Sep 18, 2022

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Surviving Night Floor Calls

Dealing with the Combative, Delirious Patient and Other Late Night Firefighting Tactics

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Non-Declaration Statement: I have no relevant relationships with ineligible companies to disclose within the past 24 months.

Objectives

1. Summarize the most common cross-cover calls received overnight.
2. Review standard approaches to routine patient care issues overnight.
3. Apply triage concepts to multiple competing priorities during night shift.
4. Demonstrate judicious decision making in pharmacologic interventions.
5. Develop a consistent strategy for cross-cover documentation and handoff communication.

General Night Considerations

- Review the med list (both active/inactive)
- Look for trends
- Check addendums
- Clear guidelines for when to call
- Document your thinking
- Bill for critical care time (>35 min)
- Rely on feedback
- Follow up

Trying to explain to Day Shift

What happened during Night Shift

David Spade & Chris Farley in *Tommy Boy* (1995).

Unspoken Rules of Cross-Cover

- **Physical presence is key**
- Engender trust
- Understand the culture
- Utilize secure texting apps
- Spot dose > pain regimen overhaul
- Use your human resources
- **TRIAGE!**
- Thriving > Surviving

Context is KEY!

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Cardiac

Hello,

I'm taking care of pt [redacted] in 750. Wanted to let.you know his HR has been sustaining between 38-42. Other vital signs stable. Last night he was around the mid 40s to low 50s.

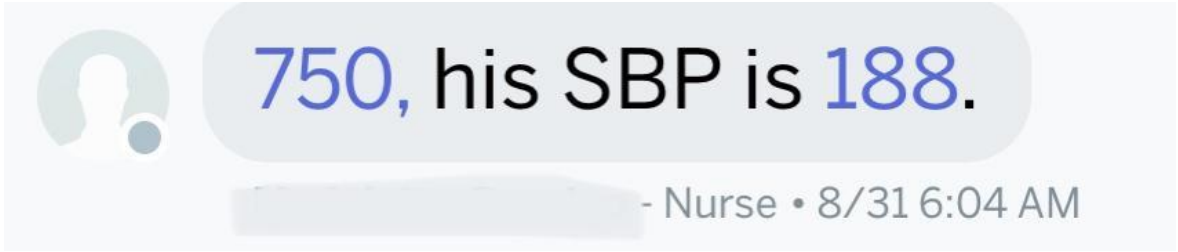
9/13 3:57 AM

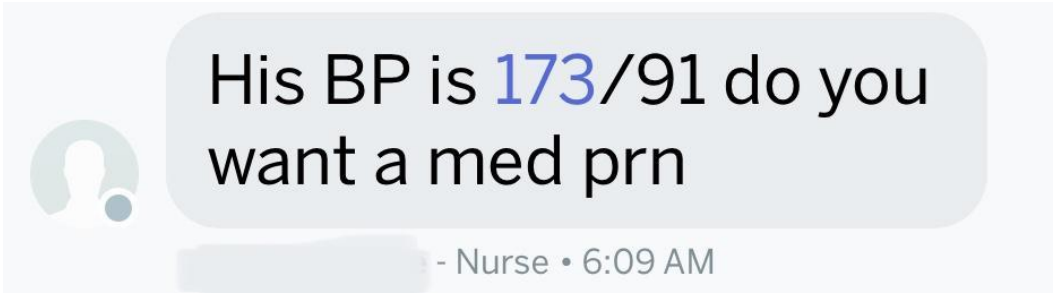
“Mr. Lee’s heart rate keeps dipping into the 40s”

- Symptomatic or asymptomatic?
  - Dizzy, lightheaded, hypotensive, syncope
- Get EKG if first episode
- Asymptomatic generally requires no intervention
- Symptomatic: IV atropine 0.5-1mg q3-5min
- Heart block:
  - Mobitz II or 3rd degree: Pacer pads & ICU

“Ms. Chavez has chest pain!!”

