × NO MRI contrast for dialysis patients
- × Can always call radiology to see what type of study needed

# Death

- × Can be pronounced by 2 RNs
- × Check for:
  - × Spontaneous or responsive movement
  - × Pupillary, corneal, gag reflexes
  - × Respirations over entire lung field
  - × Heart sounds throughout chest
  - × Carotid pulse
- × Notify patient's family & attending/covering physician
- × Ask family about autopsy if appropriate
- × Chaplain will help family with arrangements



# Death Note

- × Note the time patient was found by nurse
- × Document your physical exam findings
- × Include time death was pronounced

# Closing the loop...

## × Night Float Interns

- × 7 AM: Face to face check out of overnight events to the intern/resident (if intern is off) in the residents lounge.
- × 8 AM: Face-to-face check out of overnight events to the on-call and post-call interns in the residents lounge.

## × Wards Interns

- × Please show up by 7AM to get check out from night float.
- × Those who are post-call or on-call, please show up by 8AM at the latest to get check out from night float.
  - × Be courteous to your night float intern, and BE ON TIME!

# TIPS

- × You can access this powerpoint on the [phdres.caregate.net](http://phdres.caregate.net) website.
- × Reference this PPT on night float.
- × When in doubt, examine the patient. You may also call your resident or talk to the ICU extender or ER.
- × Do not put in orders on a patient that is NOT on teaching service.
- × Relax!