Night Hospitalist Rotation
Resident Orientation

This is a two-week rotation designed to mirror the role of a night hospitalist, wherein you will admit and provide care to patients who require admission to the hospital in the evening once the wards teams have capped. This is very different than admitting on wards as 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

- **Two Night Admitting Residents** (**NAR's**; 4pm-8am, 6pm-8am): Primarily responsible for admitting holdovers, medicine consults, 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, triages admissions, and staffs admissions and consults with the NAR's.
- **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 Hospitalist Attending on duty at the start of your shift by calling x74765 or paging the Medicine On-Call pager. Supervise sign-out from ward interns to night float interns starting at 4pm.
- **Admissions:**
    - Each NAR can admit up to 10 new patients.
    - You 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 and consults will be triaged and distributed by the Swing Hospitalist Attending. Discuss assessment and plans for these patients with the Swing Hospitalist.
    - **11:00pm – 7:00am:** You will be responsible for managing the Medicine On-Call pager, including admission triage, consult triage and assessment, and emergent lab follow-up.
    - **5:00am – 6:00am**: You are still responsible for admissions paged out during this time. During the last hour of the admission window, you are expected to perform a full evaluation and triage patients as best able according to clinical flow. If you are bolused admissions during this last hour, prioritize the

most ill patient(s) and holdover stable admits as you would below for any pages received in the 6-7am window. Keep in mind that these patients may not be seen by a provider for another 1-2 hours.
    - **6:00am – 7:00am:** Admissions may be requested from the ED. You are expected to perform a triage assessment rather than a complete assessment and admission orders. The assessment includes discussing the patient's reason for admission and initial clinical data with the ED provider. If the patient is appropriate for admission, add the patient to the admission list and notify the incoming Day Hospitalist Attending.
    - **7am:** Meet the Day Hospitalist Attending in the assigned morning sign-out workspace to review admissions and assign patients 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).
    - **7:30-8:15am:** Sign-out holdovers to the ward and hospitalist residents. The NAR must assign primary contact of each patient to the resident they signed out to before leaving the hospital to ensure no patient communication is missed.
- **Admissions Hard Cap:**
    - The admission hard cap is defined as 10 new admissions per resident (20 patients total across 2 NARs).
    - Consults and cross-cover patients do not count toward the hard cap.
    - Upon admission of the 21st patient, notify the Hospitalist Attending and hand off the Medicine On-Call pager. Additional admissions beyond 20 patients will be admitted by the Night Hospitalist Attending.

ADMITTING AND TRIAGE

- **Inpatient versus Observation:** Patients will be admitted under Medical Observation or Inpatient status. The level of care is guided by InterQual (process by Utilization Management) and clinical judgment (Medicine team).
    - When the Hospitalist Attending is present, the attending will determine the level of care based on the InterQual result and the patient's assessment.
    - All patients meeting InterQual criteria for inpatient admission ("InterQual met") should be admitted to inpatient.
    - Occasionally, patients with private insurance will only authorize observation status. These patients should be placed observation and will be re-assessed during the day.
    - Patients under Observation remain boarding in the ED. In general, no more than 6 patients should be under observation status at a time.
- **'Holdover Orders' for Inpatient Admissions:** Holdovers are focused 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 workload permits you may consider more in-depth evaluation 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 than 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.
    - Flag Observation status when discussing patients with the Day Hospitalist Attending.
- **Medication 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 available at that time. Note that this is a two-step process within ORCHID.
    - First, complete the "Document Meds by Hx" task which ensures that the patient's prior-to-admission medication list is accurate, along with compliance/adherence data.
    - After confirming the prior to admission medication list, complete the Admission Medication Reconciliation task to actually order or discontinue the medications for the inpatient setting
    - Avoid ordering home medications "de novo" and instead use the medication reconciliation tool.
- **Staffing & Documentation:**
    - For holdover patients assigned before 11pm, you should perform a complete H&P and staff with the Swing Hospitalist Attending. Use the "History and Physical" note type in ORCHID and document that you have "Discussed with attending Dr. _" at the bottom of the note.
    - For holdover patients assigned after 11pm, you should at minimum perform a focused Admission evaluation. This includes documenting presenting history, any acute events, consults called and their recommendations, the problem list, and orders placed. These cases are only briefly discussed in the morning with the Day Hospitalist for triage purposes. Document using the "History and Physical" note type with the title "Medical Resident Admission Note" or "MRAN." At the bottom of the note, indicate that you have discussed the with the Day Hospitalist and that final assessment and plan will be discussed with the accepting primary team and attending.
    - Documentation should be sufficient to communicate important information and clinical decision-making. Remember, when you and the night ER resident leave in the morning, so does the knowledge 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.
- **Triaging:** When the ER pages an admission, please call for 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 that there is insufficient data to determine the appropriate level of care (ie: med-surg vs. SDU vs. ICU) or appropriate primary service (ie: medicine vs. surgery vs. MAC transfer) it is acceptable to ask the ER for further work-up before accepting the patient to Medicine. It is best practice to evaluate the patient yourself to determine this, unless there is an obvious indication for a different level of care or service. 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.
- **Admission list:** Add all admissions to the **OVMC Medicine Night** care team list in ORCHID and assign yourself as the primary contact. You will also be given a paper list which is a preliminary copy of the next day's admission list. All holdovers/consults/OBS patients/ICU transfers that are paged out should be written on this list (name/MRN/time of admit/who did the holdover/diagnosis). Think of it as an accounting check 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 reviewed by the Hospitalist Attending for triage. The order in which the holdovers are listed on the preliminary list does not indicate which team they will ultimately go to. This will be determined on triaging in the morning with the Day Hospitalist.

- **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 list and tell the ICU to page Medicine On-call after 7am for the accepting team assignment.
- **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 pass on 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 Hospitalist Attending on duty to staff the patient. These types of urgent consults from 11pm-7am are very rare.
- **Admission to other services:** Occasionally, you may discuss a case with the ED provider and determine that a different disposition is more appropriate, e.g. admission to another service. The ED provider should continue care and take the appropriate action. If there is disagreement between you and the ED about the disposition of a patient and the disagreement cannot be resolved after discussion with the ED attending, contact the Hospitalist Attending on duty.
- **MAC/Outside transfers/EMTALA:** If you are contacted regarding a new MAC transfer to Olive View, 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 Hospitalist Attending on duty. Some patients have already been accepted and will arrive during your shift. These count as admissions towards your cap.

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.
- **Hospitalist Attending: A Hospitalist Attending is on duty at all hours and available by pager** (if no answer, then contact by cell phone; if unavailable please contact ANO office or page Chief Resident on Call). The Hospitalist Attending on duty is the Swing Hospitalist from 3pm to 11pm, then the Night Hospitalist from 11pm to 7am. Note that the Night Hospitalist listed on Amion starts at 11pm on the calendar day listed; so from midnight to 7am, the Night Hospitalist on duty is the attending starting at 11pm the day before. The Hospitalist Attendings are responsible for any issues with the inpatient hospitalist service, medicine ward service, holdover patients, medicine consult, and triage questions. Do not hesitate to call the 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. These patients tend to be sicker and can decompensate very quickly, so do not hesitate to contact the fellow for any clinical questions. You should also encourage your Night Float interns to do so.

CODES/RRT

- Please respond to all calls for Code Blue and Rapid Response Team (RRT) overnight to assist the ICU night team. Once the ICU team is present and the patient is being stabilized, please check in with the ICU team prior to leaving the code area to see if they require your continued assistance in the code/RRT.