- EKG!!!!!
  - Compare to previous
  - **NEW** signs of ischemia: ST depression/elevation, T wave inversion, LBBB
- “Typical” vs. “Atypical” symptoms
  - Troponins can hurt more than help
  - BNP, Troponin if PE risk
- Response to sublingual nitroglycerin


750, his SBP is 188.
- Nurse • 8/31 6:04 AM


His BP is 173/91 do you want a med prn
- Nurse • 6:09 AM

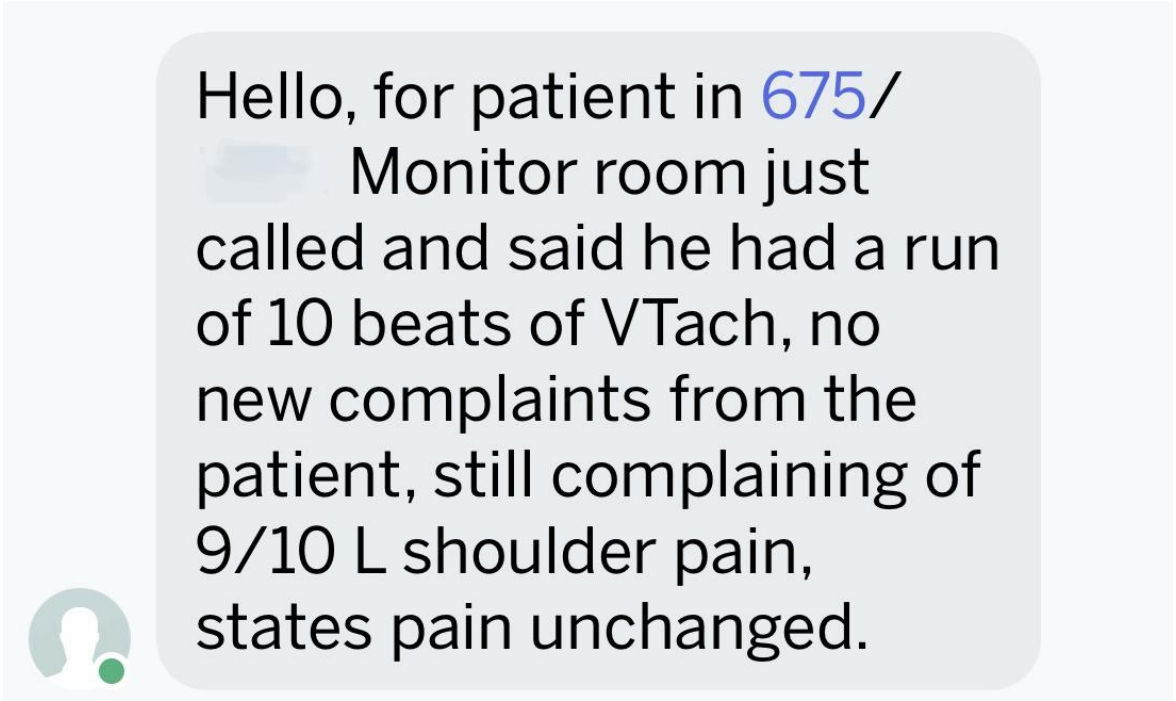
"Mr. Desai's blood pressure keeps spiking. Need PRNs."

- Symptomatic = signs of end organ dysfunction
  - Headache, blurry vision, chest pain
  - **The ONLY time you should use IV labetalol/hydralazine!!!!!!!!!!**
    - **Can cause ischemic stroke**
  - Nicardipine drip also an option and less variable
- Asymptomatic: initiate or uptitrate oral antihypertensives
  - PO Labetalol 200-400mg, PO hydralazine 25-100mg, PO amlodipine 5-10mg all have peak effect 30min-3 hours
- Nursing reassurance and guidelines for when to call

She is sustaining in 140s to 160s A fib, or if there is anything you'd like to do about it.thabk you

"758 Johnston now in AFIB."

