# Night Hospitalist Rotation
## Resident Orientation

Revised 9/21/2020

This is a two-week rotation to provide care to patients who are admitted overnight once the wards teams have capped. This is very different than admitting on wards in that the focus of this rotation is triage and initial management of newly admitted patients. You will learn how to assess and admit patients in an efficient manner, triage, and work autonomously.

### Hospitalist Night Team Composition

- Housestaff:
  - **Two Night Admitting Residents** (**NAR's**; 4pm-8am, 6pm-8am): Primarily responsible for admitting holdovers and supervising night float interns.
  - **Two Night Float Interns** (**NF's**; 4pm-8am): Primarily responsible for cross-cover.
- **Swing Hospitalist Attending** (3pm-11pm): Holds onto the Medicine on-call pager and triages admissions.
- **Night Hospitalist Attending** (11pm-7am): On-call for any issues on the inpatient medicine services.

### SCHEDULE

- Night Hospitalist rotation is 2 weeks in duration.
- Residents will be scheduled every other night with the shift starting at either 4pm or 6pm.
- You are allowed to switch 1 night shift resulting in back-to-back nights once per 2-week rotation, subject to approval by the Chief Residents.
- Absences or changes to your schedule must be approved by the Hospitalist Attending and Chief Resident.

### DAILY ROUTINE

- **Call Rooms:** Each Night Admitting Resident (NAR) has a call room on the 5th floor: 5B-103 Suite (ask the Chief Resident for door code).
- **Check-in:** Meet with the Night Hospitalist Attending in 5D-105. Supervise sign-out from ward interns starting at 4pm.
- **Admissions:**
  - Each NAR can admit up to 10 new patients.
  - NAR's are expected to follow the current Admission Policy (see separate document), including taking sign-out within 1 hour and placing admission orders within 2 hours of taking sign-out.
  - **4:00pm – 11:00pm:** Admissions will be triaged and distributed by the Swing Hospitalist Attending.
  - **11:00pm – 7:00am:** NARs will be responsible for management of the Medicine On-Call pager, including admission triage, consult triage and assessment, emergent lab follow up.
  - **6:00am – 7:00am:** It is permissible to take the full story from the ED for holdovers, assess via chart for stability and place basic admission orders on stable patients without direct evaluation. For unstable patients you should directly evaluate them for purposes of triage (e.g. ICU vs Medicine).
  - **7am:** Meet the Day Hospitalist Attending in the 4D Physician Workroom 4D-104 to review admissions and triage to the ward teams. These do not need to be full presentations, but just enough so that the attending can triage the patient appropriately according to severity, complexity and the expected length of stay (someone who is very active, sicker, and will need a

lot closer monitoring is better off going to long call whereas someone with a straightforward cellulitis can be a hospitalist/short call patient).

- **7:30-8:00am:** Sign-out holdovers to the ward and hospitalist residents (in 4D-104).

- **Admissions Hard Cap:**
  - Defined as 10 new admissions per NAR (20 patients total across 2 NARs)
  - Consults and transfers of care from other services of previously admitted patients do not count toward the hard cap.
  - Upon admission of the 20th patient, notify the Hospitalist Attending and hand off the Medicine On-Call pager. Additional admissions beyond 20 patients will be admitted by the Hospitalist Attending.

## ADMITTING AND TRIAGE

- **Inpatient versus Observation:** Patients will be admitted under Medical Observation or Inpatient, and this level of care is guided by InterQual.
  - When the Hospitalist Attending is present, the attending will determine the level of care based on the InterQual result and the patient's assessment.
  - Between 11pm and 7am, the NAR's should follow the InterQual result as follows:
    - All patients meeting InterQual criteria for inpatient admission ("InterQual met") should be admitted to inpatient
    - All patients not meeting InterQual criteria ("InterQual denied") should be admitted to observation. The Hospitalist Attending can subsequently decide to upgrade observation patients to inpatient based on your assessment.
- **'Holdover Orders' for Inpatient Admissions:** Holdovers are efficient initial evaluations for purposes of stabilization and triage. You should obtain enough history (including med list, PMH) in order to make an accurate preliminary diagnosis, triage the level of illness to the appropriate level of care, write essential initial orders and stabilize the patient overnight. Things such as antibiotics, radiology, second troponins are examples of what should be ordered.
  - Each admission requires in ORCHID the "Request for Admit" and the "Admit to Inpatient" orders (the latter is part of the MED General Admit order set).
  - Basic admission orders should be signed within 2 hours of receiving sign-out from the ED to ensure timeliness of transfer to an inpatient bed. Nurses cannot carryout patient care without physician orders.
  - As time and work load permits you may consider more in-depth evaluation and work up for advancement of care. Extensive work-up (such as CKD work-up) does not necessarily need to be ordered by you and can be deferred to the primary team.
- **Observation (OBS):** Observation patients should be assessed and managed no differently that admitted patients except for their initial orders: In ORCHID, order "Place in Observation," but do not order "Request for Admit" or "Admit to Inpatient."
  - **Level of care in Observation is med/surg or telemetry only.** If you believe a patient requires Step Down level of care contact the Hospitalist Attending for evaluation and approval of admission.
  - For chest pain evaluations where cardiac stress testing is indicated, please remember to order the repeat troponin and ETT/echo.
- **Medical Reconciliation:** Medication reconciliation is expected of all admissions, including holdovers and observation patients. It is best to do this at the time of admission as family or medication bottles are most often present at this time.
- **Staffing:** Holdovers that are completed before 11pm are staffed by the Swing Hospitalist Attending. In this case, document "Discussed with attending Dr. _" in your note and forward your note to that attending. Patients seen thereafter are only *briefly* discussed in the morning with the Day Hospitalist for triage

purposes. Your note should be assigned to that attending however you should document that the final assessment and plan will be discussed between the accepting primary team and attending.