- Most common scenario: Asymptomatic and hemodynamically stable
  - Initiate/uptitrate PO metoprolol tartrate 25 mg q8hrs
    - Up to 200mg daily
  - Emphasize reassurance
- Symptomatic with palpitations (but normal BP):
  - IV metoprolol and IV diltiazem
    - Avoid in HFrEF - can precipitate acute heart failure
- Chronically low BP: Digoxin is back in favor (ensure renal dosing)
  - Avoid amiodarone unless adequately anticoagulated
- Acute hypotension: Cardiology consult + synchronized cardioversion (transfer to IMC/ICU)


Hello, for patient in 675/
Monitor room just called and said he had a run of 10 beats of VTach, no new complaints from the patient, still complaining of 9/10 L shoulder pain, states pain unchanged.

“Patient in 455 keeps having runs of VTach”

- **<30 seconds = nonsustained**
  - Asymptomatic/asleep: restart or increase home beta blocker
  - Document in cross cover notes
  - Can check central line placement, K>4, Mg>2
- **>30 seconds = sustained**
  - Symptoms → automatic cardiology consult
  - Pacer pads, ICU transfer, amiodarone

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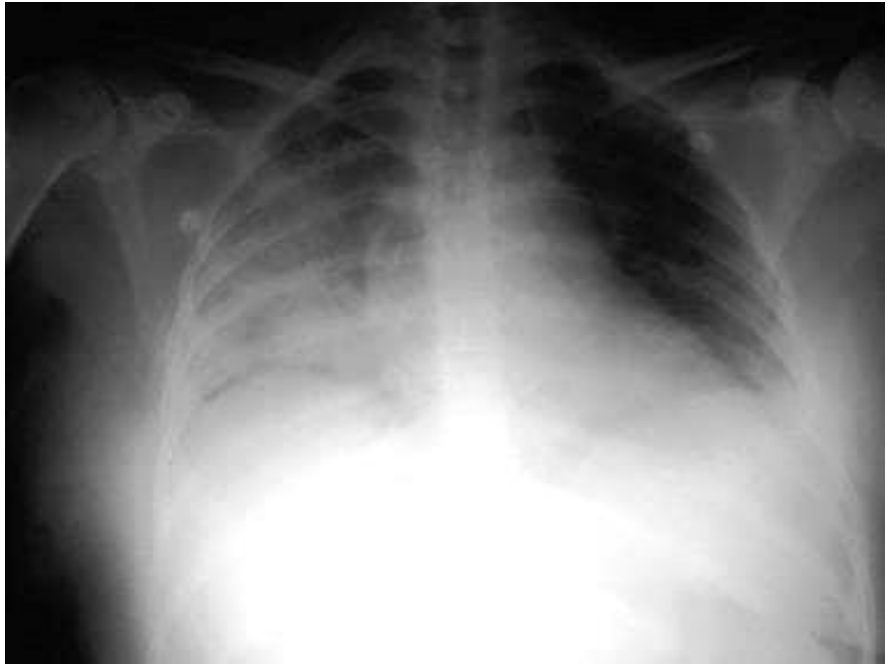
Pulmonary

Dyspnea

1. Go see the patient.
2. Order a CXR +/- VBG lactate.
   - Looking for pulmonary edema, pleural effusions, pneumonia, pneumothorax, widened mediastinum +/- pCO2 elevations
3. Exam findings:
   - Crackles: diuresis, stop IVF
     i. Lasix dose INCREASES with age and Cr
   - Stridor: ICU, racemic epinephrine, IV methylprednisolone 125mg
   - Wheezing: Albuterol 10-20mg, ipratropium 0.5mg, IV steroids

Practice using the patient context…



Mr. Menardi was found altered after a grand mal seizure where he was drooling, choking on his own spit, and may have vomited.

What's the most likely diagnosis?

A. Aspiration pneumonia
B. Aspiration pneumonitis
C. Disseminated fungal infection
D. Acute heart failure

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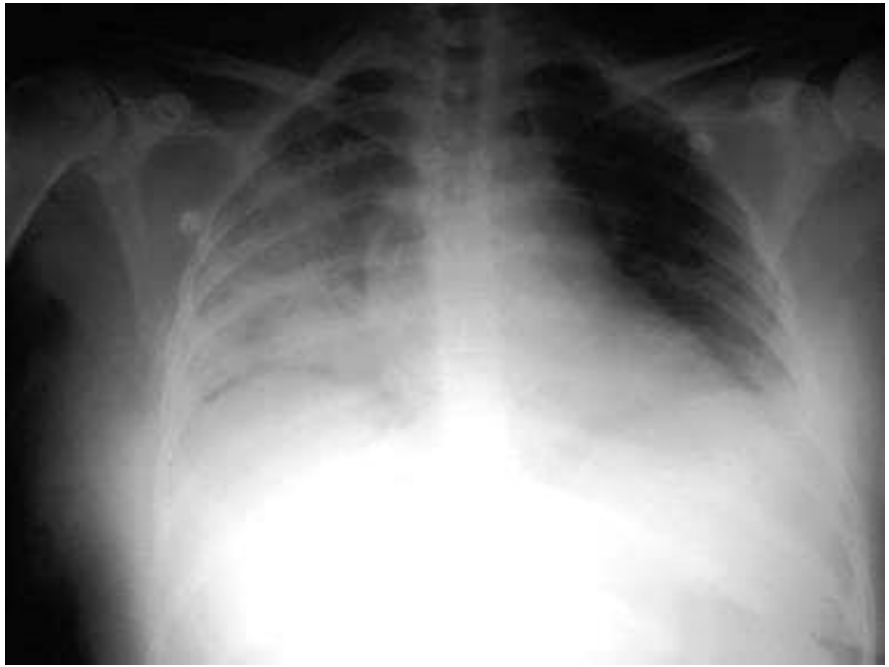

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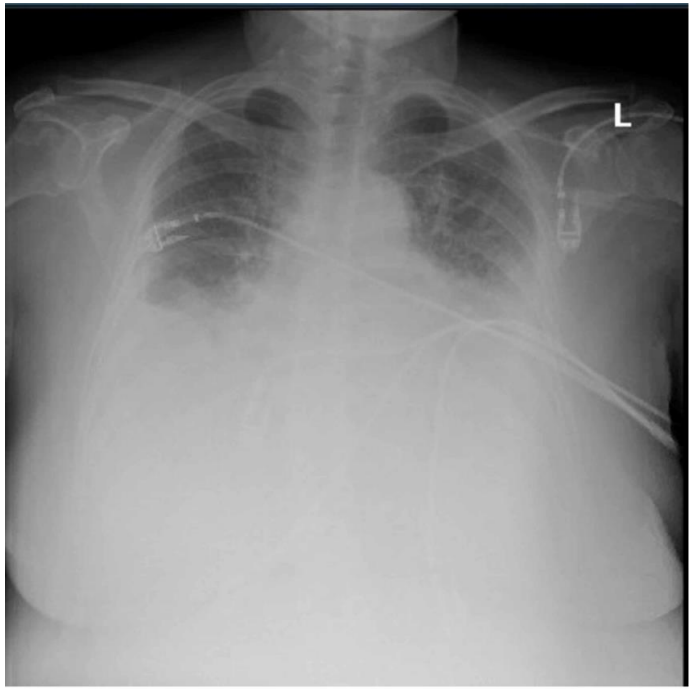
→ **Ampicillin-sulbactam … maybe?**

Mrs. Mary Elle is now on 6L O2…



Mrs. Mary Elle came in with dehydration and heat stroke and has been on 100/hr of LR for 3 days. Tonight, she was coughing and her pulse ox read 84% on room air.

What's the most likely diagnosis?