- **Documentation:** A *brief* holdover note should be written for all patients (admission or observation). Use the "History and Physical" note type in ORCHID, but these should be titled "**Medical Resident Admission Note (MRAN)"**, not History and Physical. These are brief notes that relay why the patient came in, any important data that affected your holdover assessment (e.g. important exam findings), and most importantly, what was done for the patient overnight. If it becomes too busy and you are unable to write a note for all your holdovers, at minimum, you should write down your problem list, what you ordered, any acute events overnight, any consults called and their recommendations *(Remember, when you and the night ER resident leave in the morning, so does the information of what happened overnight)*.

## TRIAGING FOR ADMISSIONS AND CONSULTS (11PM-7AM)

- **Medicine On-call pager:** From 11pm-7am, the Medicine On-call pager and admitting list will be carried by the NAR's. It is up to the residents how they want to share in holding the pager and dividing up the holdovers. All admissions (whether from the ER, clinics, direct admits, routine transfers, consults) go through the Medicine On-call pager.
- **Admission list:** You will be given a "fake admission list," which is a copy of the next day's admission list. All holdovers/consults/OBS patients/ICU transfers will be written on this "fake list" (name/MRN/time of admit/who did the holdover/diagnosis). Think of it as an accounting of all medicine patients that need to go to a team in the morning, so patients don't fall through the cracks. In the morning, these patients will be triaged by the Hospitalist Attending and names/MRN's will be transferred to the "real list." The order in which the holdovers are listed on the fake list does not indicate which team they will go to. This only happens with triaging in the morning. In addition, all patients should be added to the **OVMC Medicine Night** care team list in ORCHID.
- **ICU Transfers:** If the ICU calls you with an ICU transfer that has already made it to the floor, you should not accept the patient but please make note of the transfer. The ICU is responsible for cross-covering the ICU patient until morning. Please write the name/MRN/diagnosis and whether the patient is a bounceback on the fake list and tell the ICU to page Medicine On-call after 7am for the accepting team assignment.
- **Triaging:** When the ER calls you with an admission, get the verbal sign-out and make sure the patient is stable for their intended bed destination and that their diagnosis is appropriate for the medicine ward service. If you feel like the patient still needs further work up that can change management (i.e. a patient fell but no CT head was ordered), it's okay to ask the ER for further work-up before accepting the patient to Medicine. If you think the patient needs higher level of care, you can ask the resident to change the bed assignment, or tell them that you'll evaluate the patient first to see what the appropriate bed will be. Remember that you CANNOT block admissions from the ER. If you greatly disagree with the admission or level of care, please call the Night Hospitalist Attending to discuss the case and options. Observation is decided by InterQual status however if you believe someone needs a higher level of care please call the Night Hospitalist Attending for evaluation.
- **Medicine Consults:** If you are called for a new Medicine consult after hours and it is not urgent, ask the service if it can be deferred until after 8am. Take the story and sign out the consultation to the Day Hospitalist. If it is an urgent consult (*e.g.* pre-op for an emergent surgery or out of control HTN), then please see the patient and call the Night Hospitalist Attending to staff the patient. These types of urgent consults from 11pm-7am are very rare.
- **Admission to other services:** There is a list of admission criteria that dictates which patients go to Medicine and which ones go to other services (this has been agreed upon by the Service Chiefs). The admission criteria can be found in the Hospitalist Office (5D-105) or ED Physician Workroom. Please review these criteria and try to adhere to them overnight. This is where asking the ER to do further work up before accepting the patient is helpful (e.g. pancreatitis with gallstones and who still have their gallbladder goes to

the general surgery team as primary whereas all other ones go to medicine; thus an ultrasound is important). If there is a dispute regarding a patient's disposition you may contact the Night Hospitalist Attending to run the case by them and possibly have the Hospitalist Attending talk to the subspecialty.

- **MAC/Outside transfers/EMTALA:** If you are contacted regarding a new MAC transfer, EMTALA transfers, or transfer from another hospital, **RESIDENTS ARE NOT ALLOWED TO FIELD THESE CALLS AND ACCEPT PATIENTS** (in order to protect you). Please refer these to the Night Hospitalist Attending.

## CHAIN OF COMMAND

- **Cross-Cover Interns:** NAR's are designated either Red or Blue, which corresponds to a cross-cover intern. You are next in the Chain of Command if they have any questions. The 4pm-8am NAR will cover both interns until the 6pm NAR arrives.
- **Night Hospitalist Attending:** The Night Hospitalist Attending from 11pm-7am is available by pager (if no answer, then contact by cell phone). They are responsible for any issues with the inpatient hospitalist service, medicine ward service, holdover patients, medicine consult, or triage question. Do not hesitate to call the Back-up Hospitalist Attending if you have ANY questions!
- **Hem-Onc Wards:** Any issues with an Onc wards patient should be brought up to the Onc wards fellow.

## CODES/RRT

- Please go to all calls for Code Blue and Rapid Response Team (RRT) overnight to assist the ICU night team.