A. Aortic dissection
B. Pulmonary embolus
C. Malignancy
D. Pulmonary edema

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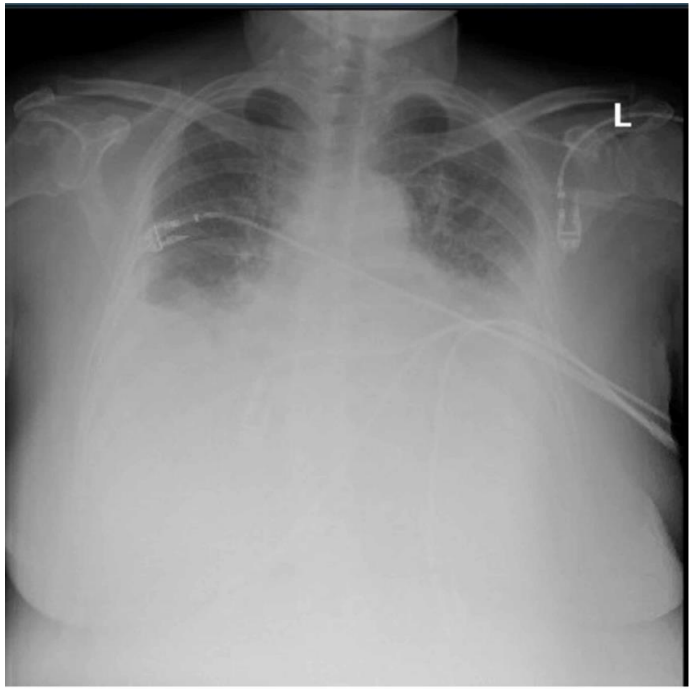

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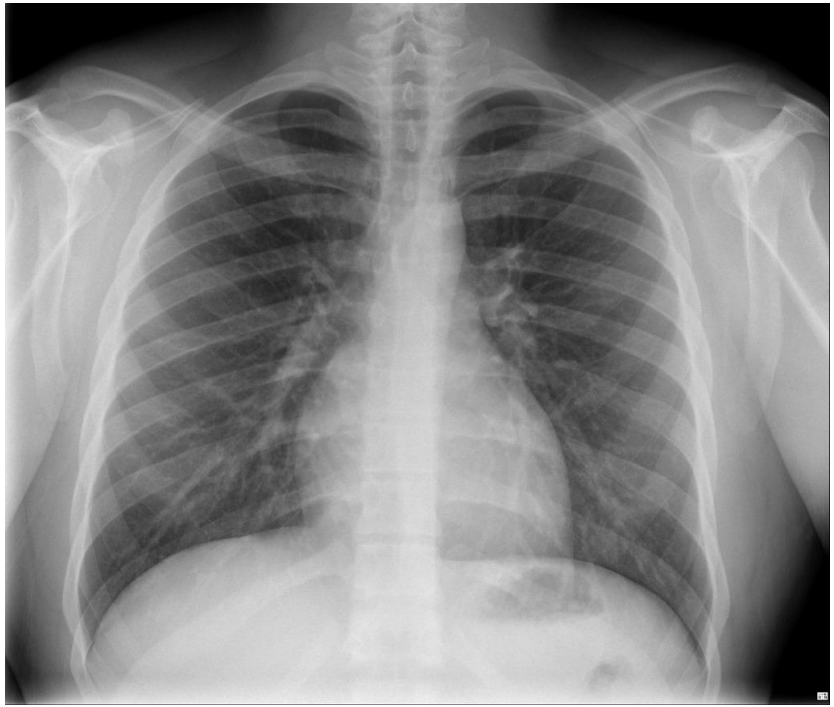
→ **IV furosemide 20-80mg**



Mr. Owale was admitted 3 days ago with cellulitis. While his leg has been improving, he was noted to be progressively “sleepy” throughout the afternoon and tonight is so groggy he only awakens to sternal rub. Neurologic exam is otherwise normal when he is awake enough to participate.

CXR shown. VBG: pH 7.2 / pCO2 78 / Lact 1.1

Hypercarbic respiratory failure

- OSA/OHS
- Opioids / benzodiazepines
- Ammonia

BiPAP: Not a cure-all, but pretty close

Initial settings: **IPAP 10/ EPAP 5 “10/5”**
Increase IPAP if higher resistance airway
Limitations: Not protecting airway, vomiting

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Gastrointestinal

Abdominal Pain

- Most common overnight:
  - constipation/ileus
  - gas/bloating (tube feeds/laxatives)
  - GERD/PUD
  - electrolyte derangement (low Mag/K or high Ca)
- Critically ill patients: never forget about possible ischemia or perforation
- Occasionally, but less common: new pancreatitis (post-ERCP), pyelo/cystitis (catheter-associated), atypical ACS, aortic dissection

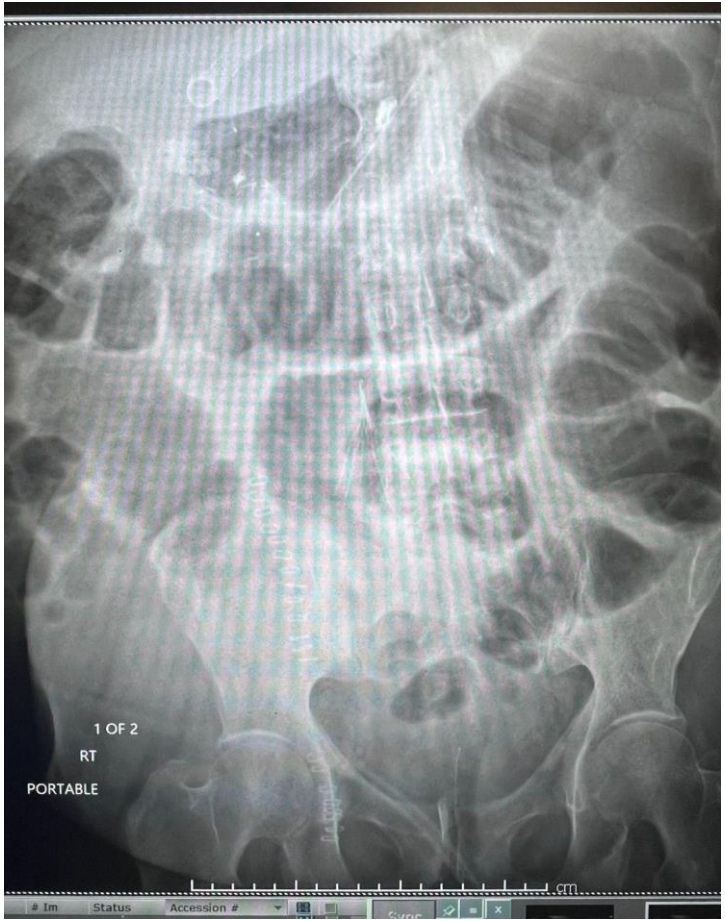
Hi 214 - TF have been off since 2030 d/t nausea. I gave zofran and phenergan but still nauseous. Hes had 2 BMs but just vomited and it looks fecal... Do you want a KUB?

7/6 11:53 PM

Ask when the last BM was!

… but remember partial obstruction is still possible, especially with liquidy BMs

- Stool softeners (from below always better… but ask if OK with patient)
- NG tube for decompression / NPO
- Minimize opioids if possible
- Can also use KUB/CXR to look for free air under the diaphragm
  - Lactate will rise with ischemia
  - POCUS to look for free fluid
  - Surgical eval if acute abdomen



Constipation[11]

- Most patients tolerate **polyethylene glycol** (MiraLax) 17g well with minimal side effects; PO **senna** (2 tablets; 17.2mg) and PO **bisacodyl** (dulcolax) 10mg also relatively gentle
  - Docusate (colace) no better than placebo in multiple studies[12]
  - Magnesium oxide 400mg PO bid (milk of magnesia) and lubiprostone (Linzess) works equally well for patients on chronic opioids[13]

➔ **Magnesium citrate** 296mL and **lactulose** 30mL oral liquids work well but very poor patient tolerability

- If no improvement with orals or already taking, offer bisacodyl suppository 10mg or enema (**Fleet (sodium phosphate)**, Soap suds, Tap water, milk of molasses)
  - Avoid Fleet (sodium phosphate) in ESRD patients

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Urologic

Pt in 321 not voided in 8 hrs. She is comfortable. Bladder scan shows 410 in her bladder. No orders for in and out Cath. Do you want to put in a foley?

2:34 AM • 4 days left

Urinary Retention

- Common post-operatively, post-CVA, after >48 hours of indwelling foley, and if on multiple opioids/anticholinergics
- Order a **bladder scan** if no void for 6-8 hours or patient discomfort
  - >300cc, consider intermittent urinary catheterization (“in and out cath”); if no discomfort, can hold off until >450cc
- **Avoid indwelling foleys** (infection risk) if possible…
  - Good reasons: strict measurement of urine output (renal failure, aggressive diuresis), groin or sacral wounds, prolonged immobilization
  - Consider placement after >3 intermittent caths (but not a must)
- Males should stand to urinate, ambulation helps

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Neurologic

Altered Mental Status

What first comes to mind?

- ➔ **Delirium**, sundowning, infection, hypoxia, hypercarbia, **medications**, illicit substances, **withdrawal**, hepatic encephalopathy, seizure
  - ◆ Withdrawal most common in first 1-3 days
  - ◆ If within 24 hours of admission, intoxication is possible as well
- ➔ If somnolent, check VBG for hypercarbia
  - ◆ Check ammonia if liver disease or on valproic acid
  - ◆ Narcan if receiving opiates AND ↓RR, ↓BP, not protecting airway
    - **0.4** - 1mg IV if acute, 0.1 - 0.2 mg if opiate dependent

in 555 here with alcohol withdrawal and pancreatitis. He's pulling off all his tele leads and trying to remove DHT. Can you order Ativan?

2:36 AM • 4 days left

Delirium

- **Goal #1 is <u>patient and staff safety</u>**
  - We only sedate patients if they are at risk of harming themselves or those around them
  - Pulling out IVs, central lines, NG/DHT, foley catheters or any other indwelling device can significantly impact care or cause bleeding
- If secondary to sundowning in dementia patients + elderly:
  - IV/IM **haloperidol** 5mg is the most studied and best tolerated
- In other patients with underlying behavior or psychiatric disorder:
  - PO **olanzapine** 5-10mg, IM olanzapine 5-10mg, IV olanzapine 2.5mg

Delirium

- **Benzodiazepines?**
  - Sometimes, in select circumstances…
  - Severe agitation (screaming, violence toward staff, harming self)
  - If QTc severely prolonged (>500)
  - Refractory to antipsychotics
  - Can make delirium worse in the elderly
- Dosing: **Lorazepam** - IV 1-2mg or PO 0.5, 1, or 2mg
- Generally try to avoid IV anticholinergics (diphenhydramine/hydroxyzine)
  - *Can worsen delirium and cause urinary retention*

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Miscellaneous

Good morning. Plts 39, Hgb 6.6 for 752. Yesterday was Plt 28 and Hgb 7.2

3:13 AM • 4 days left

Morning Labs & Transfusions

- ★ RBC Transfusion goal for most patients is Hgb>7
  - Exceptions:
    - acute CAD/ischemia, keep Hgb>8
    - sickle cell: no transfusion if at baseline Hgb (even 5-6)
  - Transfuse 1u at a time unless active bleeding
  - Hgb can drop 2-4 points s/p surgery or IVF resuscitation
- ★ Platelet Transfusion goal for most patients is Plt>10
  - Risk of spontaneous intracranial hemorrhage if <10
  - If active bleeding, general rule is transfuse to keep plt>50

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Documentation

Why write Cross-Cover notes?

- Communicate clinical changes or symptoms that may not be obvious the next day or charted in vital signs
- Explain **clinical context & medical decision making**
- Takes away guesswork of "*why did night shift do this*?"
- Outlines differential diagnosis
- Describes why diagnostics, therapeutics were ordered
- **Bill for critical care time >35 min**

+ Communicates all of the above to all team members and consultants who may not be present at check out

Try to keep succinct, organized, and methodical (i.e. do it the same way every time, develop a "style")

- Time notified and explanation of incident
- Focused physical exam
- POCUS findings or procedures
- New labs or imaging ordered, along with results
- Brief assessment and plan with justification (differential diagnoses)
- Update on clinical status after interventions

→ I also include if I discussed with RN, RT, specialists, patient family, etc.

Take-Home Points

- Don’t treat numbers, treat the patient
- Emphasize reassurance and clear guidelines
- Put the patient in context
- Nurses, RT, and pharmacy are your allies
- Document your thinking and bill appropriately
- Warm handoff to the day team

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Guide to Night Medicine

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Thank You!

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